Consultation

Please describe your Major complaint:____

Describe any Secondary complaint:____

All of the following questions on this page pertain to your <u>Major Complaint *only*</u>!

When did THIS episode begin:____

What **at do YOU think caused this?**____

Since it started THIS time, is it: About the Same / Getting Better / Getting Worse

Is it worse any particular time of day (Circle all that apply): morning / afternoon / evening / In bed / No particular time

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: __________________________

Grade Intensity/Severity of Complaint: None (0) / (1-2) / Mild (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

How often does this occur? (CHOOSE ONE)

Constant: ☐ It is constant – I have some pain or discomfort all the time
Daily: ☐ 1-2 times a day ☐ 2-3 times a day ☐ 3-4 times a day ☐ 4-5 times a day
Weekly: ☐ 1-2 times a week ☐ 2-3 times a week ☐ 3-4 times a week
☐ 4-5 times a week ☐ 5-6 times a week
Monthly: ☐ 1-2 times a month ☐ 2-3 times a month
Not Often: ☐ It occurs rarely

How long does this last? (CHOOSE ONE)

☐ Constant
☐ Short time ☐ Few minutes ☐ 10-20 minutes ☐ 20-30 minutes ☐ 40-50 minutes
☐ 1-2 hours ☐ 2-3 hours ☐ 3-4 hours ☐ 4-5 hours ☐ 5-6 hours ☐ 6-7 hours ☐ 7-8 hours
☐ All Day ☐ Other ____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ________________________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ____________________

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) ______________________________

<u>*Head-*</u> Base of Skull / Forehead / Sides-Temples R / L / Both <u>*Leg-*</u> Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

<u>*Arm-*</u> Across Shoulder / Elbow / Hand-Fingers R / L / Both <u>*Other Area:*</u> ______________________________________

Which daily activities are being affected by this condition? *(Describe)*____

<u>For this CURRENT condition, have you:</u>

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _________________**Where?**___________
- **Had any diagnostic testing?** X-rays / MRI / CT / Other:________________ **When and Where?**____________________
- **Medical requests signed and faxed**

Overall, you would say your health is: ☐poor ☐fair ☐good ☐very good ☐excellent

Have you ever seen a chiropractic doctor before?___________ **If so who?**__________________________

Medications and Supplements:

Allergies to Medications: **NONE**

Name	Name

Current Medications & Supplements: **NONE**

Medication list attached? ☐

Name	Name

Past Health History: *(Please list any past…)*

Number of Falls in the last 24 months: ____ Injuries? Y or N

Surgeries: **NONE**

Date	Type

Major Injuries / Traumas / Hospitalizations: **NONE**

Date	Describe

Family Health History: **NONE**

List *relevant* major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Please circle the most appropriate choice below.

Habit	Type
Smoking	Every Day / Some Days / Former / Never
Tobacco	Every Day / Some Days / Former / Never
Alcohol	Every Day / Some Days / Former / Never
Caffeine	Every Day / Some Days / Former / Never
Rec. Drugs	Every Day / Some Days / Former / Never

Education: High School / College Grad. / Post Grad. / Other

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

Demo

Patient Demographics

Name: *(First MI Last)*____ **Preferred Name:** ________________________

Address: ______________________________________ **City:** ________________________ **State:** _____ **Zip:** ____________

Home: ________________ **Work:** ________________ **Mobile:** ________________ **Email:** _____________________________

Sex: M / F **Race:** _______________________ **Ethnicity:** *(circle one)* Hispanic or Latino / Not Hispanic or Latino / Decline

Preferred Language: English / Other: _______________ **Marital Status:** *(circle one)* Single / Married / Other

Birthdate: ____________________ **Social Security #:** ________________________

Work Status: *(circle one)* Employed / Full-time Student / Part-time Student / Other

Referred By: *(We like to thank those who refer others!)* ___________________________ __________________________________

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)*____________________________________ **Primary Care Physician:** ______________________

Home: _________________ **Mobile:** _____________________ **Doctor's phone:** ____________________________

Relationship: Child / Parent / Spouse / Other:_______________

INSURANCE INFORMATION

Primary Insurance

Insurance Name: ___________________________________

Insured's Birthdate:___________________________________

Relationship to Insured: Self / Spouse / Child / Other:______

Other than Self:

Insured's Name: _________________________ **Gender:** M/F

Address: ____

City: ______________________ **State:** _____ **Zip:** _________

Secondary Insurance

Insurance Name: _______________________________

Relationship to Insured: Self / Spouse / Child / Other:______

Insured's Name: _________________________ **Gender:** M/F

Address: ____

City: ______________________ **State:** _____ **Zip:** _________

NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of Haas Chiropractic Center, LLC.

Patient / Guardian Signature:____________________________________ **Date:**___________________________

XRAY ASSIGNMENT AGREEMENT

I understand that to insure the highest quality of interpretation of my x-rays, the services of a chiropractic radiologist are being utilized. I acknowledge that these services are separate from those of Haas Chiropractic Center, LLC, and that the charges for these services will be submitted to my insurance carrier, workers compensation carrier or state bureau, or to my attorney in the case of a personal injury. In the event that I receive payment for these services, I agree to promptly remit payment to ADVANTAGE RADIOLOGY SERVICE (ARS). I assign my insurance benefits and rights to payment to ARS to the extent of thes charges, and authorize them or their agents to bill and release information to my insurance company, and/or third party to provide information concerning my claim, their services, and/or payment for services provided. By my signature below, I acknowledge that I have read, understand and agree to the above provisions, and assign my insurance benefits as described above.

Patient / Guardian Signature:____________________________________ **Date:**___________________________

Account

Are you currently experiencing any of these symptoms? (Circle all that apply)

Many of the following conditions respond to Chiropractic and Acupuncture

ROS

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems ______________
- ☐ Leg Problems______________
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones ______________
- ☐ Other:____________________
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or Lightheaded
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Strokes
- ☐ Other:____________________
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other:____________________
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other:____________________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movement
- ☐ Painful Bowel Movement
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other:____________________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat Changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles or Fee
- ☐ Heart Problems
- ☐ Other:____________________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other:____________________
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts / glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other:____________________
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Ringing in the ears
- ☐ Ear – Ache or Drainage
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other:____________________
- ☐ *None in this Category*

Endocrine, hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Heat or Cold Intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problems
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other:____________________
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing Sores
- ☐ Change in appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other:____________________
- ☐ *None in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes – Due Date** ___/___/_____
- ☐ **No – Last Menstrual Period** ___/___/_____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other:____________________
- ☐ *None in this Category*

Pregnancies:

Date	Outcome

Comments:____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature ______________________________________ Date ____________________

Functional Rating Index

For use with **Neck and Back Problems** only.

In order to properly assess your condition, we must understand how your **neck and back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
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.)

0	1	2	3	4
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

0	1	2	3	4
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

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
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

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
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

0	1	2	3	4
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

Account

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