Chiropractic Patient Information Form Form 1B

Practitioner Last Name	First Name	M.I.	License #	Phone #	Fax #

Patient to complete the following sections:

Patient Last Name	Patient First Name	M.I.	Gender ☐M ☐F	Age	Date of Birth (MM/DD/YYYY) / /

Insured I.D. or SSN	Insured Last Name	M.I.	First Name	Patient Daytime Phone

Patient Address	City	State	Zip

Employer Name	Insurance Company	Group Plan # or Union Local

Is illness or injury related to: ☐Work ☐Auto ☐Other	Do you have other insurance that might cover this injury/illness? ☐Yes ☐No	If yes, please list other insurance company name:

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), **circle** the number that best reflects your condition: ↓ **none . . . . . to . . . . . severe** ↓	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
1 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
2 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
3 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
4 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%

For each of the reasons or conditions listed above, please mark how it happened:

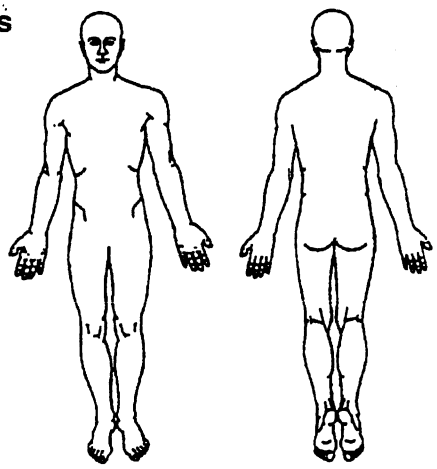
1. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
2. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
3. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
4. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐_____
Reason 2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐_____
Reason 3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐_____
Reason 4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐_____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/// Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Intercourse	☐	☐	☐
Computer work/typing	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐
Other (list below)	☐	☐	☐

_____

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Please continue ...

a. During what time of the day do you feel worse? _____

b. Do you sleep well? ❑ Yes ❑No What are your normal sleeping hours? _____to _____

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
❑ No ❑ Yes → For what condition? _____

Name of doctor/provider _____ Phone number _____

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
❑ No ❑ Yes If yes, please describe each event below:

Event _____ Year _____

Event _____ Year _____

e. Do you exercise? ❑ Yes ❑ No If yes, please describe activity _____

How many days a week? _____ How many minutes per session?_____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ❑ Neck pain with difficulty swallowing
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

Types of pain

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102°F
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury

Previously diagnosed condition/ medical history

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes with cold, burning or numb feet
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as from chemotherapy, organ transplant, etc.
- ❑ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family history

❑ Autoimmune disorders ❑ Cancer ❑ Heart disease ❑ Mental illness
❑ Arthritis ❑ Diabetes ❑ Kidney disease ❑ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date:_____/_____/_____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____ Today's date:_____/_____/_____