remove obstacles • restore function • improve performance • maximize potential

Patient Registration

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id	date

1 PATIENT CONTACT

last name	first name	m.i.
preferred to be called		
street		
city	state	zip
home phone	mobile phone	
work phone	e-mail	

2 PATIENT PERSONAL

age	date of birth	social security #	sex	☐ male	☐ female
status	☐ single	☐ married	☐ partnered	☐ widowed	☐ separated ☐ divorced

3 EMERGENCY CONTACT

name	home phone
relationship	work phone

4 SPOUSE OR GUARDIAN

last name	first name	m.i.
employer name		
work phone	date of birth	social security #

5 PATIENT EMPLOYMENT

employer name	occupation	
street		
city	state	zip

Which one of our patients referred you to our clinic?

____

List the symptoms you are experiencing today: Circle the severity level associated with each symptom.

______________________ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

______________________ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

______________________ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

For Office Use Only

Date: ____________________

Acct #: ____________________

Patient Height ____________

Patient Weight ____________

Patient BMI ______________

Patient Blood Pressure ________

Patient Intake Form

Race (circle only 1)
- American Indian
- Asian
- Black or African American
- Native Hawaiian
- Declined to State
- Alaska Native
- White
- Other Pacific Islander

Ethnicity (circle only 1)
- Declined to State
- Hispanic or Latino
- Not Hispanic or Latino

Preferred Language ________________________________

Are your present problems job related or from an auto accident? □Yes □No

Enter the date of the injury: ____________________

HABITS

❑Drinking Alcohol: (Cups/day): _____ ❑Coffee Cups/Day: _______

❑Soft Drink Bottles or Cans/Day: _____ ❑Water Cups/Day: _______

Current every day smoker_____ Current some day smoker_____

Former smoker_____ When Quit_____ Never Smoker_____

EXERCISE

❑None

❑Moderate

❑Daily

FAMILY HISTORY

	Diabetes	Cancer	Back Pain	Other
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Sibling(s)	❑	❑	❑	❑

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: ________________________
Route: Oral
Intravenous
Other: ________________
Frequency: ____________________
Began Use: ____________________
Discontinued Use: ________________

Medication: ________________________
Route: Oral
Intravenous
Other: ________________
Frequency: ____________________
Began Use: ____________________
Discontinued Use: ________________

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: ________________________
Reaction: ________________________
Start Date: ______________________
End Date: _______________________

Allergy: ________________________
Reaction: ________________________
Start Date: ______________________
End Date: _______________________

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate **date** of surgery.)

DATE		DATE		DATE	
________	Back Operation	________	Hernia	________	Gall Bladder
________	Female Organs	________	Thyroid	________	Stomach

Other ____

OPERATIONS AND PROCEDURES

Please check the box for each current symptom listed.

GENERAL SYMPTOMS

- ❑ Allergy (What?) ____________ ____________
- ❑ Bronchitis
- ❑ Swollen Joints
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Tremors
- ❑ Headache
- ❑Strokes
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL

- ❑ Belching or Gas
- ❑ Spinal Curvature
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Swelling Ankles
- ❑ Liver Trouble
- ❑ Varicose Veins
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT

- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Noises
- ❑ Sore Throats
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Sinusitis

RESPIRATORY

- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY

- ❑ Prostate Trouble
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination

MUSCLES & JOINTS

- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders
- ❑ Painful Tail Bone
- ❑ Stiff Neck

CARDIO-VASCULAR

- ❑ High Blood Pressure
- ❑ Poor Circulation
- ❑ Chest Pain
- ❑ Heart Trouble

SKIN OR ALLERGIES

- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching
- ❑ Sensitive Skin
- ❑ Skin Eruptions

FOR FEMALES ONLY

- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge
- ❑ Pregnant Now?
- ________ Last Pap Date

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis ❑Anemia ❑Heart Disease ❑Arthritis ❑Measles ❑Epilepsy
❑Mumps ❑Chicken Pox ❑Lumbago ❑Diabetes ❑Cancer

Consent to Exam and Treat

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Today we will conduct a through history, consultation and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Financial Responsibility Agreement

I fully understand that A+Healthcare has agreed to complete and submit insurance claims on my behalf to my insurance carrier. In the process of filling such claims, it is often necessary to release copies of my records. I give my full and complete permission to A+ Healthcare to release my records to any party necessary for my treatment of payment of such.

I also understand that the submitting of a claim in no way guarantees payment for the claim. I therefore, understand and acknowledge that I also am fully and completely responsible for the total bill.

I agree to pay A+Healthcare for any and all charges, which result from my care, in the office at the time the care is rendered. (Exceptions will only be made with prior approval from the Doctor). In the event that any overpayment occurs, A+ Healthcare will credit your account or refund said funds, whichever you prefer. Any additional amount owed will be sent to you in the form of a bill.

I understand and agree to the following:

Responsible Party/Patient Signature: ______________________________ **Date:** ____________

Witness Signature: ______________________________ **Date:** ____________

General Pain Index Questionnaire

We would like to know how much you pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present paid has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **Family / Home Responsibilities** such as yard work, chores around the house or driving the kids to school.

0 1 2 3 4 5 6 7 8 9 10

Completely Able To Function — Totally Unable To Function

2. **Recreation** including hobbies, sports, or other leisure activities.

0 1 2 3 4 5 6 7 8 9 10

Completely Able To Function — Totally Unable To Function

3. **Social Activities** including parties, theater, concerts, dining-out and attending other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely Able To Function — Totally Unable To Function

4. **Employment** including volunteer work and homemaking tasks.

0 1 2 3 4 5 6 7 8 9 10

Completely Able To Function — Totally Unable To Function

5. **Self-Care** such as taking a shower, driving or getting dressed.

0 1 2 3 4 5 6 7 8 9 10

Completely Able To Function — Totally Unable To Function

6. **Life-Support** activities such as eating and sleeping.

0 1 2 3 4 5 6 7 8 9 10

Completely Able To Function — Totally Unable To Function

Neck Pain Index Questionnaire

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please mark in each section the one box that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that most closely describes your present-day situation.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dresses. I wash with difficulty and stay in bed.

Section 3 – Lifting

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Reading

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

Section 7 – Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Section 8 – Driving

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my car at all because of neck pain.

Section 9 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleeping is slightly disturbed (less than 1hr sleepless).
- ❑ My sleeping is mildly disturbed (1-2 hrs sleepless).
- ❑ My sleeping is moderately disturbed (2-3 hrs sleepless).
- ❑ My sleeping is greatly disturbed (3-5 hrs sleepless).
- ❑ My sleeping is completely disturbed (5-7 hrs sleepless).

Section 10 – Recreation

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

Low Back Pain Index Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement, which best applies to you. We realize you may consider that two or more statements in any one section apply but please just check the spot that indicates the statement, which most clearly describes your problem.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently place eg. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me sitting more than 1 hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain I have less than 6 hours of sleep.
- ☐ Because of pain I have less than 4 hours of sleep.
- ☐ Because of pain I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normally but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg. sport.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social like to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys less than 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but is overall getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.