Providing Spinal Health

COMMONHEALTH CHIROPRACTIC

Est. 1996

To the Commonwealth

Date: _____

Case Number: _____ (For Office Use Only)

Name: _____

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____-____-_____ Birthday: _____-_____-_____

Spouse's Name: _____

Social Security#: _____-____-_____ Birthday: _____-_____-____

Contact Information

Home: _____-_____-_____ Work: _____-_____-____

Cell: _____-_____-_____ Mobile Provider _____ Email: _____@_____

Emergency Contact: _____ (relationship) _____

Emergency Contact's Number: _____-_____-_____

How did you hear about us? _____

Please help us work to improve the quality of health care. Your responses to these questions help us ensure quality care for all groups of people.

Please circle the appropriate response:

Race:

American Indian or Alaska Native Asian Black or African American Native Hawaiin or Other Pacific Islander White Other

Ethnicity:

Hispanic/Latino Not Hispanic/Not Latino Undefined

Preferred Language:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRIMARY COMPLAINT

Area of Complaint:_____ Right Left Bilateral

When did your complaint begin? _____

How did your complaints begin? Unknown Suddenly Gradually

What happened to cause or re-aggravate your complaint?

Not Known Work Accident Auto Accident Home Accident Sports Injury

Other, explain:_____

Has this complaint existed in the past? Yes, how long ago_____ No

Have you received any recent treatment for this complaint? Yes No

If yes, please list dates, treatment type and doctor_____

_____

Have you experienced a change in any of the following since your symptoms began?

Bowel Function Bladder Function Sexual Function None

Is your condition: Improving Worsening Not Changing

What is the rate of change: Slowly Gradually Quickly

Has change occurred since: Last Month Last Week Other:_____

What is the quality of your pain: Stiff Dull Achy Sharp Shooting Burning Tingling Throbbing Other:_____

Is your pain: Mild Moderate Severe

Please Rate Your Pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Is the pain Constant Frequent Intermittent Occasional

Does the pain radiate? Y N To where:_____

What time of day does it feel worse: Morning Afternoon Evening While Sleeping

What aggravates your pain?_____

What alleviates your pain?_____

Is there numbness? Y N Where:_____

Is there spasm? Y N Where:_____

Is there swelling? Y N Where:_____

If your complaint involves headaches, please complete the following:

What is the location of your headaches: Front Side Back Sinus (Of Head)

What time of day does it feel worse: Morning Afternoon Evening While Sleeping

How often do they occur: _____ times per: Hour Day Week Month

Please Rate Your Pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

What is the duration of your headaches: _____ Minutes Hours Constant

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR SECONDARY COMPLAINT

Area of Complaint:_____ Right Left Bilateral

When did your complaint begin? _____

How did your complaints begin? Unknown Suddenly Gradually

What happened to cause or re-aggravate your complaint?

Not Known Work Accident Auto Accident Home Accident Sports Injury

Other, explain:_____

Has this complaint existed in the past? Yes, how long ago_____ No

Have you received any recent treatment for this complaint? Yes No

If yes, please list dates, treatment type and doctor_____

_____

Have you experienced a change in any of the following since your symptoms began?

Bowel Function Bladder Function Sexual Function None

Is your condition: Improving Worsening Not Changing

What is the rate of change: Slowly Gradually Quickly

Has change occurred since: Last Month Last Week Other:_____

What is the quality of your pain: Stiff Dull Achy Sharp Shooting Burning Tingling Throbbing Other:_____

Is your pain: Mild Moderate Severe

Please Rate Your Pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

Is the pain Constant Frequent Intermittent Occasional

Does the pain radiate? Y N To where:_____

What time of day does it feel worse: Morning Afternoon Evening While Sleeping

What aggravates your pain?_____

What alleviates your pain?_____

Is there numbness? Y N Where:_____

Is there spasm? Y N Where:_____

Is there swelling? Y N Where:_____

If your complaint involves headaches, please complete the following:

What is the location of your headaches: Front Side Back Sinus (Of Head)

What time of day does it feel worse: Morning Afternoon Evening While Sleeping

How often do they occur: _____times per: Hour Day Week Month

Please Rate Your Pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain possible)

What is the duration of your headaches: _____ Minutes Hours Constant

HISTORY

With whom do you currently live: Alone Spouse Spouse/Children (#) Other

Smoking Status: Current Former Never

Alcohol Intake: None Casual Moderate Severe

Caffeine Intake: None < 3/day 3 to 6/day >6/day

Recreational Drugs: None Recreational User Addict

Exercise Frequency: Never Daily (3-7x/week) Weekly

Exercise Type: _____

What is your Occupation? _____

Are you currently: In School Employed Unemployed Retired

How long have you been at your current job? _____

What is your: Height: _____ **Weight:** _____

Female Patients, to the best of your knowledge are you pregnant? Y N

Do you currently have a Primary Care Physician? Y N

Doctor's Name: _____

Have you been to a chiropractor prior to today's visit? Y N

Please complete the following regarding medications you are currently taking:

DATE STARTED	DRUG NAME	PRESCRIBED BY

Please list any allergies:

Allergy	Reaction

Please list any surgeries:

Date (Approximate)	Surgery

Please list hospitalizations (you can exclude surgery related if listed above):

Date (Approximate)	Reason	Hospital

Please list any major illnesses:

Date (Approximate)	Illness

Please list any pertinent family history:

Relationship	History	Deceased Y/N	Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Paternal Grandparent			
Maternal Grandparent			

To the best of my knowledge, all of the information completed above is correct.

Signature: _____ Date: _____