PATIENT INFORMATION

Date: _____ First Name: _____ MI: _____ Last Name: _____ Age: _____

Mailing Adress: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: S M W D Spouse's Name: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Cell Carrier: (Verizon, Sprint, etc.): _____ Accept Texts? Y/N Email: _____

Contact Preference: ☐ Cell ☐ Email Emergency Contact/Phone: _____

Your Occupation: _____ Employer/Name of Company: _____

How did you hear about us: ☐ Friend/Family (Name: _____), ☐ Yellow Pages, ☐ Office Sign

Internet (which site? _____), Other _____

FINANCIAL INFORMATION

☐ Self Pay

Health Insurance: ☐ Medicare ☐ Aetna Medicare ☐ TriWest ☐ Auto

Please check one payment type: ☐ Cash ☐ Check ☐ Credit/Debit Card

ASSIGNMENT & RELEASE

I authorize release of information to family physicians and employer.
I authorize release of information to insurance companies.
I authorize the taking of x-rays to be used for treatment purposes.
I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
I authorize my insurance benefits to be paid directly to Long Chiropractic.

Patient's Signature (or parent for a minor): _____ Date _____

PAYMENT POLICIES

1. PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.

2. At the completion of your first visit you will be advised as to a time you can return for your examination results and whether or not your case has been accepted. You will then also be advised concerning financial arrangements and insurance coverage as appropriate.

I acknowledge that I am financially responsible for non-covered services.

Patient's Signature (or parent for a minor): _____ Date _____

PATIENT'S MEDICAL HISTORY

Patient Name: _____ Date: _____

CONDITIONS & OFFICIAL DIADNOSES (EX: DIABETES, HIGH BLOOD PRESSURE, CANCER, STROKE, ETC.):

Name of condition, disease, or official diagnoses	Date Diagnosed	Still a problem?
_____	_____	Y / N
_____	_____	Y / N
_____	_____	Y / N

CURRENT & RECENT PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS, SUPPLEMENTS & HERBS:

Name of medication	Purpose of medication	Still taking?
_____	_____	Y / N
_____	_____	Y / N
_____	_____	Y / N

ALLERGIES TO MEDICATIONS, FOODS, INDOOR OR OUTDOOR ALLERGENS:

Description of allergy	Reaction to allergen
_____	_____
_____	_____
_____	_____

SURGERIES, HOSPITALIZATIONS, E.R. VISITS, TRAUMAS, ACCIDENTS & MAJOR ILLNESSES:

Description of event	Date occurred
_____	_____
_____	_____
_____	_____

SOCIAL / LIFESTYLE FACTORS THAT AFFECT OVERALL HEALTH & HEALING CAPACITY:

Current or former smoker? Y / N Describe frequency: _____

Do you drink alcohol? Y / N Describe frequency: _____

Drink caffeinated beverages? Y / N Describe frequency: _____

Recreational drug use? Y / N Describe frequency: _____

Exercise: Y / N Describe frequency: _____

PATIENT'S CURRENT COMPLAINTS

Patient Name: _____ Date: _____

MAIN COMPLAINT:_____

When did it start?_____

What caused it?_____

Mark location of pain on the figure to the right with "xxx's"

Description: Sharp, dull, tingling, numb, other:_____

Pain scale: Mark below; far left (no pain) far right (worst pain)

0 1 2 3 4 5 6 7 8 9 10

Frequency: ☐25% ☐50% ☐75% ☐100% of the time?

Other info.:_____

_____

SECOND COMPLAINT:_____

When did it start?_____

What caused it?_____

Mark location of pain on the figure to the right with "xxx's"

Description: Sharp, dull, tingling, numb, other:_____

Pain scale: Mark below; far left (no pain) far right (worst pain)

0 1 2 3 4 5 6 7 8 9 10

Frequency: ☐25% ☐50% ☐75% ☐100% of the time?

Other info.:_____

_____

THIRD COMPLAINT:_____

When did it start?_____

What caused it?_____

Mark location of pain on the figure to the right with "xxx's"

Description: Sharp, dull, tingling, numb, other:_____

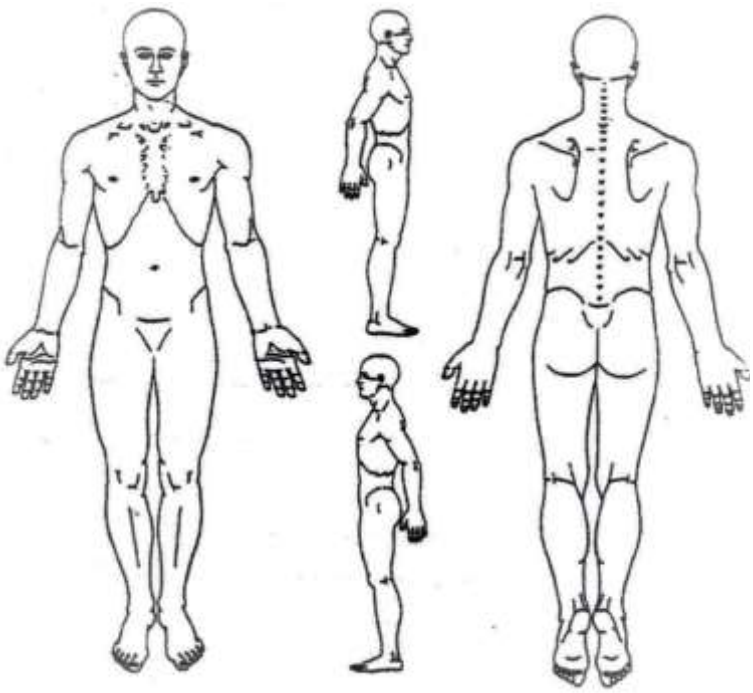
Pain scale: Mark below; far left (no pain) far right (worst pain)

0 1 2 3 4 5 6 7 8 9 10

Frequency: ☐25% ☐50% ☐75% ☐100% of the time?

Other info.:_____

_____



GENERAL QUESTIONS:

What have you tried to alleviate your pain?

_____

_____

What seems to aggravate your pain?

_____

_____

List health care providers you have seen for your complaints

_____

_____

Who is your Primary Care Physician/Family Doctor?

Name & city:_____

Have you ever seen a Chiropractor? Y / N

Name & city:_____

When was your last chiropractic treatment? _____

FEMALES: Possibility you are pregnant? Y / N

Last period:_____

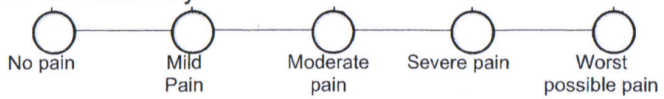
Any other concerns or requests?_____

Functional Rating Index

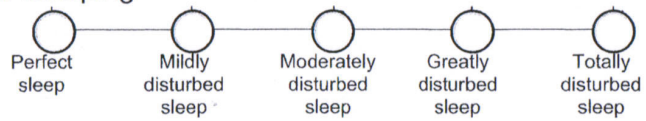
For use with **Neck and/or Back Problems** only

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please check the circle that most closely describes your condition right now.

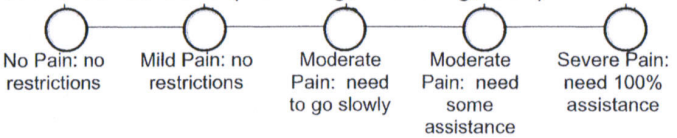
1. Pain Intensity



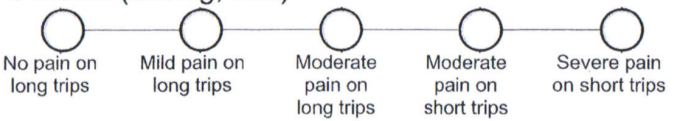
2. Sleeping



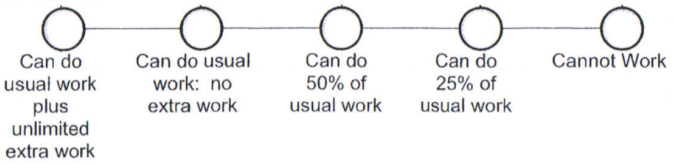
3. Personal Care (washing, dressing, etc.)



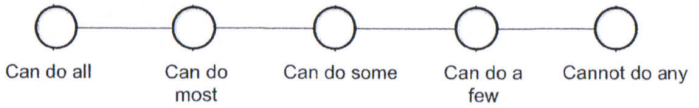
4. Travel (driving, etc.)



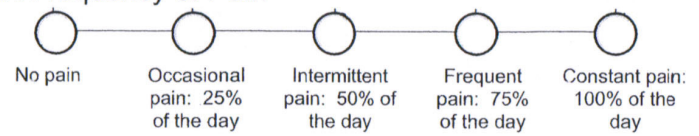
5. Work



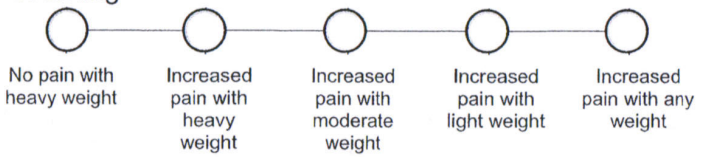
6. Recreation



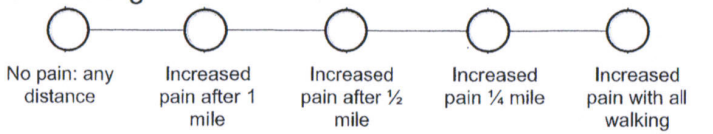
7. Frequency of Pain



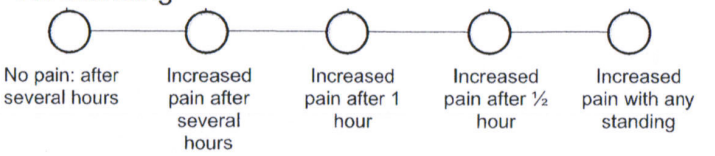
8. Lifting



9. Walking



10. Standing



Patient Signature _____ Date _____