# Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

## About this Patient

**First Name** _____

**Last Name** _____

**Cell Phone** _____

**Birthday** _____

**Marital Status**

◯ Single ◯ Divorced ◯ Widowed
◯ Married ◯ Other

**Gender**

◯ Female ◯ Male

**Email** _____

**Social Security #** _____

**Mailing Address** _____

**City** _____

**State/Province** _____

**Zip Code** _____

## About the Spouse

**First Name** _____

**Last Name** _____

**Spouse's Cell Phone** _____

## Reason for this Visit

**What type of complaint?**

☐ an acute ☐ a chronic ☐ a recurring ☐ a sub-acute

**Where is chief complaint?** _____

**What was date of onset of this condition?** _____

**GIVE DETAILS: Mechanism of injury or condition**

◯ OTHER
◯ after a long drive
◯ after a slip
◯ after performing household chores
◯ after a prolonged or chronic illness
◯ without a known origin
◯ after a long flight
◯ after lifting an object
◯ after performing yardwork
◯ after a fall
◯ after a poor night's sleep
◯ after over-arching or reaching
◯ after sitting in one place too long

**Frequency of pain?**

- ◯ OTHER
- ◯ Constant (100% of the time)
- ◯ Frequent (< 75% but > 50% of the time)
- ◯ Occasional (< 50% but > 25% of the time)
- ◯ Intermittent (less than 25% of the time)
- ◯ On and off
- ◯ Random
- ◯ Recurring

**What is quality of discomfort?**

- ☐ OTHER
- ☐ discomfort
- ☐ aching
- ☐ annoying
- ☐ burning
- ☐ deep
- ☐ diffuse
- ☐ dull
- ☐ heavy
- ☐ intolerable
- ☐ pulling
- ☐ sharp
- ☐ shock like
- ☐ stabbing
- ☐ stiffness
- ☐ throbbing
- ☐ tightness
- ☐ tingling

**If the discomfort radiates, where does travel to? Otherwise choose non-radiating.**

- ☐ non-radiating
- ☐ radiating to front of left chest
- ☐ radiating to front of right chest
- ☐ radiating to front of left abdomen/groin
- ☐ radiating to front of right abdomen/groin
- ☐ radiating to front of left thigh
- ☐ radiating to front of left lower leg
- ☐ radiating to top of left foot
- ☐ radiating to front of left shoulder
- ☐ radiating to front of left upper arm
- ☐ radiating to front of left lower arm
- ☐ radiating to front of left hand
- ☐ radiating to front of left face
- ☐ radiating to front of right thigh
- ☐ radiating to front of right lower leg
- ☐ radiating to top of right foot
- ☐ radiating to front of right shoulder
- ☐ radiating to front of right upper arm
- ☐ radiating to front of right lower arm
- ☐ radiating to front of right hand
- ☐ radiating to front of right face
- ☐ radiating to back of left thigh
- ☐ radiating to back of left lower leg
- ☐ radiating to bottom of left foot
- ☐ radiating to back of left shoulder
- ☐ radiating to back of left upper arm
- ☐ radiating to back of left lower arm
- ☐ radiating to back of left hand
- ☐ radiating to back of left side of head
- ☐ radiating to back of right thigh
- ☐ radiating to back of right lower leg
- ☐ radiating to bottom of right foot
- ☐ radiating to back of right shoulder
- ☐ radiating to back of right upper arm
- ☐ radiating to back of right lower arm
- ☐ radiating to back of right hand
- ☐ radiating to back of right side of head

**Is complaint getting better, worse?**

- ◯ improved
- ◯ stayed the same
- ◯ worsened
- ◯ relief which lasted for awhile

**On a scale from 1-10, with 10 being the worst pain, what would you rate your pain?**

- ◯ 1/10
- ◯ 2/10
- ◯ 3/10
- ◯ 4/10
- ◯ 5/10
- ◯ 6/10
- ◯ 7/10
- ◯ 8/10
- ◯ 9/10
- ◯ 10/10

**Symptom relieved by?**

- ☐ OTHER
- ☐ chiropractic adjustment
- ☐ cold packs
- ☐ exercise
- ☐ heat packs
- ☐ massage
- ☐ nothing
- ☐ over the counter medication
- ☐ physical therapy
- ☐ prescription medication
- ☐ re-direct attention
- ☐ rest
- ☐ stretching
- ☐ work

**What aggravates the symptoms?**

- [ ] OTHER
- [ ] almost any movement
- [ ] carrying
- [ ] concentrating
- [ ] driving
- [ ] getting out of bed
- [ ] household chores
- [ ] pulling
- [ ] repetitive motions
- [ ] squatting
- [ ] talking on the telephone
- [ ] working
- [ ] none
- [ ] bathing
- [ ] changing positions
- [ ] cooking
- [ ] eating
- [ ] getting up from lying down
- [ ] lifting
- [ ] pushing
- [ ] resting
- [ ] standing
- [ ] turning
- [ ] yard work
- [ ] none reported
- [ ] bending
- [ ] climbing stairs
- [ ] coughing and sneezing
- [ ] falling or staying asleep
- [ ] getting up from sitting
- [ ] looking over shoulder
- [ ] reaching
- [ ] running
- [ ] stress
- [ ] twisting
- [ ] unknown action
- [ ] caring for family
- [ ] computer use
- [ ] daily child or pet care
- [ ] getting in or out of car
- [ ] grocery shopping
- [ ] lying down
- [ ] reading
- [ ] sitting
- [ ] stretching
- [ ] walking

**Any past episodes of this complaint?**

- ◯ OTHER
- ◯ confirms
- ◯ denies

**Has patient received any past care for this complaint?**

- [ ] OTHER
- [ ] Craniosacral therapy
- [ ] medical care
- [ ] Osteopathic medicine
- [ ] psychotherapy
- [ ] nothing
- [ ] Homeopathic medicine
- [ ] Naturopathic therapy
- [ ] over-the-counter medications
- [ ] Reiki
- [ ] Acupuncture
- [ ] hypnosis
- [ ] nutritional supplements
- [ ] prescribed medications
- [ ] surgery
- [ ] Chiropractic care
- [ ] injection therapy
- [ ] occupational therapy
- [ ] physical therapy

**Have any recent diagnostic images or tests been performed?**

- ◯ OTHER
- ◯ Yes
- ◯ No

**Activity of daily living most affected by condition?**

- [ ] OTHER
- [ ] homemaking
- [ ] sitting
- [ ] standing
- [ ] None
- [ ] lifting
- [ ] sleeping
- [ ] traveling and/or driving
- [ ] employment
- [ ] personal care (washing, dressing, etc.)
- [ ] social life
- [ ] walking

**What does patient have difficulty performing due to this specific complaint?**

- [ ] OTHER
- [ ] concentrating
- [ ] getting in/out of car
- [ ] lifting objects
- [ ] reaching overhead
- [ ] standing
- [ ] participating in yard work
- [ ] bending over
- [ ] dressing self
- [ ] getting to sleep
- [ ] looking over shoulder
- [ ] rising out of chair or bed
- [ ] staying asleep
- [ ] caring for family
- [ ] driving car
- [ ] grocery shopping
- [ ] making love
- [ ] showering or bathing
- [ ] using a computer
- [ ] climbing stairs
- [ ] exercising
- [ ] performing household chores
- [ ] lying down
- [ ] sitting
- [ ] walking

**he/she**

- ◯ he
- ◯ she

**What were the patient's specific goals?**

- ☐ to have no functional limitations
- ☐ to sleep throughout the night w/o pain
- ☐ to decrease swelling
- ☐ to improve all ranges of motion w/o pain
- ☐ to be able to lift w/o pain
- ☐ to improve strength
- ☐ to improve overall flexibility
- ☐ to decrease stiffness
- ☐ to relieve pain
- ☐ to walk on all terrain without limitation
- ☐ to able to hunt without limitation
- ☐ to return to sport activity without limitation
- ☐ to return to work without limitation
- ☐ to walk without need of assistive device
- ☐ ability to transfer supine to sitting w/o pain
- ☐ ability to transfer from bed to device w/o pain
- ☐ ability to transfer from device to bed w/o pain
- ☐ ability to transfer sitting to standing w/o pain
- ☐ ability to transfer sitting to supine w/o pain
- ☐ ability to transfer standing to sitting w/o pain

**If addtl' complaints are present, select yes**

- ◯ Yes
- ◯ No additional concerns relayed by patient.

**What type of complaint?**

- ☐ an acute
- ☐ a chronic
- ☐ a recurring
- ☐ a sub-acute

**Where is Complaint #2?**

---

**What was date of onset of this condition?**

---

**GIVE DETAILS: Mechanism of injury or condition**

- ◯ OTHER
- ◯ without a known origin
- ◯ after a fall
- ◯ after a long drive
- ◯ after a long flight
- ◯ after a poor night's sleep
- ◯ after a slip
- ◯ after lifting an object
- ◯ after over-arching or reaching
- ◯ after performing household chores
- ◯ after performing yardwork
- ◯ after sitting in one place too long
- ◯ after a prolonged or chronic illness

**Frequency of pain?**

- ◯ OTHER
- ◯ Constant (100% of the time)
- ◯ Frequent (< 75% but > 50% of the time)
- ◯ Occasional (< 50% but > 25% of the time)
- ◯ Intermittent (less than 25% of the time)
- ◯ On and off
- ◯ Random
- ◯ Recurring

**What is quality of discomfort?**

- ☐ OTHER
- ☐ discomfort
- ☐ aching
- ☐ annoying
- ☐ burning
- ☐ deep
- ☐ diffuse
- ☐ dull
- ☐ heavy
- ☐ intolerable
- ☐ pulling
- ☐ sharp
- ☐ shock like
- ☐ stabbing
- ☐ stiffness
- ☐ throbbing
- ☐ tightness
- ☐ tingling

**If the discomfort radiates, where does travel to? Otherwise choose non-radiating.**

- ☐ non-radiating
- ☐ radiating to front of left abdomen/groin
- ☐ radiating to front of left chest
- ☐ radiating to front of right abdomen/groin
- ☐ radiating to front of right chest
- ☐ radiating to front of left thigh
- ☐ radiating to front of left lower leg
- ☐ radiating to top of left foot
- ☐ radiating to front of left shoulder
- ☐ radiating to front of left upper arm
- ☐ radiating to front of left lower arm
- ☐ radiating to front of left hand
- ☐ radiating to front of left face
- ☐ radiating to front of right thigh
- ☐ radiating to front of right lower leg
- ☐ radiating to top of right foot
- ☐ radiating to front of right shoulder
- ☐ radiating to front of right upper arm
- ☐ radiating to front of right lower arm
- ☐ radiating to front of right hand
- ☐ radiating to front of right face
- ☐ radiating to back of left thigh
- ☐ radiating to back of left lower leg
- ☐ radiating to bottom of left foot
- ☐ radiating to back of left shoulder
- ☐ radiating to back of left upper arm
- ☐ radiating to back of left lower arm
- ☐ radiating to back of left hand
- ☐ radiating to back of left side of head
- ☐ radiating to back of right thigh
- ☐ radiating to back of right lower leg
- ☐ radiating to bottom of right foot
- ☐ radiating to back of right shoulder
- ☐ radiating to back of right upper arm
- ☐ radiating to back of right lower arm
- ☐ radiating to back of right hand
- ☐ radiating to back of right side of head

**Is complaint getting better, worse?**

- ◯ improved
- ◯ stayed the same
- ◯ worsened
- ◯ relief which lasted for awhile

**On a scale from 1-10, with 10 being the worst pain, what would you rate your pain?**

- ◯ 1/10
- ◯ 2/10
- ◯ 3/10
- ◯ 4/10
- ◯ 5/10
- ◯ 6/10
- ◯ 7/10
- ◯ 8/10
- ◯ 9/10
- ◯ 10/10

**Symptom relieved by?**

- ☐ OTHER
- ☐ chiropractic adjustment
- ☐ cold packs
- ☐ exercise
- ☐ heat packs
- ☐ massage
- ☐ nothing
- ☐ over the counter medication
- ☐ physical therapy
- ☐ prescription medication
- ☐ re-direct attention
- ☐ rest
- ☐ stretching
- ☐ work

**What aggravates the symptoms?**

- ☐ OTHER
- ☐ none
- ☐ none reported
- ☐ unknown action
- ☐ almost any movement
- ☐ bathing
- ☐ bending
- ☐ caring for family
- ☐ carrying
- ☐ changing positions
- ☐ climbing stairs
- ☐ computer use
- ☐ concentrating
- ☐ cooking
- ☐ coughing and sneezing
- ☐ daily child or pet care
- ☐ driving
- ☐ eating
- ☐ falling or staying asleep
- ☐ getting in or out of car
- ☐ getting out of bed
- ☐ getting up from lying down
- ☐ getting up from sitting
- ☐ grocery shopping
- ☐ household chores
- ☐ lifting
- ☐ looking over shoulder
- ☐ lying down
- ☐ pulling
- ☐ pushing
- ☐ reaching
- ☐ reading
- ☐ repetitive motions
- ☐ resting
- ☐ running
- ☐ sitting
- ☐ squatting
- ☐ standing
- ☐ stress
- ☐ stretching
- ☐ talking on the telephone
- ☐ turning
- ☐ twisting
- ☐ walking
- ☐ working
- ☐ yard work

**Any past episodes of this complaint?**

- ◯ OTHER
- ◯ confirms
- ◯ denies

**Has patient received any past care for this complaint?**

- ☐ OTHER
- ☐ nothing
- ☐ Acupuncture
- ☐ Chiropractic care
- ☐ Craniosacral therapy
- ☐ Homeopathic medicine
- ☐ hypnosis
- ☐ injection therapy
- ☐ medical care
- ☐ Naturopathic therapy
- ☐ nutritional supplements
- ☐ occupational therapy
- ☐ Osteopathic medicine
- ☐ over-the-counter medications
- ☐ prescribed medications
- ☐ physical therapy
- ☐ psychotherapy
- ☐ Reiki
- ☐ surgery

**Have any recent diagnostic images or tests been performed?**

◯ OTHER ◯ Yes ◯ No

**Activity of daily living most affected by condition?**

☐ OTHER ☐ None ☐ employment
☐ homemaking ☐ lifting ☐ personal care (washing, dressing, etc.)
☐ sitting ☐ sleeping ☐ social life
☐ standing ☐ traveling and/or driving ☐ walking

**What does patient have difficulty performing due to this specific complaint?**

☐ OTHER ☐ bending over ☐ caring for family ☐ climbing stairs
☐ concentrating ☐ dressing self ☐ driving car ☐ exercising
☐ getting in/out of car ☐ getting to sleep ☐ grocery shopping ☐ performing household chores
☐ lifting objects ☐ looking over shoulder ☐ making love ☐ lying down
☐ reaching overhead ☐ rising out of chair or bed ☐ showering or bathing ☐ sitting
☐ standing ☐ staying asleep ☐ using a computer ☐ walking
☐ participating in yard work

**he/she**

◯ he ◯ she

**If addtl' complaints are present, select yes**

◯ Yes ◯ No additional concerns relayed by patient.

**What type of complaint?**

☐ an acute ☐ a chronic ☐ a recurring ☐ a sub-acute

**Where is Complaint #3?**

---

**What was date of onset of this condition?**

---

**GIVE DETAILS: Mechanism of injury or condition**

◯ OTHER ◯ without a known origin ◯ after a fall
◯ after a long drive ◯ after a long flight ◯ after a poor night's sleep
◯ after a slip ◯ after lifting an object ◯ after over-arching or reaching
◯ after performing household chores ◯ after performing yardwork ◯ after sitting in one place too long
◯ after a prolonged or chronic illness

**Frequency of pain?**

◯ OTHER ◯ Constant (100% of the time)
◯ Frequent (< 75% but > 50% of the time) ◯ Occasional (< 50% but > 25% of the time)
◯ Intermittent (less than 25% of the time) ◯ On and off
◯ Random ◯ Recurring

**What is quality of discomfort?**

☐ OTHER ☐ discomfort ☐ - - - - - - ☐ aching ☐ annoying
☐ burning ☐ deep ☐ diffuse ☐ dull ☐ heavy
☐ intolerable ☐ pulling ☐ sharp ☐ "shock like" ☐ stabbing
☐ "stiffness" ☐ throbbing ☐ "tightness" ☐ tingling

**If the discomfort radiates, where does travel to? Otherwise choose non-radiating.**

- ☐ non-radiating
- ☐ radiating to front of left abdomen/groin
- ☐ radiating to front of left chest
- ☐ radiating to front of right abdomen/groin
- ☐ radiating to front of right chest
- ☐ radiating to front of left thigh
- ☐ radiating to front of left lower leg
- ☐ radiating to top of left foot
- ☐ radiating to front of left shoulder
- ☐ radiating to front of left upper arm
- ☐ radiating to front of left lower arm
- ☐ radiating to front of left hand
- ☐ radiating to front of left face
- ☐ radiating to front of right thigh
- ☐ radiating to front of right lower leg
- ☐ radiating to top of right foot
- ☐ radiating to front of right shoulder
- ☐ radiating to front of right upper arm
- ☐ radiating to front of right lower arm
- ☐ radiating to front of right hand
- ☐ radiating to front of right face
- ☐ radiating to back of left thigh
- ☐ radiating to back of left lower leg
- ☐ radiating to bottom of left foot
- ☐ radiating to back of left shoulder
- ☐ radiating to back of left upper arm
- ☐ radiating to back of left lower arm
- ☐ radiating to back of left hand
- ☐ radiating to back of left side of head
- ☐ radiating to back of right thigh
- ☐ radiating to back of right lower leg
- ☐ radiating to bottom of right foot
- ☐ radiating to back of right shoulder
- ☐ radiating to back of right upper arm
- ☐ radiating to back of right lower arm
- ☐ radiating to back of right hand
- ☐ radiating to back of right side of head

**Is complaint getting better, worse?**

- ◯ improved
- ◯ stayed the same
- ◯ worsened
- ◯ relief which lasted for awhile

**On a scale from 1-10, with 10 being the worst pain, what would you rate your pain?**

- ◯ 1/10
- ◯ 2/10
- ◯ 3/10
- ◯ 4/10
- ◯ 5/10
- ◯ 6/10
- ◯ 7/10
- ◯ 8/10
- ◯ 9/10
- ◯ 10/10

**Symptom relieved by?**

- ☐ OTHER
- ☐ chiropractic adjustment
- ☐ cold packs
- ☐ exercise
- ☐ heat packs
- ☐ massage
- ☐ nothing
- ☐ over the counter medication
- ☐ physical therapy
- ☐ prescription medication
- ☐ re-direct attention
- ☐ rest
- ☐ stretching
- ☐ work

**What aggravates the symptoms?**

- ☐ OTHER
- ☐ none
- ☐ none reported
- ☐ unknown action
- ☐ almost any movement
- ☐ bathing
- ☐ bending
- ☐ caring for family
- ☐ carrying
- ☐ changing positions
- ☐ climbing stairs
- ☐ computer use
- ☐ concentrating
- ☐ cooking
- ☐ coughing and sneezing
- ☐ daily child or pet care
- ☐ driving
- ☐ eating
- ☐ falling or staying asleep
- ☐ getting in or out of car
- ☐ getting out of bed
- ☐ getting up from lying down
- ☐ getting up from sitting
- ☐ grocery shopping
- ☐ household chores
- ☐ lifting
- ☐ looking over shoulder
- ☐ lying down
- ☐ pulling
- ☐ pushing
- ☐ reaching
- ☐ reading
- ☐ repetitive motions
- ☐ resting
- ☐ running
- ☐ sitting
- ☐ squatting
- ☐ standing
- ☐ stress
- ☐ stretching
- ☐ talking on the telephone
- ☐ turning
- ☐ twisting
- ☐ walking
- ☐ working
- ☐ yard work

**Any past episodes of this complaint?**

- ◯ OTHER
- ◯ confirms
- ◯ denies

**Has patient received any past care for this complaint?**

- ☐ OTHER
- ☐ nothing
- ☐ Acupuncture
- ☐ Chiropractic care
- ☐ Craniosacral therapy
- ☐ Homeopathic medicine
- ☐ hypnosis
- ☐ injection therapy
- ☐ medical care
- ☐ Naturopathic therapy
- ☐ nutritional supplements
- ☐ occupational therapy
- ☐ Osteopathic medicine
- ☐ over-the-counter medications
- ☐ prescribed medications
- ☐ physical therapy
- ☐ psychotherapy
- ☐ Reiki
- ☐ surgery

**Have any recent diagnostic images or tests been performed?**

◯ OTHER ◯ Yes ◯ No

**Activity of daily living most affected by condition?**

☐ OTHER ☐ None ☐ employment
☐ homemaking ☐ lifting ☐ personal care (washing, dressing, etc.)
☐ sitting ☐ sleeping ☐ social life
☐ standing ☐ traveling and/or driving ☐ walking

**What does patient have difficult**

☐ OTHER ☐ bending over ☐ caring for family ☐ climbing stairs
☐ concentrating ☐ dressing self ☐ driving car ☐ exercising
☐ getting in/out of car ☐ getting to sleep ☐ grocery shopping ☐ performing household chores
☐ lifting objects ☐ looking over shoulder ☐ making love ☐ lying down
☐ reaching overhead ☐ rising out of chair or bed ☐ showering or bathing ☐ sitting
☐ standing ☐ staying asleep ☐ using a computer ☐ walking
☐ participating in yard work

**he/she**

◯ he ◯ she

**If addtl' complaints are present, select yes**

◯ Yes ◯ No additional concerns relayed by patient.

**What type of complaint?**

☐ an acute ☐ a chronic ☐ a recurring ☐ a sub-acute

**Where is Complaint #4?**

---

**What was date of onset of this condition?**

---

**GIVE DETAILS: Mechanism of injury or condition**

◯ OTHER ◯ without a known origin ◯ after a fall
◯ after a long drive ◯ after a long flight ◯ after a poor night's sleep
◯ after a slip ◯ after lifting an object ◯ after over-arching or reaching
◯ after performing household chores ◯ after performing yardwork ◯ after sitting in one place too long
◯ after a prolonged or chronic illness

**Frequency of pain?**

◯ OTHER ◯ Constant (100% of the time)
◯ Frequent (< 75% but > 50% of the time) ◯ Occasional (< 50% but > 25% of the time)
◯ Intermittent (less than 25% of the time) ◯ On and off
◯ Random ◯ Recurring

**What is quality of discomfort?**

☐ OTHER ☐ discomfort ☐ aching ☐ annoying ☐ burning
☐ deep ☐ diffuse ☐ dull ☐ heavy ☐ intolerable
☐ pulling ☐ sharp ☐ shock like ☐ stabbing ☐ stiffness
☐ throbbing ☐ tightness ☐ tingling

**If the discomfort radiates, where does travel to? Otherwise choose non-radiating.**

- ☐ non-radiating
- ☐ radiating to front of left abdomen/groin
- ☐ radiating to front of left chest
- ☐ radiating to front of right abdomen/groin
- ☐ radiating to front of right chest
- ☐ radiating to front of left thigh
- ☐ radiating to front of left lower leg
- ☐ radiating to top of left foot
- ☐ radiating to front of left shoulder
- ☐ radiating to front of left upper arm
- ☐ radiating to front of left lower arm
- ☐ radiating to front of left hand
- ☐ radiating to front of left face
- ☐ radiating to front of right thigh
- ☐ radiating to front of right lower leg
- ☐ radiating to top of right foot
- ☐ radiating to front of right shoulder
- ☐ radiating to front of right upper arm
- ☐ radiating to front of right lower arm
- ☐ radiating to front of right hand
- ☐ radiating to front of right face
- ☐ radiating to back of left thigh
- ☐ radiating to back of left lower leg
- ☐ radiating to bottom of left foot
- ☐ radiating to back of left shoulder
- ☐ radiating to back of left upper arm
- ☐ radiating to back of left lower arm
- ☐ radiating to back of left hand
- ☐ radiating to back of left side of head
- ☐ radiating to back of right thigh
- ☐ radiating to back of right lower leg
- ☐ radiating to bottom of right foot
- ☐ radiating to back of right shoulder
- ☐ radiating to back of right upper arm
- ☐ radiating to back of right lower arm
- ☐ radiating to back of right hand
- ☐ radiating to back of right side of head

**Is complaint getting better, worse?**

- ◯ improved
- ◯ stayed the same
- ◯ worsened
- ◯ relief which lasted for awhile

**On a scale from 1-10, with 10 being the worst pain, what would you rate your pain?**

- ◯ 1/10
- ◯ 2/10
- ◯ 3/10
- ◯ 4/10
- ◯ 5/10
- ◯ 6/10
- ◯ 7/10
- ◯ 8/10
- ◯ 9/10
- ◯ 10/10

**Symptom relieved by?**

- ☐ OTHER
- ☐ chiropractic adjustment
- ☐ cold packs
- ☐ exercise
- ☐ heat packs
- ☐ massage
- ☐ nothing
- ☐ over the counter medication
- ☐ physical therapy
- ☐ prescription medication
- ☐ re-direct attention
- ☐ rest
- ☐ stretching
- ☐ work

**What aggravates the symptoms?**

- ☐ OTHER
- ☐ none
- ☐ none reported
- ☐ unknown action
- ☐ almost any movement
- ☐ bathing
- ☐ bending
- ☐ caring for family
- ☐ carrying
- ☐ changing positions
- ☐ climbing stairs
- ☐ computer use
- ☐ concentrating
- ☐ cooking
- ☐ coughing and sneezing
- ☐ daily child or pet care
- ☐ driving
- ☐ eating
- ☐ falling or staying asleep
- ☐ getting in or out of car
- ☐ getting out of bed
- ☐ getting up from lying down
- ☐ getting up from sitting
- ☐ grocery shopping
- ☐ household chores
- ☐ lifting
- ☐ looking over shoulder
- ☐ lying down
- ☐ pulling
- ☐ pushing
- ☐ reaching
- ☐ reading
- ☐ repetitive motions
- ☐ resting
- ☐ running
- ☐ sitting
- ☐ squatting
- ☐ standing
- ☐ stress
- ☐ stretching
- ☐ talking on the telephone
- ☐ turning
- ☐ twisting
- ☐ walking
- ☐ working
- ☐ yard work

**Any past episodes of this complaint?**

- ◯ OTHER
- ◯ confirms
- ◯ denies

**Has patient received any past care for this complaint?**

- ☐ OTHER
- ☐ nothing
- ☐ Acupuncture
- ☐ Chiropractic care
- ☐ Craniosacral therapy
- ☐ Homeopathic medicine
- ☐ hypnosis
- ☐ injection therapy
- ☐ medical care
- ☐ Naturopathic therapy
- ☐ nutritional supplements
- ☐ occupational therapy
- ☐ Osteopathic medicine
- ☐ over-the-counter medications
- ☐ prescribed medications
- ☐ physical therapy
- ☐ psychotherapy
- ☐ Reiki
- ☐ surgery

**Have any recent diagnostic images or tests been performed?**

- ◯ OTHER
- ◯ Yes
- ◯ No

**Activity of daily living most affected by condition?**

- ☐ OTHER
- ☐ None
- ☐ employment
- ☐ homemaking
- ☐ lifting
- ☐ personal care (washing, dressing, etc.)
- ☐ sitting
- ☐ sleeping
- ☐ social life
- ☐ standing
- ☐ traveling and/or driving
- ☐ walking

**What does patient have difficulty performing due to this specific complaint?**

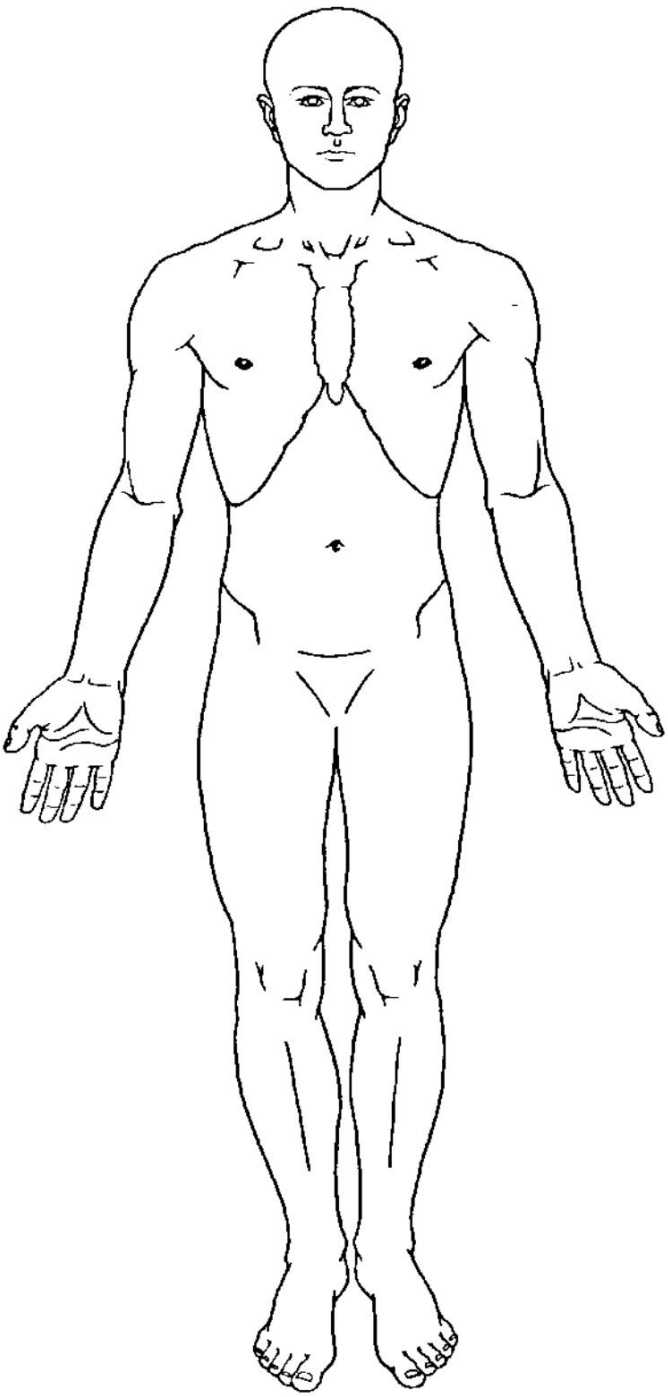
- ☐ OTHER
- ☐ bending over
- ☐ caring for family
- ☐ climbing stairs
- ☐ concentrating
- ☐ dressing self
- ☐ driving car
- ☐ exercising
- ☐ getting in/out of car
- ☐ getting to sleep
- ☐ grocery shopping
- ☐ performing household chores
- ☐ lifting objects
- ☐ looking over shoulder
- ☐ making love
- ☐ lying down
- ☐ reaching overhead
- ☐ rising out of chair or bed
- ☐ showering or bathing
- ☐ sitting
- ☐ standing
- ☐ staying asleep
- ☐ using a computer
- ☐ walking
- ☐ participating in yard work

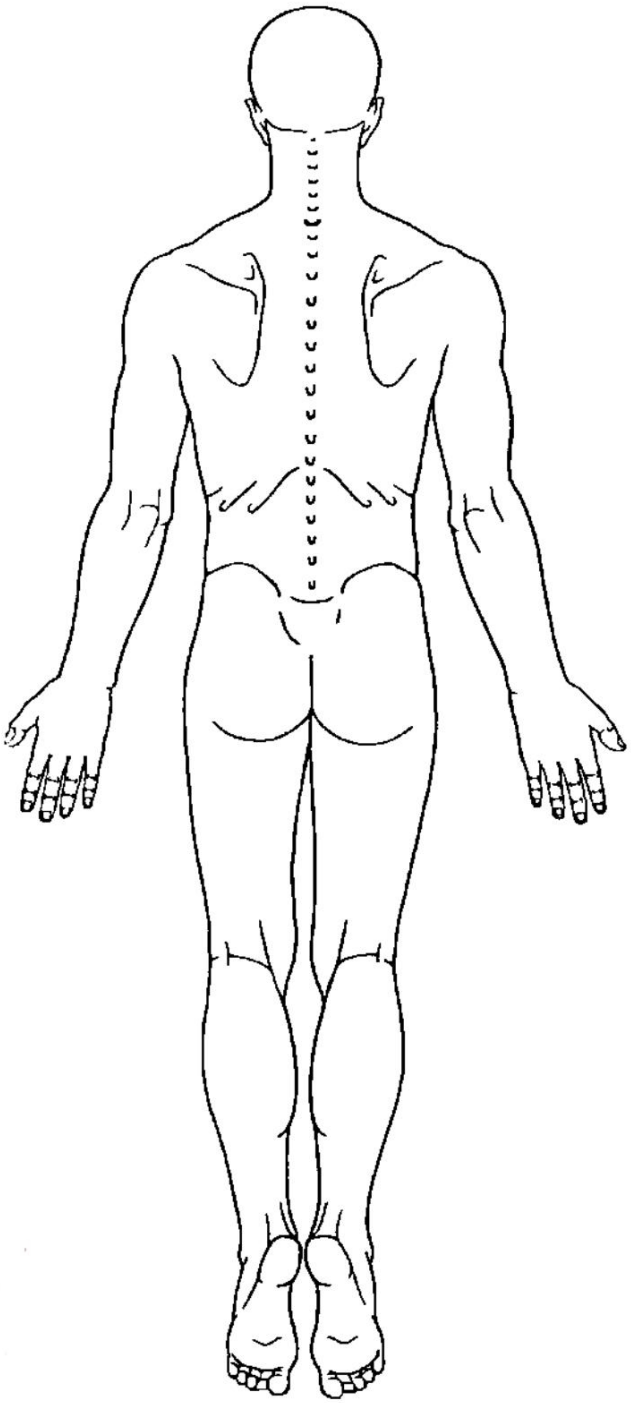
**he/she**

- ◯ he
- ◯ she

# Place an X on the image below, where you feel pain, numbness or tingling:

**Mark your Pain Point**





**Patient's surgical history?**

- [ ] none reported
- [ ] abdominal aortic aneurysm repair
- [ ] appendectomy
- [ ] bunionectomy
- [ ] C-Section
- [ ] cardiac bypass
- [ ] cardiac valve replacement
- [ ] carpal tunnel- left
- [ ] carpal tunnel- right
- [ ] cataract- left
- [ ] cataract- right
- [ ] cosmetic- breast reduction or enlargement
- [ ] cosmetic- face lift
- [ ] cosmetic- nose
- [ ] cosmetic- OTHER
- [ ] cosmetic- tummy tuck
- [ ] discectomy level
- [ ] ear tubes
- [ ] gall bladder removed
- [ ] ganglion cyst
- [ ] gastric bypass
- [ ] hysterectomy- complete
- [ ] hysterectomy- partial
- [ ] implants
- [ ] knee left
- [ ] knee right
- [ ] Lasik
- [ ] mastectomy
- [ ] shoulder- left
- [ ] shoulder- right
- [ ] spinal fusion
- [ ] thyroidectomy
- [ ] tonsils
- [ ] tonsils & adenoids
- [ ] transplant
- [ ] wisdom teeth

**Drugs and medication(s)?**

- [ ] none
- [ ] no new or deleted medications
- [ ] over-the-counter
- [ ] prescription
- [ ] -
- [ ] anti-depressant
- [ ] muscle relaxer
- [ ] NSAID
- [ ] pain reliever
- [ ] steroidal anti-inflammatory
- [ ] --
- [ ] anti-acid
- [ ] anti-viral
- [ ] aspirin
- [ ] chemotherapy
- [ ] codeine
- [ ] hallucinogenic
- [ ] marijuana
- [ ] mood elevator
- [ ] sleeping pill
- [ ] stimulant
- [ ] tranquilizer

**Name past illnesses:**

- [ ] Denies Hx of diabetes, cancer, hypertension
- [ ] progressive neurological disorders
- [ ] no change in family health history
- [ ] none reported
- [ ] number of children -
- [ ] number of pregnancies -
- [ ] number of deliveries -
- [ ] cancer -
- [ ] congenital anomaly -
- [ ] extremity issues -
- [ ] fracture -
- [ ] hereditary disorder -
- [ ] hospitalization -
- [ ] neuromuscular issues -
- [ ] trauma/injury -
- [ ] AIDS/HIV
- [ ] alcoholism
- [ ] alzheimer's
- [ ] anemia
- [ ] anorexia
- [ ] arthritis
- [ ] asthma
- [ ] bleeding disorders
- [ ] breast lump
- [ ] bronchitis
- [ ] bulimia
- [ ] chemical dependency
- [ ] depression
- [ ] diabetes
- [ ] emphysema
- [ ] epilepsy
- [ ] heart disease
- [ ] hepatitis
- [ ] hernia
- [ ] herniated disc
- [ ] high blood pressure
- [ ] high cholesterol
- [ ] kidney disease
- [ ] liver disease
- [ ] migraine headaches
- [ ] miscarriage
- [ ] multiple sclerosis
- [ ] natural labor
- [ ] osteoarthritis
- [ ] osteoporosis
- [ ] pacemaker
- [ ] Parkinson's disease
- [ ] pinched nerve
- [ ] pneumonia
- [ ] polio
- [ ] previous chiropractic care
- [ ] prostate problems
- [ ] psychiatric care
- [ ] rheumatoid arthritis
- [ ] stroke
- [ ] suicide attempt
- [ ] thyroid problems
- [ ] tumor
- [ ] ulcers
- [ ] vaginal infection
- [ ] venereal disease

**Past history of accidents or trauma?**

- [ ] OTHER
- [ ] no previous trauma reported
- [ ] no new trauma reported since initial intake
- [ ] single automobile accident
- [ ] multiple automobile accidents
- [ ] slip and fall
- [ ] multiple slip and falls
- [ ] single motorcycle accident
- [ ] multiple motorcycles accident
- [ ] single boating accident
- [ ] multiple boating accidents
- [ ] resulting in fracture(s) -
- [ ] resulting in permanent injury or disability -
- [ ] resulting in hospitalization(s) -
- [ ] resulting in no significant injury or loss
- [ ] resulting in sprains/strains
- [ ] resulting in loss of consciousness

**what is the present work status?**

- ☐ none reported
- ☐ no change in work habits since condition began
- ☐ cannot work due to presenting condition
- ☐ permanently fully disabled
- ☐ permanently partially disabled
- ☐ full-time
- ☐ part-time
- ☐ homemaker
- ☐ retired
- ☐ student
- ☐ unemployed
- ☐ to 20 hrs per week
- ☐ 20 to 40 hours per week
- ☐ 40 to 50 hours per week
- ☐ 50 to 60 hours per week
- ☐ 60 to 70 hours per week
- ☐ over 70 hours per week
- ☐ mostly sitting
- ☐ mostly standing
- ☐ mostly walking
- ☐ light labor
- ☐ moderate labor
- ☐ heavy labor
- ☐ sedentary
- ☐ computer
- ☐ repetitive
- ☐ telephone
- ☐ difficult
- ☐ enjoyable
- ☐ relaxed
- ☐ stressful

**Social habits?**

- ☐ no change is social habits since injury
- ☐ does not smoke, drink alcohol, or take rec. drugs
- ☐ does not drink alcohol
- ☐ is a social drinker
- ☐ is a light drinker
- ☐ is a moderate drinker
- ☐ is a heavy drinker
- ☐ is an alcoholic
- ☐ is a recovering alcoholic
- ☐ current every day smoker
- ☐ current some day smoker
- ☐ ex-smoker
- ☐ heavy tobacco smoker
- ☐ light tobacco smoker
- ☐ never smoked tobacco
- ☐ smoker, current status unknown
- ☐ unknown if ever smoked
- ☐ does not drink caffeine
- ☐ drinks 1 cup of caffeine in the morning
- ☐ drinks 2 to 4 cups of caffeine per day
- ☐ drinks 5 or more cups of caffeine per day
- ☐ does not use recreational drugs
- ☐ light use of recreational drugs
- ☐ moderate use of recreational drugs
- ☐ heavy use of recreational drugs
- ☐ is drug addicted
- ☐ is a recovering drug addict

**Exercise routine?**

- ☐ no changes in exercise habits
- ☐ none
- ☐ daily
- ☐ none reported
- ☐ every other day
- ☐ few times a week
- ☐ once a week
- ☐ almost nothing
- ☐ aerobic
- ☐ stretching
- ☐ strength
- ☐ baseball
- ☐ basketball
- ☐ blading
- ☐ boating
- ☐ climbing
- ☐ cycling
- ☐ football
- ☐ golf
- ☐ handball
- ☐ hang gliding
- ☐ hiking
- ☐ mountain climbing
- ☐ ping-pong
- ☐ racquetball
- ☐ running
- ☐ skiing
- ☐ skydiving
- ☐ snowboarding
- ☐ soccer
- ☐ surfing
- ☐ tennis
- ☐ volleyball
- ☐ walking
- ☐ waterskiing
- ☐ weight training
- ☐ weight training with a personal trainer
- ☐ Pilates
- ☐ Spinning
- ☐ Step
- ☐ Yoga
- ☐ Zumba

**Diet and nutrition?**

- ☐ no changes in diet or nutrition
- ☐ controlled
- ☐ out-of-control
- ☐ restricted
- ☐ unrestricted
- ☐ 1 to 2 meals a day
- ☐ 2 to 3 meals a day
- ☐ more than 3 meals a day
- ☐ reports eating too little
- ☐ reports eating too much
- ☐ binges
- ☐ purges
- ☐ balanced
- ☐ high protein
- ☐ low carbohydrate
- ☐ low-fat
- ☐ low-cholesterol
- ☐ no red meat
- ☐ Atkins
- ☐ diabetic
- ☐ gluten free
- ☐ Ideal Protein
- ☐ Jenny Craig
- ☐ kosher
- ☐ Macrobiotic
- ☐ Paleo
- ☐ raw food
- ☐ SouthBeach
- ☐ vegan
- ☐ vegetarian
- ☐ Weight Watchers
- ☐ Zone
- ☐ does not take daily supplements
- ☐ takes daily supplements

**Any other changes to Medical History since last visit to this office?**

_____

# FOR WOMEN ONLY:

**Are you pregnant?**

◯ OTHER ◯ Yes ◯ No

**Are you nursing?**

◯ OTHER ◯ Yes ◯ No

# Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

**Patient's Signature** _____ **Date** _____

**Guardian or Spouse's Signature** _____ **Date** _____

**Who should receive bills for payment on your account?**

☐ Patient ☐ Spouse ☐ Parent ☐ Workers Comp
☐ Medicare ☐ Personal Health Insurance ☐ Auto Insurance

# Ownership of X-ray Films

It is understood and agreed that the payments to the Doctor for X-rays is for the examination of X-rays only. The X-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

# Emergency Contact

**First Name** _____ **Last Name** _____

**Relationship**

**Work Phone** **Home Phone**

# My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

**Primary Insurance Company/Secondary Insurance Company**

**Primary Policy #/ Secondary Policy #** **Primary Group #/ Secondary Group #**

**Primary Phone Number/ Secondary Phone Number**

## ABOUT THE INSURED PERSON

**First Name** **Last Name**

**Social Security #** **Date of Birth** **Relation**

## Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on the below named minor child by Brian Lank, D.C., James Morosky, D.C., Alex Humbert, D.C., Jennifer Gambino, D.C. and/or Paul Hrvol, D.C. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure(s) which he/she feels at the time, based upon the facts then known, is in my best interests. I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications, which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor(s). I have read or have had read to me the above consent, and by signing below, acknowledge my understanding of its contents.

## Insurance:

We will verify all insurances and your benefits per your agreement with your carrier. After verification the Doctor will give his recommendations and an appropriate plan will be designed for each individual. Please let the front-desk know if you have been in some type of accident or have been injured on the job. This will enable us to give you any and all information necessary to serve you completely and accurately.

## Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

# HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the

law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

x Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

x The practice reserves the right to change the privacy policy as allowed by law.

x The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

x The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

x The practice may condition receipt of treatment upon execution of this consent

**Signature** **Date Signed**

_____

**Printed Name** **Email**

_____ _____

# Office Policies & Procedures For All Appointments

Thank you for trusting Coastal Integrative Health with your healthcare needs. When you set an appointment with Coastal Integrative Health, we set aside enough time to provide you with the highest quality care. Should you need to cancel, or reschedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule another patient who may be waiting for much needed treatment. Additionally, missed appointments are to be made up within the same week so that you may achieve your results and move to the maintenance phase of your treatment plan.

**Established Patients:**

• Effective January 3, 2023, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a **$30.00 fee.**

• Any established patient who fails to show or cancels/reschedules an appointment with no 24 hours' notice a second consecutive time will be charged a **$50.00 fee**.

• If a third consecutive No Show or cancellation/reschedule without a 24-hour notice should occur the patient may be dismissed from Coastal Integrative Health and will be billed **$75.00.**

• The fee is charged to the patient, not the insurance company, and is due at the time of the patients next office visit or as billed in our monthly statements.

• As a courtesy to you, we have appointment reminder systems in place to help avoid scheduling conflicts. As always, it is up to you to remember your appointment and cancel within 24 hours if needed.

**New Patients:**

• New Patient appointments block off a considerable amount of time on our providers schedules for proper evaluation. When there is a cancellation without 24-hour notice, this restricts the possibility of another patient receiving the care they need due to our books being "full."

• Any new patient who fails to show or cancels/reschedules an appointment without a 24-hour notice will be charged a **$50.00 fee.**

• If the new patient fails to show or cancels/reschedules an appointment a second consecutive time, the patient will be charged a **$75.00 fee.**

• If a third consecutive no show or cancellation/reschedule without 24-hr notice occurs, the patient may be dismissed from Coastal Integrative Health and will be billed **$100.00.**

***Payment is due at the time of service unless prior arrangements have been made.***

**Signature** **Date Signed**

_____

**Printed Name** **Email**

_____ _____