

ADVANCED HEALTH SOLUTIONS

CHIROPRACTIC & DYNAMIC THERAPY

Date: _____
First Name: _____ Middle: _____ Last: _____
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Home Phone: _____ Cell Phone: _____
Address _____
City _____ State: _____ Zip: _____
SS# _____ Email: _____
Birth date: _____ Age: _____ Marital Status: S M W D
Job Title: _____ Work Phone: _____
Spouses Name: _____ Spouse's Birthdate: _____
Insurance Holder: _____
Name of Employer for Insurance Holder _____ City _____
Employer Phone: _____
Children: Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Emergency Contact: Name: _____ Phone: _____
Family Physician: _____ Phone: _____
Your Primary Complaint: _____ _____
Is this a work comp case: Y: <input type="checkbox"/> N: <input type="checkbox"/> Personal Injury: Y: <input type="checkbox"/> N: <input type="checkbox"/>

Patient Informed Consent:

I, _____, the undersigned patient, consent to the treatment(s) provided by this office. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the regions of my body that may need to be examined. I understand and consent to office staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the office staff providing said treatment (s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform office staff. There are times when individual other than staff may see me receive treatment at the office or overhear discussions of my condition or insurance, I consent to others perceiving these interactions at the office. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____

NAME: _____ DATE: ____ / ____ / ____ ACCT #: _____

History of Illness / Injury / Pain

LOCATION

Chief complaint and it's location: _____

What caused the onset? _____

Date of onset? ____ / ____ / ____

TIMING AND DURATION

How often do you experience this pain? ____ constant ____ frequent ____ intermittent ____ occasional

SEVERITY

Use the key below to rate the severity of your pain on a scale from 1 to 10

1 = minimal	6 = moderate to severe
2 = very mild	7 = mildly severe restricts some activity
3 = mild	8 = severe, limits most activity
4 = mild to moderate	9 = very severe
5 = moderate	10 = excruciating

What is the intensity of **your pain right now** on a scale from 0 to 10

0 1 2 3 4 5 6 7 8 9 10 _____

What is the **least intense** your symptom has been in the last 2 weeks?

0 1 2 3 4 5 6 7 8 9 10 _____

What is the **most intense** the symptom has been on a scale of 0 to 10?

0 1 2 3 4 5 6 7 8 9 10 _____

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ____ inflexibility ____ stiffness ____ spasms ____ cramps

Other: _____

How would you best describe the sensation of the pain/symptom? (Check all that apply)

Deadness		Dull		Shooting		Pulsating		Crawling		Excruciating	
Stabbing		Prickly		Sharp		Throbbing		Pins & Needles		Tingling	
Burning		Hurting		Numb		Aching		Stinging		Pounding	

Does your pain or symptom radiate or travel to legs arms or head, please identify where to: Yes No

MODIFYING FACTORS

What relieves this pain/symptom? (Check all that apply)

Resting		Sleeping		Heat		Cold		Sitting		Exercise/movement	
Shower		Advil		Tylenol		Aspirin		Pain meds		Treatment	
Mineral ice		Other: _____									

Doctor Signature: _____

NAME: _____ DATE: ____ / ____ / ____ ACCT #: _____

What aggravates the pain/symptom? (Check all that apply)

Flashing lights	Sneezing	Lifting	Exercising
Coughing	Sitting	Stooping	Looking side/side
Standing	Depression	Stress	Driving
Getting out of bed	Pushing	Emotional upset	Pulling
Carrying	Straining during BM	Climbing stairs	Walking up hill
Looking up/down	Anger	Walking	Getting in/out of car
Repetitive movement	Other:		

Over the past weeks/months this complaint is: improving about the same getting worse

Have you seen anyone about this condition? Yes No if yes, whom _____

ANY ADDITIONAL COMPLAINTS AND LOCATION (i.e. head aches, arm, foot pain etc.)

1. _____

Please rate this pain on a scale of 1 to 10, with 1 being minimal pain and 10 being excruciating pain:

2. _____

Please rate this pain on a scale of 1 to 10, with 1 being minimal pain and 10 being excruciating pain:

Review of Systems

Please circle any symptoms you are experiencing and date of last occurrence:

	Date		Date		Date		Date
Back pain		Muscle pain		Muscle cramps		Joint tenderness	
Stiff neck		Joint swelling		Joint stiffness		Hot joints	
Muscle weakness		Pain only at night		Loss of sensation		Loss of coordination	
Weak grip		Paralysis		Tingling		Numbness	
Tremors		Soreness		Fatigue		Fainting	
Seizures		Memory loss		Nervousness			
Loss of sleep		Chills		Fever		Physical masses	
Migraines		Dizziness		Pain with repetitive movement			

(P = present, N = Now)

P	N	Past Problem	When and Explanation of Condition
		Cancer	
		Balance problems	
		Stroke	
		Thyroid problems	
		Asthma	
		Heart Attack	
		HIV	
		Angina/Chest pain	
		Diabetes	
		Gout	
		Arthritis	

Doctor Signature: _____

NAME: _____ DATE: ____ / ____ / ____ ACCT #: _____

	Serious Depression	
What other major injuries have you had?	Date	

Have you had any spine surgeries or fusions before? If yes, when and location of surgery: _____

What medications are you currently taking?	For how long?

Are you pregnant? Yes No Do you have a pacemaker? Yes No

Please list any allergies: _____

Marital Status: Married Divorced Single Separated Widowed

Number of Children (if applicable): _____

Frequency of exercise: Regularly Moderately Occasionally Rarely Never

Intensity of exercise: Mild Medium High level Competition level

Well balanced diet: Never Rarely Occasionally Moderately

Sufficient rest: Never Rarely Occasionally Moderately

Usual hours of sleep per night:

Do You Smoke: Never Occasionally 1 to 2 packs/day 2 to 3 packs/day

Do you drink caffeinated beverages? Yes No Number of cups per Day / Week _____

Do you drink alcoholic beverages? No Occasionally 1 to 2/day 2 to 3/day
 4 to 5/day More than 5 drinks a day

Hobbies: _____

Patient history obtained from: Patient _____ Other _____ Relationship _____

Patient signature: _____ Date: _____

Doctor Signature: _____