First Visit Date:_____

Patient Information

Dodge Chiropractic, PLLC, at Soulitudes Wellness Center, 1387 Fairport Road, Building 500, Suite 520, Fairport, NY 14450

Patient to complete the following sections:

Patient Last Name	First Name	MI	Gender □M □F	Age	Date of Birth

Patient Address	City	State	Zip Code

Home Phone #	Work Phone #	Height	Weight

In case of emergency contact:	Marital Status □M □D □S □W	# of Children	Social Security #

Referred By:	Previous chiropractic care? □Yes □No	Patient Email: *(Always Kept Private)*

Insurance Information:

Insured Last Name	First Name	MI	Insurance ID #	Date of Birth

Employer	Insurance Company Name

Is Illness or injury related to: □Work □Auto □Other	Do you have secondary insurance that might cover this injury/illness: □Yes □No	If yes, other insurance company name:

Primary Care Physician Information:

Doctor's Last Name	First Name	Have you seen your primary doctor for this complaint? □Yes □No Date:

Address	City	State	Zip Code	Phone Number

History of Injury or Current Complaint:

Please briefly describe your injury or current complaint and date of onset: _____

When does your complaint feel worse? □**AM** □**PM** Please explain: _____

Does your pain interrupt your sleep? □**No** □**Yes** Please explain: _____

What activity is affected most due to this complaint? _____

Previous Conditions and Treatment:

Please briefly list any previous medical conditions and treatment: _____

List all medications and supplements: _____

Do you have any allergies □NO □YES Please explain: _____

List all dates of hospital visits and/or types of surgeries: _____

Are any of these conditions in your family history? □ Autoimmune disorders □ Cancer □GI disorders
□ Heart disease □ Neurological □ Arthritis □ Diabetes □ Kidney disease □ Seizures

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 this form, sign your name and state relationship (i.e.,parent, translator)

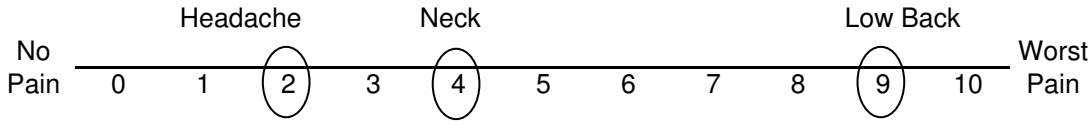
Name_____ Relationship_____Today's date:____/____/_____

Quadruple Visual Analogue Scale

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at min/max using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

Example:



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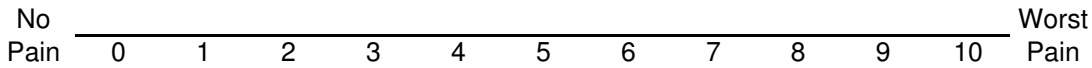
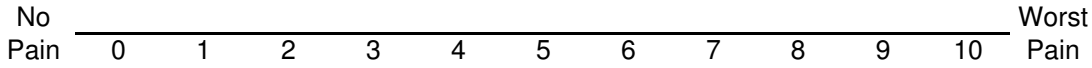
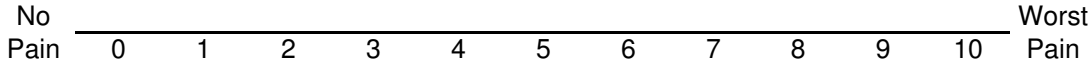
1. What is your pain **RIGHT NOW**?



2. What is your **TYPICAL** or **AVERAGE** pain?

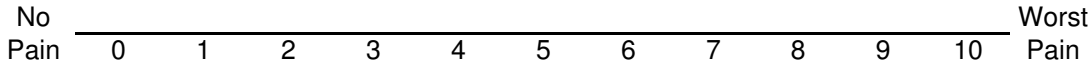


3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best?



What percentage of your awake hours is your pain at its best? _____ %

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____ %

Name _____ Age _____ Date _____ Score _____

Score: #1 _____ + #2 _____ + #4 _____ = _____/3x10=_____

- ❑ Low Intensity = <50
- ❑ High Intensity = >50

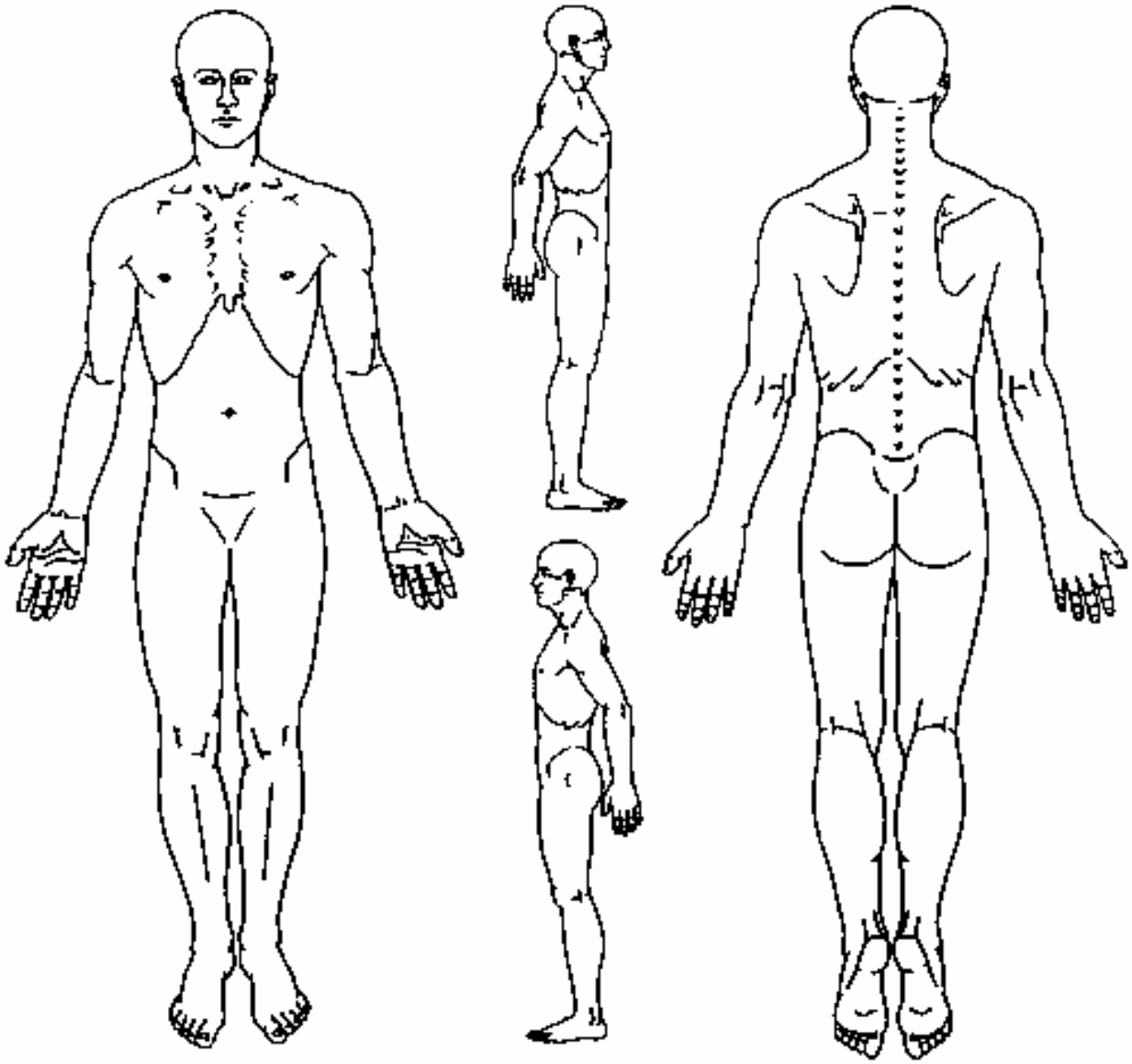
Dodge Chiropractic, PLLC, 1387 Fairport Road, Building 500, Suite 520
Fairport, NY 14450 (Tel) 585-377-4070

Pain Diagram

NAME _____ DATE _____

How long have you had neck pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

_____

Patient Signature