



Date: _____

First Name: _____

Last Name: _____

Middle Initial: _____

MAJOR COMPLAINT INFORMATION

What is your major complaint(s)? _____

When did symptom(s) begin? _____

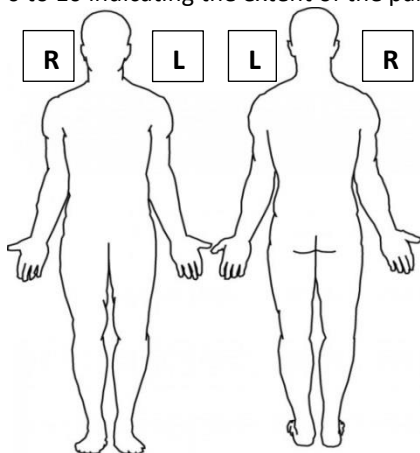
Have you experienced these symptoms before? Circle YES or NO When? _____

Are symptoms due to an auto accident or work injury? Circle YES or NO

Please circle if you have reported accident to: Auto Insurance or Employer

PAIN DIAGRAM

Using the symbols in the Pain Index, mark the areas on the diagram below where you are experiencing pain, followed by a number from 0 to 10 indicating the extent of the pain. (0 being no pain, 10 being the worst possible pain)



PAIN INDEX

- ~ Spasm
Δ Aching/Dull
* Numbness/Tingling
Burning
\ Sharp/Stabbing
T Throbbing
R Radiating

If this is an injury, describe what happened:

On a scale of 0 through 10, how do you feel now? (0 being no pain, 10 being the worst pain)

0 1 2 3 4 5 6 7 8 9 10

Check all that apply:

Symptoms:

- come & go
are constant
came on gradually
came on suddenly

Symptoms have persisted for:

- days
weeks
months
years

Symptoms are worse in:

- AM
midday
PM

Symptoms are better in:

- AM
midday
PM

Do you have "pins & needles" in arms or legs? If yes, please specify: _____

What activities make symptoms worse? _____

What activities make symptoms better? _____

HEADACHES

Do you get headaches? If yes, how often? _____

Nausea, vomiting, or visual disturbances? ___ yes ___ no

When was your last eye exam? ___ 1-6 mo. ___ 7-12 mo. ___ years ___ never

Abnormal blood pressure? ___ yes ___ no ___ high ___ low

Do you have jaw problems? ___ yes ___ no



DAILY ACTIVITIES AFFECTED BY CONDITION

Please circle all that apply:

- | | | | | | |
|--------------------------------|-------------------------|-----------|--------------|-------------------------------|---------------|
| coughing or sneezing | walking short distances | sleeping | kneeling | stooping | lying on back |
| bending over forward | getting out of car | climbing | pushing | gripping | dressing self |
| lying flat on stomach | turning over in bed | balancing | pulling | reaching | sex activity |
| lying on side w/ knees bent | standing > 1 hr. | sitting | holding baby | lifting | bathing |
| bending forward to brush teeth | carrying bag/backpack | driving | exercise | other (please specify): _____ | |

Have you consulted a doctor for this condition? If yes, please provide doctor's name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? ___ yes ___ no If yes, how so? _____

How do you sleep? ___ On stomach ___ on back ___ on side ___ other (please explain: _____)

Do you sleep with a pillow? ___ yes ___ no If yes, how many? ___

Do you wear a *heel lift* or *orthotic* (circle one)? ___ yes ___ no If yes: ___ right ___ left

OTHER HEALTH HISTORY

Date of last physical exam? _____ Reason for exam? _____ Date of most recent x-rays? _____

List all medications you are taking now, including over-the-counter, and reason(s) for taking them:

Medicine	Dosage/Frequency	Reason for taking medicine

Please list all known allergies: _____

Have you ever been hospitalized or had surgery? ___ yes ___ no If yes, please list below:

Date: _____ Reason: _____ Date: _____ Reason: _____

Date: _____ Reason: _____ Date: _____ Reason: _____

Do you have a family physician? ___ yes ___ no If yes, physician's name: _____

Physician's phone #: _____ City and state of physician's practice: _____

Have you ever received chiropractic care? ___ yes ___ no If yes, date last seen: _____

Have you ever had a concussion? ___ yes ___ no If yes, please explain: _____

Have you ever had any broken bones? ___ yes ___ no If yes, please explain: _____

Have you ever had any accidents resulting in serious injury? If yes, please explain: _____

Have you ever had professional clinical massage? ___ yes ___ no

Do you have a massage therapist you see regularly? ___ yes ___ no

Do you see or have you ever seen a medical specialist? ___ yes ___ no If yes, what specialty? _____

Medical specialist's name: _____ City and state of specialist's practice: _____

How often do you exercise? _____

What type(s) of physical exercise do you enjoy or prefer? _____



ADDITIONAL COMPLAINTS

Check any of the following disease(s) you have or have ever had:

- | | | | | |
|--|---------------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Addiction | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Eczema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> AIDS | <input type="checkbox"/> Gout |

REVIEW OF SYSTEMS

Check any of the following you now have or have had in the past:

F = frequently O = occasionally N = never

<p>Head/Ears/Eyes/Nose/Throat</p> <input type="checkbox"/> blurred vision <input type="checkbox"/> floaters in vision <input type="checkbox"/> hearing loss <input type="checkbox"/> ringing in ears <input type="checkbox"/> loss of taste <input type="checkbox"/> loss of smell <input type="checkbox"/> glaucoma <input type="checkbox"/> ear infection <input type="checkbox"/> sinusitis <input type="checkbox"/> postnasal drip <input type="checkbox"/> nasal polyps <input type="checkbox"/> strep throat <input type="checkbox"/> Mononucleosis <input type="checkbox"/> dental issues	<p>Neurological</p> <input type="checkbox"/> dizziness <input type="checkbox"/> balance difficulty <input type="checkbox"/> blurred vision <input type="checkbox"/> loss of concentration <input type="checkbox"/> depression/confusion <input type="checkbox"/> anxiety/nervousness <input type="checkbox"/> sleep disturbance <input type="checkbox"/> fatigue/energy loss <input type="checkbox"/> fainting <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic pain <input type="checkbox"/> Mood disorders <input type="checkbox"/> Other: _____	<p>Gastro-Intestinal</p> <input type="checkbox"/> ulcer <input type="checkbox"/> anorexia/bulimia <input type="checkbox"/> food sensitivities <input type="checkbox"/> indigestion <input type="checkbox"/> unusual appetite <input type="checkbox"/> excessive thirst <input type="checkbox"/> frequent urination <input type="checkbox"/> vomiting <input type="checkbox"/> constipation <input type="checkbox"/> sudden weight change <input type="checkbox"/> hemorrhoids <input type="checkbox"/> liver issues <input type="checkbox"/> abdominal cramps <input type="checkbox"/> gas/bloating <input type="checkbox"/> heartburn <input type="checkbox"/> black bloody stool <input type="checkbox"/> diverticulitis/-osis <input type="checkbox"/> gall bladder disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Celiac <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Irritable Bowel Syndrome	<p>Musculoskeletal</p> <input type="checkbox"/> headache <input type="checkbox"/> neck pain <input type="checkbox"/> pain between shoulders <input type="checkbox"/> arm pain/tingling/numb <input type="checkbox"/> mid back pain <input type="checkbox"/> low back pain <input type="checkbox"/> hip pain <input type="checkbox"/> leg pain/tingling/numb <input type="checkbox"/> walking problems <input type="checkbox"/> chewing difficulty
<p>Cardiovascular</p> <input type="checkbox"/> poor circulation <input type="checkbox"/> chest pain <input type="checkbox"/> shortness of breath <input type="checkbox"/> irregular blood pressure <input type="checkbox"/> irregular heart beat <input type="checkbox"/> heart problems <input type="checkbox"/> lung issues/congestion <input type="checkbox"/> varicose veins <input type="checkbox"/> ankle swelling	<p>Genitourinary</p> <input type="checkbox"/> kidney stones <input type="checkbox"/> prostate issues <input type="checkbox"/> erectile dysfunction <input type="checkbox"/> bedwetting <input type="checkbox"/> PMS symptoms <input type="checkbox"/> infertility <input type="checkbox"/> urinary tract infection <input type="checkbox"/> yeast infection <input type="checkbox"/> abnormal PAP <input type="checkbox"/> sexually transmitted disease <input type="checkbox"/> decreased libido <input type="checkbox"/> menstrual cramping <input type="checkbox"/> menstrual irregularity <input type="checkbox"/> vaginal pain	<p>Family History Has your: <i>Grandmother, Grandfather, Father, Mother, Sister, Brother, Daughter, or Son ever had:</i></p> <input type="checkbox"/> cancer <input type="checkbox"/> heart disease <input type="checkbox"/> stroke <input type="checkbox"/> arthritis <input type="checkbox"/> osteoporosis <input type="checkbox"/> high cholesterol Other (please explain): _____	<p>Habits:</p> Do you smoke? _____ _y _n How many per day? _____ Do you drink alcohol? _____ _y _n How much per day? _____ Do you consume caffeine? _____ _y _n How much per day: _____ List vitamins/supplements: _____ Water intake: _____ ounces per day How old is your bed? _____ Sleep quality? _____ Rate your stress level: <input type="radio"/> Stress free <input type="radio"/> Low stress <input type="radio"/> Moderate stress <input type="radio"/> High stress <input type="radio"/> The worst possible stress Stress factors: <i>Check all that apply.</i> <input type="radio"/> Relationship <input type="radio"/> Family <input type="radio"/> Work <input type="radio"/> School <input type="radio"/> Other: _____ _____
<p>Integumentary</p> <input type="checkbox"/> dry skin <input type="checkbox"/> psoriasis <input type="checkbox"/> eczema <input type="checkbox"/> acne	<p>Constitutional</p> <input type="checkbox"/> poor appetite <input type="checkbox"/> weakness <input type="checkbox"/> sudden weight change <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> fainting <input type="checkbox"/> difficulty losing weight	<p>Endocrine</p> <input type="checkbox"/> thyroid issues <input type="checkbox"/> hypoglycemia <input type="checkbox"/> low energy <input type="checkbox"/> swollen glands <input type="checkbox"/> polycystic ovarian syndrome	

Name _____



Atlas Chiropractic Health Center

EMERGENCY CONTACT

Name: _____
Phone: _____ Is this a cell phone? yes no
Address: _____

Relation: _____
Work Phone: _____
City/State/Zip: _____

INSURANCE INFORMATION

Insurance Company: _____
Address: _____
Insured's Name: _____
Group #: _____ Member ID#: _____
Insured's Employer: _____

Phone: _____
City/State/Zip: _____
Insured's SS#: _____
Insured's Birth Date: _____

PERSONAL INFORMATION

Address: _____
Phone: _____ Is this a cell phone? yes no
Email: _____

City/State/Zip: _____
Work Phone: _____

Date of Birth (mm/dd/yyyy): ___/___/___ Age: _____ Legal Gender (for insurance use): female male
SS#: _____ Driver License #: _____ US State of Issue: _____

Occupation: _____ Circle one: *full-time* *part-time* School or Employer's Name: _____

Work or School City/State: _____

How were you referred to our office?

Single Married Partnered Divorced Widowed

Optional questions:

Gender Identity: female male transgender non-binary other: _____
My preferred pronouns are: she/her he/him them/they other: _____

PLEASE READ, SIGN, AND DATE BELOW

I hereby acknowledge that the information provided above is true and accurate. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Atlas Chiropractic Health Center** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Atlas Chiropractic Health Center** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my financial responsibility. Any dispute between legal parties shall be resolved by binding arbitration. It is not our intention to cause you undue hardship, however we must collect our receivables as efficiently as possible in order to continue our service to the community. Interest of 1% per month will be charged on delinquent accounts. If you discontinue your care, all charges are due immediately.

Patient Signature: _____

Date: _____

Guardian/Spouse Signature Authorizing Care: _____

Date: _____

Printed Guardian/Spouse Full Name: _____

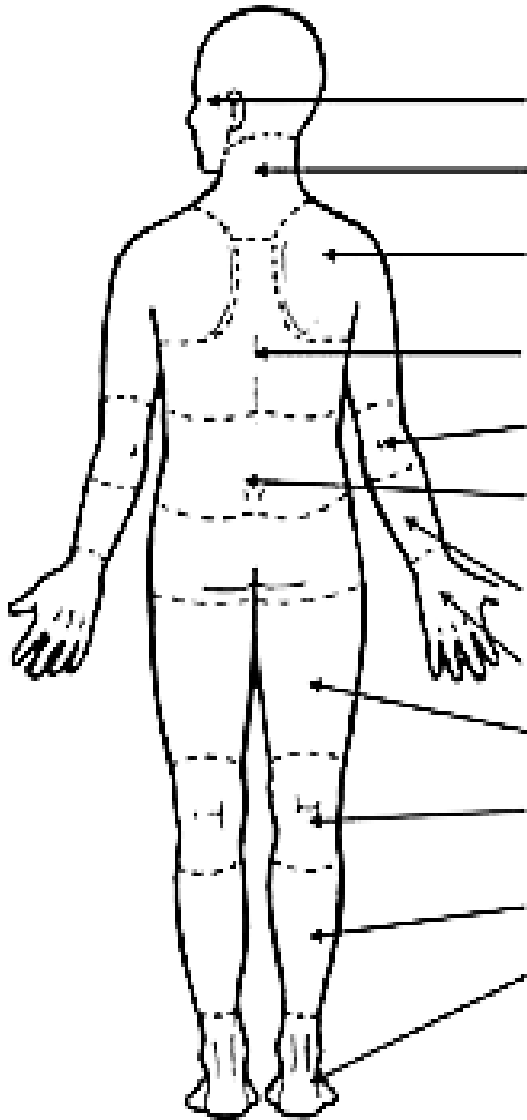


**Atlas Chiropractic
Health Center**

Functional Pain Index

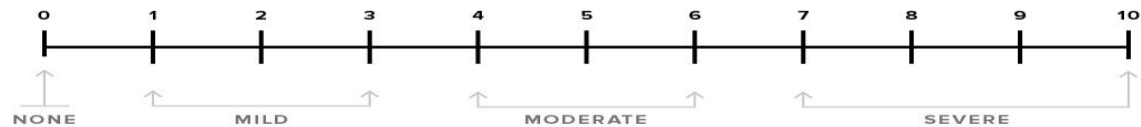
Please check the appropriate box to let us know how you feel TODAY.

Patient Name: _____ Date: _____



Body Part	Right/Left	0	1	2	3	4	5	6	7	8	9	10
<i>BODY-OVERALL</i>												
<i>Head</i>												
<i>Neck</i>	Right/Left											
<i>Shoulders/Chest</i>	Right/Left											
<i>Upper Back</i>	Right/Left											
<i>Elbow</i>	Right/Left											
<i>Lower Back</i>	Right/Left											
<i>Arm</i>	Right/Left											
<i>Wrist/Hand</i>	Right/Left											
<i>Pelvis/Hips</i>	Right/Left											
<i>Thigh</i>	Right/Left											
<i>Knee</i>	Right/Left											
<i>Lower Leg</i>	Right/Left											
<i>Feet/Ankle</i>	Right/Left											

0-10 NUMERIC PAIN RATING SCALE





NECK PAIN EVALUATION

NECK PAIN DISABILITY INDEX

Name: _____ Age: _____ Date: _____ Score: _____

PLEASE READ: Please complete this questionnaire. It is designed to give us information as to how your **NECK** trouble has affected your ability to manage in everyday life.
Please answer **every section**. Mark one box only in each section that most closely described you **today**.

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 (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- 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 me extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. 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 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 hardly read at all because of severe pain in my neck.
- I cannot 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 all the time.

Section 6 – Concentration

- I can concentrate fully when I want with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty concentrating when I want to.
- I have a lot of difficulty concentrating when I want to.
- I have a great deal of difficulty concentrating when I want to.
- I cannot 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 cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Section 8 – Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight neck pain.
- I can drive my car as long as I want with moderate neck pain.
- I can't drive my car 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.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1 to 2 hours sleepless).
- My sleep is moderately disturbed (2 to 3 hours sleepless).
- My sleep is greatly disturbed (3 to 5 hours sleepless).
- My sleep is completely disturbed (5 to 7 hours sleepless).

Section 10 – Recreation

- I am able to engage in all of my recreation activities with no neck pain.
- I am able to engage in all my recreation activities with some neck pain.
- I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- I am able to engage in a few of my usual recreation activities because of neck pain.
- I can hardly do any recreation activities because of neck pain.
- I can't do any recreation activities at all because of neck pain.



LOW BACK & LEG EVALUATION

OSWESTRY Disability Index 2.0

Name: _____ Age: _____ Date: _____ Score: _____

PLEASE READ: Please complete this questionnaire. It is designed to give us information as to how your BACK (OR LEG) trouble has affected your ability to manage in everyday life. Please answer every section. Mark one box only in each section that most closely described you today.

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 (washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
I can look after myself normally but it is very painful.
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, 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 me extra pain.
Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. 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 only 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 walking more than 1 mile.
Pain prevents me walking more than 1/4 of a mile.
Pain prevents me walking more than 100 yards.
I can only walk using a stick or crutches.
I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- I can sit in any chair as long as I like.
I can sit in my favorite chair as long as I like.
Pain prevents me from sitting for more than 1 hour.
Pain prevents me from sitting for more than 1/2 hour.
Pain prevents me from sitting for 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 more than 1 hour.
Pain prevents me from standing for more than 1/2 an hour.
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 sleep.
Because of pain, I have less than 4 hours sleep.
Because of pain, I have less than 2 hours sleep.
Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)

- My sex life is normal and causes no extra pain.
My sex life is normal but causes some extra pain.
My sex life is nearly normal but is very painful.
My sex life is severely restricted by pain.
My sex life is nearly absent because of pain.
Pain prevents any sex life at all.

Section 9 - Social Life

- My social life is normal and cause me no extra pain.
My social life is normal but increases the degree of pain.
Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
Pain has restricted my social life and I do not go out as often.
Pain has restricted social life to my home.
I have no social life because of pain.

Section 10 - Traveling

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



Name: _____ Age: _____ Date: _____

Fill Out If You Have Been in a Job Related Injury

Was your accident directly related to your work? Yes No

Briefly describe the events that occurred just before and during your accident: _____

Give the address where the accident occurred: (if other than employer's address) _____

Was anyone else present during your accident? Yes No

Did you report your accident to your employer? Yes No

What recommendations did your employer make just after your accident?

Has this type of accident happened to you before? Yes No

To the best of your knowledge, has this accident occurred in your workplace before? Yes No
In general:

Is your job physically stressful? Yes No

Is your job mentally stressful? Yes No

Is your workplace noisy? Yes No

Have you changed jobs in the last year? Yes No

After Injury

Did accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a hospital or seen any other Doctor? Yes No

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance Private transportation

Name of hospital and/ or attending doctor:

Was he/she a D.C. M.D. D.O. D.D.S.

Describe any treatment you received: _____

Were X-Rays taken? Yes No Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury? Yes No



Name: _____ Age: _____ Date: _____

Indicate the symptoms that are a result of this accident:

- Dizziness Difficulty Sleeping Jaw Problems Nausea
- Memory Loss Irritability Arms/Shoulder Pain Back Pain
- Headache(s) Fatigue Numb hands/ fingers Lower Back Pain
- Blurred vision Tension Back Stiffness Buzzing in ear
- Neck Pain Chest Pain Leg Pain Ears Ringing
- Stiff Neck Shortness of Breath Stomach Upset Numb feet/ toes
- Other _____

Is your condition getting worse? Yes No Constant Comes and goes

Indicate your degree of comfort while performing the following activities:

- | | | | |
|------------------|--------------------------------------|--|----------------------------------|
| Lying on back | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Lying on side | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Lying on stomach | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Sitting | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Standing | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Stretching | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Lovemaking | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Walking | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Running | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Sports | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Working | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Lifting | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Bending | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Kneeling | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Pulling | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |
| Reaching | <input type="checkbox"/> Comfortable | <input type="checkbox"/> Uncomfortable | <input type="checkbox"/> Painful |

Have you attained an attorney? Yes No

If yes:

Name: _____

Address: _____

Phone Number _____ Fax: _____

Email: _____



Name: _____ Age: _____ Date: _____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

- Standing Driving Operating equipment
- Sitting Twisting Work with arms above head
- Walking Crawling Typing
- Lifting Bending Stooping
- Other _____

What positions can you work in with minimum physical effort and for how long?

_____ N/A

Prior to the injury were you capable of working on an equal basis with others your age? Yes No N/A

Do you work with others who can help you with any heavy lifting? Yes No N/A

While in recovery, is there any light duty work you could request? Yes No N/A

- o We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient
- o Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- o I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- o I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date: ____/____/____

- Adult patient Parent or Guardian Spouse