

PATIENT INFORMATION

Date: _____ First Name: _____ MI: _____ Last Name: _____ Age: _____
Mailing Address: _____ 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.):

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

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

<u>Name of medication</u>	<u>Purpose of medication</u>	<u>Still taking?</u>
_____	_____	Y / N
_____	_____	Y / N
_____	_____	Y / N

ALLERGIES TO MEDICATIONS, FOODS, INDOOR OR OUTDOOR ALLERGENS:

<u>Description of allergy</u>	<u>Reaction to allergen</u>
_____	_____
_____	_____
_____	_____

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

<u>Description of event</u>	<u>Date occurred</u>
_____	_____
_____	_____
_____	_____

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"

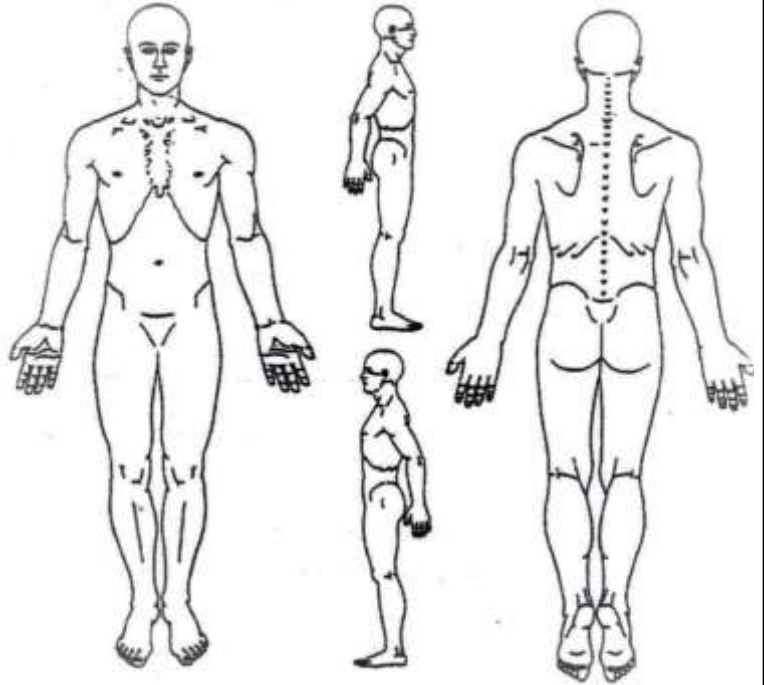
Description: Sharp, dull, tingling, numb, other: _____

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

☐ — ☐ — ☐ — ☐ — ☐

No pain Mild Pain Moderate pain Severe pain Worst possible pain

2. Sleeping

☐ — ☐ — ☐ — ☐ — ☐

Perfect sleep Mildly disturbed sleep Moderately disturbed sleep Greatly disturbed sleep Totally disturbed sleep

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

☐ — ☐ — ☐ — ☐ — ☐

No Pain: no restrictions Mild Pain: no restrictions Moderate Pain: need to go slowly Moderate Pain: need some assistance Severe Pain: need 100% assistance

4. Travel (driving, etc.)

☐ — ☐ — ☐ — ☐ — ☐

No pain on long trips Mild pain on long trips Moderate pain on long trips Moderate pain on short trips Severe pain on short trips

5. Work

☐ — ☐ — ☐ — ☐ — ☐

Can do usual work plus unlimited extra work Can do usual work: no extra work Can do 50% of usual work Can do 25% of usual work Cannot Work

6. Recreation

☐ — ☐ — ☐ — ☐ — ☐

Can do all Can do most Can do some Can do a few Cannot do any

7. Frequency of Pain

☐ — ☐ — ☐ — ☐ — ☐

No pain Occasional pain: 25% of the day Intermittent pain: 50% of the day Frequent pain: 75% of the day Constant pain: 100% of the day

8. Lifting

☐ — ☐ — ☐ — ☐ — ☐

No pain with heavy weight Increased pain with heavy weight Increased pain with moderate weight Increased pain with light weight Increased pain with any weight

9. Walking

☐ — ☐ — ☐ — ☐ — ☐

No pain: any distance Increased pain after 1 mile Increased pain after ½ mile Increased pain ¼ mile Increased pain with all walking

10. Standing

☐ — ☐ — ☐ — ☐ — ☐

No pain: after several hours Increased pain after several hours Increased pain after 1 hour Increased pain after ½ hour Increased pain with any standing

Patient Signature

Date