Name: _____ Age: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Home Telephone (  ) _____ Work (  ) _____ Cell (  ) _____

We use text messaging for appointment reminders. Who is your cell phone company? _____

Email Address: _____ Male _____ Female _____

Social Security # _____ Birth Date: _____

Occupation: _____

Employer Name and Address: _____

Single _____ Married _____ Spouse's Name _____

Have you seen a Chiropractor before? Yes No If yes, when? _____

Whom may we thank for referring you to our office ? _____

## YOUR HEALTH SUMMARY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problem.

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Pins and Needles in legs | ☐ Fainting | ☐ Neck Pain |
| ☐ Pins and Needles in arms | ☐ Loss of smell | ☐ Back Pain | ☐ Loss of balance |
| ☐ Dizziness | ☐ Buzzing in ears | ☐ Ringing in ears | ☐ Nervousness |
| ☐ Numbness in fingers | ☐ Numbness in toes | ☐ Loss of taste | ☐ Stomach upset |
| ☐ Fatigue | ☐ Depression | ☐ Irritability | ☐ Tension |
| ☐ Sleeping problems | ☐ Neck stiff | ☐ Cold hands | ☐ Cold feet |
| ☐ Diarrhea | ☐ Constipation | ☐ Fever | ☐ Hot flashes |
| ☐ Cold sweats | ☐ Lights bother eyes | ☐ Problem urinating | ☐ Heartburn |
| ☐ Mood swings | ☐ Menstrual Pain | ☐ Menstrual irregularity | ☐ Ulcers |

List any medications you are taking _____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office To examine me for further evaluation.

Patient Signature_____ Date_____

Guardian Signature _____ Date_____

# Functional Rating Index

For use with Neck and/or Back Problems only.
In order 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 circle the one choice which 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**

| | | | | |
|---|---|---|---|---|
| No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

**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 w/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 1/2 mile | Increased pain after 1/4 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 1/2 hour | Increased pain with any standing |

Name _____
PRINTED

_____ _____
Signature Date

*©1999-2001 Institute of Evidence-Based Chiropractic*

# Family Health History

Name: _____ Date: _____

For the following family members, please mark current health issues with a "C" and past health issues with a "P". Leave blank those that do not apply.

| | Father | Mother | Brother(s) | | Sister(s) | | Spouse | Children | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First Name: | | | | | | | | | | |
| | Age___ | Age___ | Age___ | Age___ | Age___ | Age___ | Age___ | Age___ | Age___ | Age___ |
| **Condition** | | | | | | | | | | |
| Allergies | | | | | | | | | | |
| Arthritis | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Back Trouble | | | | | | | | | | |
| Bursitis | | | | | | | | | | |
| Cancer | | | | | | | | | | |
| Constipation | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Disc Problems | | | | | | | | | | |
| Emotional Problems | | | | | | | | | | |
| Emphysema | | | | | | | | | | |
| Epilepsy | | | | | | | | | | |
| Headaches | | | | | | | | | | |
| Heart Trouble | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| Insomnia | | | | | | | | | | |
| Kidney Trouble | | | | | | | | | | |
| Liver Trouble | | | | | | | | | | |
| Migraines | | | | | | | | | | |
| Nervousness | | | | | | | | | | |
| Neuritis | | | | | | | | | | |
| Pinched Nerves | | | | | | | | | | |
| Scoliosis | | | | | | | | | | |
| Sinus Trouble | | | | | | | | | | |
| Other: | | | | | | | | | | |