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C.A.R.E. CHIROPRACTIC & ACUPUNCTURE

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NAME_____AGE_____DOB_____SS#_____

*If minor, please list responsible party_____ DOB_____SS#_____

MAILING ADDRESS_____CITY_____STATE_____ZIP_____

PRIMARY PHONE#_____ EMPLOYER_____WORK#_____

SPOUSE_____SPOUSE DOB_____EMPLOYER_____

ARE YOU PRIMARY INSURED? YES____ NO____ PLEASE LIST NAME_____DOB_____

WHO CAN WE THANK FOR REFERRING YOU TO US? _____

EMAIL ADDRESS_____

LIST YOUR COMPLAINTS IN ORDER OF SEVERITY:

1._____HOW LONG? _____

2._____HOW LONG? _____

3. _____HOW LONG? _____

4._____HOW LONG? _____

CAUSE OF YOUR **PRIMARY** CONDITION? INJURY_____OTHER_____DON'T KNOW_____

TYPE OF INJURY? AUTO_____WORK_____OTHER_____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS IN REGARD TO YOUR PRIMARY COMPLAINT:

Using a scale from 0-10, (10 being the worst), how would you rate your pain?

Primary Complaint	0	1	2	3	4	5	6	7	8	9	10 (Please Circle)
2nd Complaint	0	1	2	3	4	5	6	7	8	9	10
3rd Complaint	0	1	2	3	4	5	6	7	8	9	10
4th Complaint	0	1	2	3	4	5	6	7	8	9	10

How are your symptoms changing with time?

❑ Getting worse ❑ Not changing ❑ Getting better

Do you have a previous history of your primary condition? Yes_____ No_____

How would you describe the pain? (choose all that apply)

❑ Sharp ❑ Diffuse ❑ Dull ❑ Aching
❑ Burning ❑ Shooting ❑ Stiff ❑ Numbness
❑ Tingling ❑ Sharp with motion ❑ Shooting with motion ❑ Electric with motion
❑ Other _____

How often do you experience your symptoms?

❑ Constantly (76-100% of the day) ❑ Frequently (51-75% of the day) ❑ Occasionally (26-50% of the day) ❑ Intermittently (0-25% of the day)

Who have you seen for your symptoms?

❑ No one ❑ Chiropractor ❑ MD ❑ PT
❑ Neurologist ❑ Massage Therapist ❑ ER Physician ❑ Neurosurgeon
❑ Other_____

What treatments have you already received or tried?

- ❑ None
- ❑ Injections
- ❑ Surgery
- ❑ Acupuncture
- ❑ Dry Needling
- ❑ OTC medication
- ❑ Exercise/stretching
- ❑ Chiropractic
- ❑ Massage
- ❑ Physical Therapy
- ❑ Medication
- ❑ Other_____

What imaging or testing have you received?

- ❑ None
- ❑ MRI
- ❑ Ultrasound
- ❑ CT
- ❑ Blood test
- ❑ UA
- ❑ Other_____
- ❑ X-ray

What makes your primary problem worse? _____

What makes your primary problem better? _____

Please check/list any of the previous surgeries you have had: ❑ None

- ❑ Aneurysm repair
- ❑ Cervical fusion
- ❑ Knee replacement
- ❑ Pacemaker
- ❑ Lumbar Fusion
- ❑ Cervical Discectomy
- ❑ Shoulder Replacement
- ❑ Rotator cuff repair
- ❑ Hip replacement
- ❑ Breast enhancement
- ❑ Lumbar Discectomy
- ❑ Carpal tunnel
- ❑ Vertebroplasty
- ❑ Spine surgery
- ❑ Joint replacement
- ❑ Other_____

Other musculoskeletal Symptoms/Conditions: ❑None

- ❑ Arthritis
- ❑ Cramping
- ❑ Foot/ankle pain
- ❑ Elbow/wrist pain
- ❑ Gout
- ❑ Joint stiffness
- ❑ Osteoporosis
- ❑ Shoulder Pain
- ❑ Neck pain
- ❑ Low back pain
- ❑ Scoliosis
- ❑ Compression Fx

Neurological Symptoms: ❑None

- ❑ Dizziness
- ❑ Headache
- ❑ Stroke
- ❑ Depression
- ❑ Anxiety
- ❑ Epilepsy/seizures
- ❑ Loss of smell/taste
- ❑ Numbness

Cardiovascular Symptoms: ❑None

- ❑ Blood Clots
- ❑ Hypertension
- ❑ Chest pain
- ❑ High Cholesterol
- ❑ Palpitations
- ❑ Heart Murmur
- ❑ Hypotension
- ❑ Other _____

Respiratory Symptoms: ❑None

- ❑ Apnea
- ❑ Asthma
- ❑ Persistent cough
- ❑ Pneumonia

Family History – Has anyone in your family had any of the following conditions ❑None

- ❑ Heart Disease
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ Cancer
- ❑ High Cholesterol
- ❑ Scoliosis
- ❑ Other_____ _____

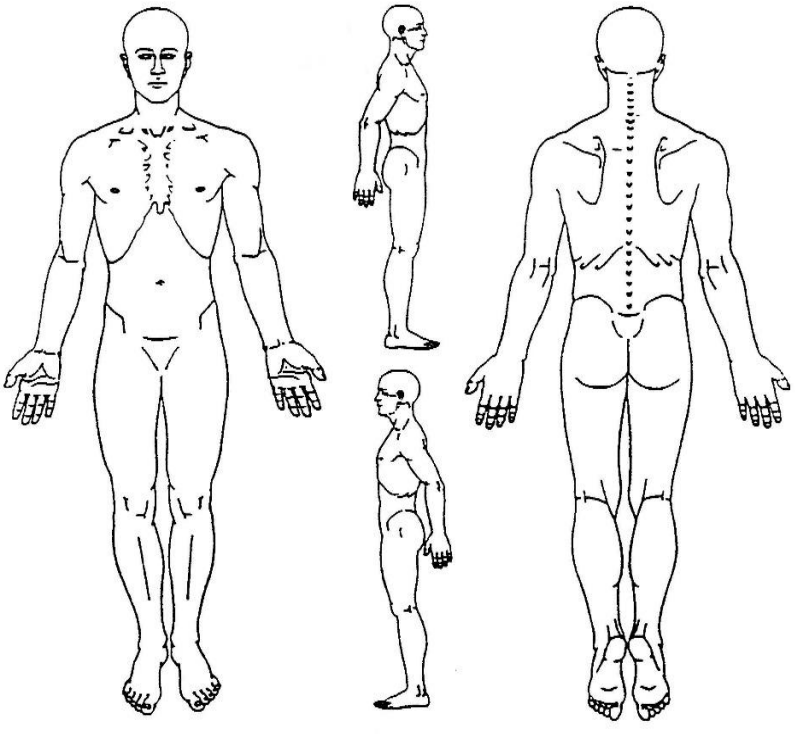
Are any of the following daily activities affected, and if so, how?

	Can do but painful	Painful but limited	Unable to perform
Sitting			
Walking			
Sleeping			
Standing			
Bending			
Standing to Sitting			
Other			

Are there any other activities that are affected or any other comments/concerns about your health or condition that you would like us to know or address?

_____
_____
_____
_____

PAIN DIAGRAM



Please mark on the body diagram to the left all areas of pain, discomfort, or altered sensation and use the key below:

A = Ache B= Burning

N = Numb S = Stabbing

T = Throbbing E = Electrical

P = Pins and needles

O = Other R- Radiating

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____ Date _____