

DATE: _____

PATIENT INFORMATION

NAME: _____ E-MAIL: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ REFERRED BY: _____

BIRTH DATE: _____ SOCIAL SECURITY #: _____

HEIGHT: _____ WEIGHT: _____ RIGHT OR LEFT HANDED: RIGHT LEFT

MARITAL STATUS: MARRIED/SPOUSE'S NAME: _____ SINGLE DIVORCED WIDOWED

OCCUPATION: _____ EMPLOYER: _____

HEALTH HISTORY

HAVE YOU EVER HAD ANY SURGERY? YES NO IF YES, PLEASE DESCRIBE BELOW AND GIVE APPROXIMATE DATE.

HAVE YOU EVER FRACTURED A BONE OR HAD A SEVERE SPRAIN TO A JOINT? YES NO IF YES, PLEASE DESCRIBE BELOW AND GIVE APPROXIMATE DATE.

ARE YOU CURRENTLY TAKING ANY MEDICATION? YES NO IF YES, PLEASE LIST BELOW.

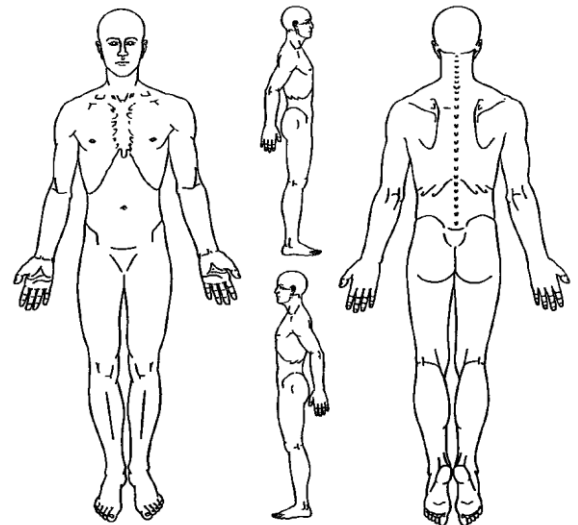
HAVE YOU EVER BEEN INVOLVED IN AN AUTO ACCIDENT OR OTHER INJURY THAT REQUIRED MEDICAL CARE?
 YES NO IF YES, PLEASE DESCRIBE BELOW AND GIVE APPROXIMATE DATE.

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? YES NO DOCTOR: _____

DO YOU CURRENTLY HAVE A FAMILY PHYSICIAN? YES NO DOCTOR: _____

OFFICE USE

SPECIAL MANAGEMENT



PATIENT INFORMATION

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY MEDICAL HEALTH PROBLEMS?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> DIGESTIVE DISORDERS | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> POLIO | <input type="checkbox"/> HEART CONDITION | <input type="checkbox"/> BOWEL DISORDER | <input type="checkbox"/> ALLERGIES |
| <input type="checkbox"/> FOOT PROBLEMS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> KIDNEY DISORDER | <input type="checkbox"/> SINUS CONDITION |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> CIRCULATION PROBLEMS | <input type="checkbox"/> PROSTATE PROBLEM | <input type="checkbox"/> EAR CONDITION |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> STROKE | <input type="checkbox"/> HERNIA | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> HYPOGLYCEMIA | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> FEMALE DISORDER | <input type="checkbox"/> TMJ PROBLEM |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> EPILEPSY / SEIZURE | <input type="checkbox"/> THYROID CONDITION | <input type="checkbox"/> FIBROMYALGIA |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> LYME DISEASE | <input type="checkbox"/> CARPAL TUNNEL | <input type="checkbox"/> CHRONIC FATIGUE |
| <input type="checkbox"/> NO HEALTH PROBLEMS | <input type="checkbox"/> OTHER | | |

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING DISEASES?

- | | | | | | |
|---|---------------------------------------|---------------------------------|---------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> GRANDPARENTS | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> SIBLINGS | <input type="checkbox"/> CHILDREN |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> GRANDPARENTS | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> SIBLINGS | <input type="checkbox"/> CHILDREN |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> GRANDPARENTS | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> SIBLINGS | <input type="checkbox"/> CHILDREN |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> GRANDPARENTS | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> SIBLINGS | <input type="checkbox"/> CHILDREN |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> GRANDPARENTS | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> SIBLINGS | <input type="checkbox"/> CHILDREN |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> GRANDPARENTS | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> SIBLINGS | <input type="checkbox"/> CHILDREN |
| <input type="checkbox"/> BACK / NECK PROBLEMS | <input type="checkbox"/> GRANDPARENTS | <input type="checkbox"/> FATHER | <input type="checkbox"/> MOTHER | <input type="checkbox"/> SIBLINGS | <input type="checkbox"/> CHILDREN |

PLEASE DESCRIBE YOUR HABITS THAT AFFECT YOUR HEALTH.

- | | | | |
|--|------------------------------|-----------------------------|---|
| 1. DO YOU EAT WHAT YOU THINK IS A WELL BALANCED DIET? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| 2. DO YOU EXERCISE REGULARLY? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| 3. DO YOU SLEEP 6-8 HOURS PER NIGHT? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| 4. DO YOU TAKE DAILY VITAMINS? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| 5. DO YOU DRINK 6-8 GLASSES OF WATER PER DAY? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| 6. DO YOU DRINK MORE THAN A COUPLE CUPS OF COFFEE EACH DAY? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| 7. DO YOU DRINK MORE THAN A COUPLE GLASSES OF SODA EACH DAY? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| 8. DO YOU DRINK ALCOHOLIC BEVERAGES? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOCIALLY ONLY <input type="checkbox"/> DAILY |
| 9. DO YOU SMOKE OR USE TOBACCO PRODUCTS? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | PACKS/CANS PER DAY? _____ |
| 10. DO YOU HAVE A STRESSFUL HOME OR WORK ENVIRONMENT? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| 11. ARE YOU OVERWEIGHT? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |

HAVE YOU EVER HAD ANY X-RAYS TAKEN OF YOUR NECK OR BACK?

YES NO

DATE: _____	BODY PART: _____	WHERE TAKEN: _____
DATE: _____	BODY PART: _____	WHERE TAKEN: _____
DATE: _____	BODY PART: _____	WHERE TAKEN: _____

FEMALES ONLY

TO THE BEST OF YOUR KNOWLEDGE ARE YOU PREGNANT? YES NO

WHAT WAS THE DATE OF YOUR LAST MENSTRUAL CYCLE? _____

HOW MANY CHILDREN DO YOU HAVE? _____

HM	HA	UPMC	SP	Van	MED	Sec B	Fre B	Adv	Am Pro	WC/AA	99202	99213	CMT	
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1. Name: _____ **Date:** _____

2. Main complaint: _____

3. Type of Problem: New Problem Return of the same problem Always some problem, worse now

4. Caused By: lifting bending reaching over exertion repetitive motion
 (choose one) slip / fall slept wrong unknown gradual worsening no injury

Describe the onset/injury: _____ Work Related

5. Quality of Pain: sore stiff ache tight sharp stab shoot catch
 (check all that apply to you) burn throb numb tingle asleep other: _____

6. Severity:

With Activity	0	1	2	3	4	5	6	7	8	9	10
	No pain		Mild pain			Moderate pain			Severe pain		Extreme pain
At Rest	0	1	2	3	4	5	6	7	8	9	10

7. When did this start? Started or worsened: (approximately) _____

8. Have you had similar problems? Last episode/Last occurred: _____ No similar problem in past

9. Timing: (check all that apply to you)

Worse: morning daytime night time with activity with inactivity same all day

Better: nothing helps moving stretching applying heat applying cold resting
 OTC meds RX meds lying down sitting standing walking

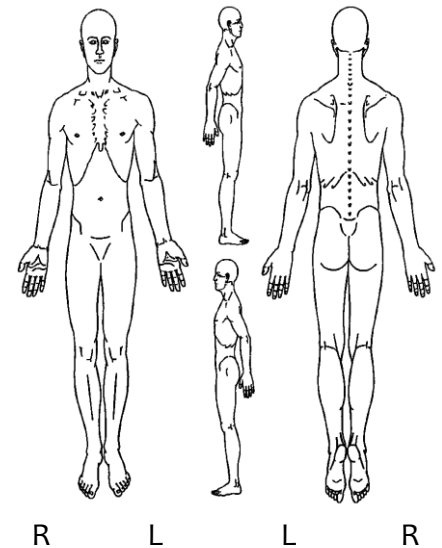
10. Other symptoms:

<input type="checkbox"/> headaches	<input type="checkbox"/> tingling/numb	<input type="checkbox"/> joint stiffness	<input type="checkbox"/> muscles spasm	<input type="checkbox"/> muscle knots	<input type="checkbox"/> chronic fatigue
<input type="checkbox"/> sleep problems	<input type="checkbox"/> hard to walk	<input type="checkbox"/> hard to breathe	<input type="checkbox"/> cold hands/feet	<input type="checkbox"/> dizziness	<input type="checkbox"/> swelling
<input type="checkbox"/> nausea/vomiting	<input type="checkbox"/> heartburn	<input type="checkbox"/> blurred vision	<input type="checkbox"/> depression	<input type="checkbox"/> anxiety/panic	<input type="checkbox"/> mood swings

Only mark a few activities that bother you the most.

11. Difficulty with ADL's (Activities of Daily Living)	Mild Pain But can do	Moderate Pain Limits ability	Severe Pain Unable to do
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended computer use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting / Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning / Moving head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rolling over / Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching up / out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job, occupational work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Shade the Areas of Symptoms



Prn	Res		M	T	W	R	F	M	T	W	R	F	2-3	3-4	1w	2wk	3wk	1mn		Prn	Res	
Same	Exac	Cont			CH	CBN	LSN	SN	CS	TS	LSS	SIS	CP	TP	LBP	C	T	L	S	I	UE	LE
2PC	1A	1DV	w/ A	w/ Pro				SP	PRN	1x	2x	3x	1w	2w	3w	4w		WE	1	2-3	3-4	6