Patient Primary Complaint Form

Name:_____ Date:_____

What is the number one thing that bothers you the most today:

_____

_____

When did your pain begin? _____

Pain Level: **0 1 2 3 4 5 6 7 8 9 10**

Is your condition: **getting better getting worse**

Is your condition: **on & off or constant**

Type of pain: **Sharp Stabbing Burning Achy Dull Stiff &Sore**

Radiating: **Left/Right Base of Skull Shoulder Arm Hand Hip Leg Knee Foot Ribs Other:**_____

What makes it better? **Ice Heat Rest Movement Stretching Other:**_____

What makes it worse? **Sitting Standing Walking Lying down Sleep Overuse Other:**_____

Have you seen anyone else for this condition?

_____

Were you involved in an accident? **(Auto, Fall, Work etc?)**

_____

PATIENT CONFIDENTIALITY PERSONAL DATA

Date_____
Patient:_____ **Date of Birth:**_____
Home Address:_____ **City:**_____ **State:**____ **Zip:**____
Social Security No.:_____ **Home Phone:**_____ **Mobile:**_____
Work Phone:_____ **Email:**_____
Employer:_____ **Address:**_____
Name of Spouse:_____ **SS No.:**_____ **No. of Children:**___
Spouse's Employer:_____ **Address:**_____
Emergency contact:_____ **Relationship**_____ **Phone:**_____
Who is responsible for payment? _ Self _ Spouse _Other_____

PATIENT'S INSURANCE	SECONDARY/SPOUSE'S INSURANCE
Name of Company:_____	**Name of Company:**_____
Address:_____	**Address:**_____
ID & Group No.:_____	**ID & Group No.:**_____
Phone No.:_____	**Phone No.:**_____

Primary insured's DOB (if other than patient)_____
Purpose of this appointment and list your complaints:_____

_____
Date of illness: _____ **Time:**_____ **Location:**_____
How did accident occur? _ Auto _ On the job _ Other_____
Please describe the circumstances and what makes the condition(s) better or worse_____

_____
Other Doctor seen for this condition:_____
Have you been treated by a Doctor for any health condition in the last year? _ Yes _ No
If yes, please describe:_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature
Physician:_____ **SignaturePatient:**_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATON

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature:_____
Parent's or Guardian's Signature:_____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Stiff joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Spasms
- ❑ Broken bones
- ❑ Shoulder pain

GENITO-URINARY SYSTEM

- ❑ Bladder trouble
- ❑ Excessive urination
- ❑ Scanty urination
- ❑ Painful urination
- ❑ Discolored urine

FEMALE

- ❑ Vaginal discharge
- ❑ Vaginal bleeding
- ❑ Vaginal pain
- ❑ Breast pain
- ❑ Lumps on the breast

ARE YOU PREGNANT?
❑ YES ❑ NO

GASTRO-INTESTIONAL SYSTEM

- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Difficult swallowing
- ❑ Excessive thirst
- ❑ Nausea
- ❑ Vomiting Blood
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stool
- ❑ Bloody stool
- ❑ Hemorrhoids
- ❑ Liver trouble
- ❑ Gall bladder problems
- ❑ Weight trouble

NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss of feeling
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

HABITS

- ❑ Cigarettes
- ❑ Alcohol Abuse
- ❑ Coffee or Tea
- ❑ Drug Abuse
- ❑ _____

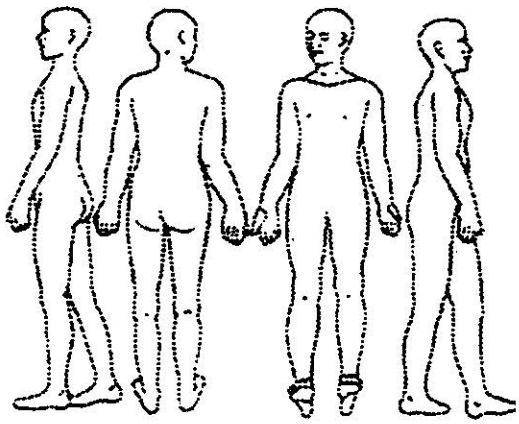
CARDIO-VASCULAR RESPIRATORY

- ❑ Chest pain
- ❑ Pain over heart
- ❑ Difficult breathing
- ❑ Persistent cough
- ❑ Coughing phlegm
- ❑ Coughing blood
- ❑ Rapid heartbeat
- ❑ Blood pressure problems
- ❑ Heart problems
- ❑ Lung problems
- ❑ Varicose veins

EYE, EAR, NOSE AND THROAT

- ❑ Eye strain
- ❑ Eye inflammation
- ❑ Vision problems
- ❑ Ear pain
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose pain
- ❑ Nose bleeding
- ❑ Nose discharge
- ❑ Difficult breathing through nose
- ❑ Sore gums
- ❑ Dental problems
- ❑ Sore mouth
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Sinus
- ❑ Allergy
- ❑ Jaw Pain

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

• DO NOT WRITE BELOW THIS LINE •

_____

_____

_____

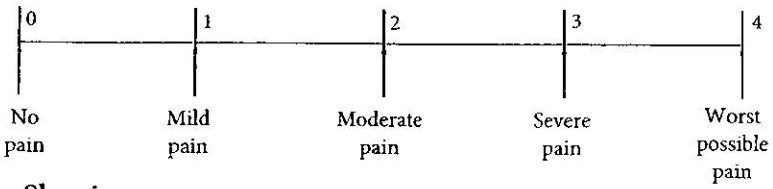
_____

Patient Accepted? ❑ Yes ❑ No Doctor's Signature _____

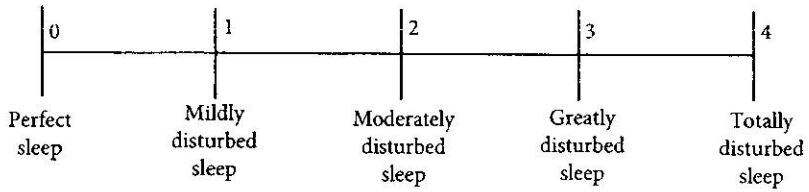
Functional Rating Index

In order to properly assess your condition, we must understand how much your condition has affected your ability to manage everyday activites. For each item below, **please circle the number which most closely describes your condition right now.**

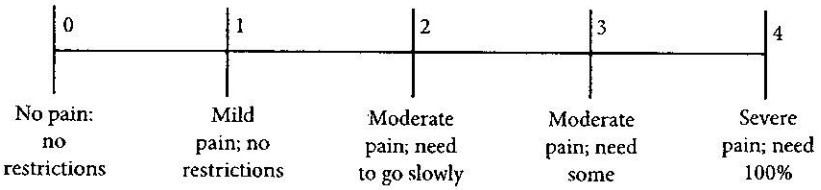
1. Pain Intensity



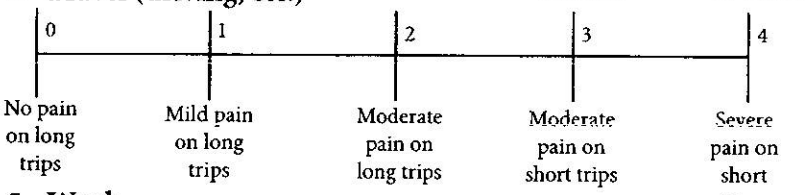
2. Sleeping



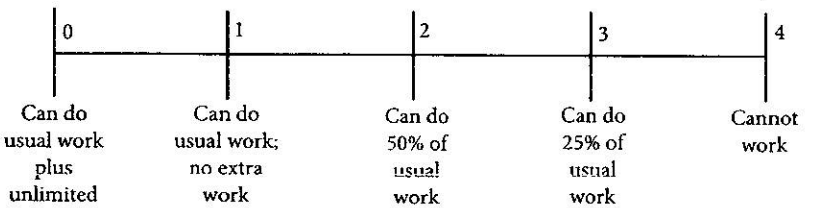
3. Personal Care (washing, dressing, etc.)



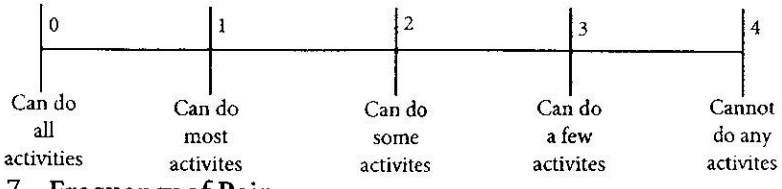
4. Travel (driving, etc.)



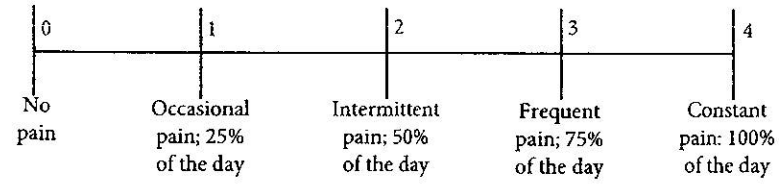
5. Work



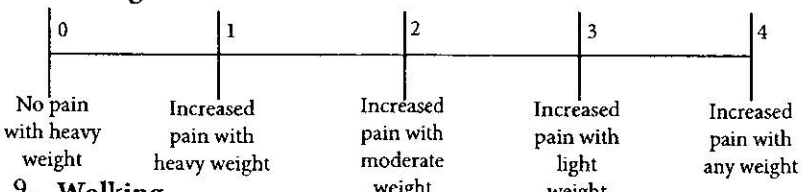
6. Recreation



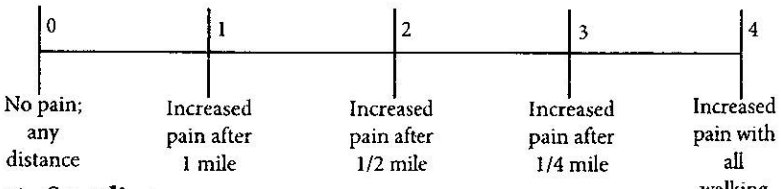
7. Frequency of Pain



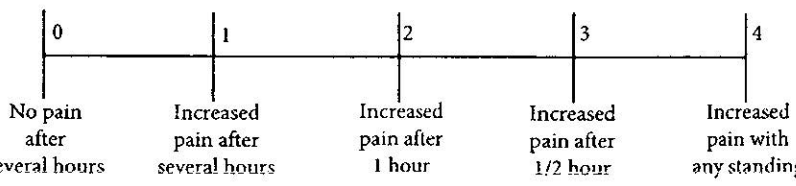
8. Lifting



9. Walking



10. Standing



Name_____

PRINTED

Total Score_____

_____

Signature

_____

Date