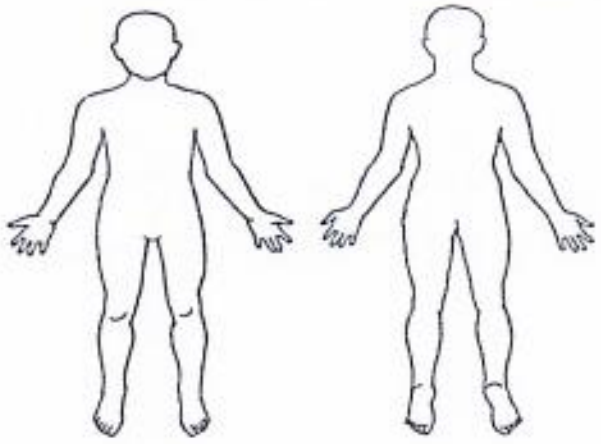
Family Chiropractic &
Spinal Health Care Center

INITIAL HEALTH STATUS

Patient Name: _____ Birth date: _____ Sex: M / F
Address_____ City _____State _____ Zip _____
Home Phone (___)_____Cell Phone (___)_____ S.S. #_____Marital Status: S M D W
E-Mail Address_____ Referred By:_____
Emergency Contact:_____ Emergency Phone (___)_____
Occupation _____ Employer _____Work Phone (___)_____
Primary Insurance Company_____ Subscriber S.S. #_____
Subscriber Name _____Subscriber Birth Date _____Self/Spouse/Other_____
Subscriber ID # _____ Group # _____ Type Health Plan: PPO/POS/HMO
2nd Insurance Company_____Subscriber S.S. #_____Subscriber D.O.B._____
Primary Care Name_____Last Exam_____ PCP Phone (___)_____
OB/GYN Name_____Last Exam_____OB/GYN Phone(___)_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

Right



Right

Front

Back

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐Headache ☐Neck pain ☐Mid-back pain ☐Low Back pain ☐Other_____

Is This? ☐Work Injury ☐Auto Injury ☐N/A

Date Problem Began: _____ **How Problem Began:** Gradual / Sudden _____

Chief complaint (The level of Your WORST & BEST pain):

No Pain **0 1 2 3 4 5 6 7 8 9 10** Unbearable Pain

How often are your symptoms present?
(Intermittent) ☐ 0 – 25% ☐26 – 50% ☐51 – 75% ☐76 – 100% (Constant)
In the past week has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference **0 1 2 3 4 5 6 7 8 9 10** Unable to carry on any activities

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When was the onset of this problem? □ **gradual** □ **sudden**
□ about a day ago □ several days ago □ about a week ago □ several weeks ago
□ about a year ago □ several years ago □ other:

In the past week, on average how often have your symptoms been present?
(Intermittent) □ 0 – 25% □ 26 – 50% □ 51 – 75% □ 76 – 100% (Constant)
How frequently? □ intermittent □ occasional □ frequent □ constant

How severe? □ mild □ mild to moderate □ moderate □ moderate to severe □ severe

Select the type of pain that best describes your complaint:
□ achy □ numb ache □ shooting □ burning □ pounding □ stabbing □ dull □ pulsating
□ stinging □ sharp □ throbbing

Select each choice that applies to you:
Movement □ cramps □ inflexibility □ spasm □ stiffness □ prickly
Sensation □ crawling □ dead □ numb □ pins and needles □ tingling

Please indicate everything that makes you feel better:
□usually better in the morning □ usually better during the day □ usually better at night

Please indicate everything that makes you feel worse or aggravates your condition:
□ usually worse in the morning □ usually worse during the day □ usually worse at night

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? □No □Yes
Date(s) Taken _____ **What areas were taken?** _____
Please check all of the following that apply to you:

□Recent fever
□High Blood Pressure
□Currently pregnant, # Weeks ____
□Abnormal Weight □Gain □Loss
□Dizziness/Fainting
□Nausea
□Cancer/Tumor (explain)_____
□Osteoporosis
□Allergies _____
□Prostate Problems
□Heart Disease
□Stroke (date) _____
□Corticosteroid Use (cortisone, prednisone, etc.)_____
□Taking Birth Control Pills
□Pain Unrelieved by Position or Rest
□Change in Bowel/Bladder
□Epilepsy/Seizures
□Arthritis
□Diabetes
□Urinary Problem
□Menstrual Problems
□Lungs Disease
□Marked Morning Pain/Stiffness
□Numbness in Groin/Buttocks
□Pain at Night
□Visual Disturbance
□Headaches
□Asthma

□Other Health Problems (explain)_____
□Surgeries_____ Medications_____
Family History: □Cancer □Diabetes □High Blood Pressure □Heart Problem/Stroke □Rheumatoid Arthritis
□Other_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature _____ Date _____