RIVERSIDE FAMILY CHIROPRACTIC

Welcome to Our Office!

Chiropractic Case History/Patient Information

Name: _____ Social Security # _____-_____-_____

Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Home # _____- _____-_____ Cell # _____-_____-_____

Date of Birth: _____/_____/_____ Marital: M S W D How many children? ____

Occupation: _____ Employer: _____

Work Address: _____ Office # _____-_____-_____

Spouse: _____ Phone # _____-_____-_____

Emergency Contact: _____ Phone # _____-_____-_____

How were you referred? _____ Have you had Chiropractic Care before? (y or n)

Any medications? _____ If yes, when was your last treatment? _____

_____ PCP _____ Phone_____

Current Health Condition

Chief Complaint (why are you here today?) Have you seen any other doctors for this condition? (y or n)

_____ If yes, who? _____

Type of treatment: _____ Results: _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

☐Yes ☐No ☐ Uncertain ☐ N/A

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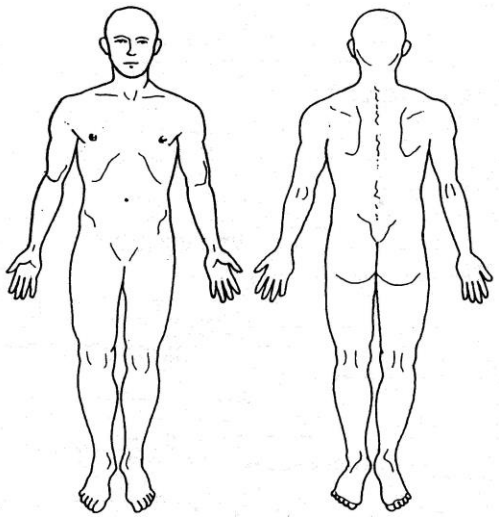
78 Tuscarawas Road
Beaver, PA 15009
724-709-7793

QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > >	Numbness = = = = = =	Pins & Needles o o o o
Burning x x x x	Stabbing / / / / /	Throbbing ~ ~ ~ ~ ~ ~



When did this condition begin? _____

Has it ever happened before? _____

Is condition:
____ Auto related
____ Work related
____ Other
____ No injury

If auto related, list the date and time of accident? _____

If work related, have you filed an injury report? (y or n)

If yes, claim #: _____

##########

1. What is your pain RIGHT NOW?

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

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

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

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)?

no pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

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

NAME _____ AGE_____ DATE_____ SCORE_____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

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Review of Systems

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can effect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections even if "NONE".

Constitutional: ☐ None	☐ Chills ☐ Weight Loss	☐ Daytime Somnolence	☐ Fatigue	☐ Fever	☐ Night Sweats	☐ Weight Gain
Eyes/Vision: ☐ None	☐ Blindness ☐ Field Cuts	☐ Blurred Vision ☐ Glasses/Contacts	☐ Cataracts ☐ Glaucoma	☐ Change in Vision ☐ Itching	☐ Double Vision ☐ Photophobia	☐ Eye Pain ☐ Tearing
ENT: ☐ None	☐ Bleeding ☐ Ear Pain ☐ Hoarseness ☐ Sinus Infections	☐ Dentures ☐ Fainting ☐ Loss of Smell ☐ Snoring	☐ Difficulty Swallowing ☐ Frequent Sore Throats ☐ Nasal Congestion ☐ Tinnitus (Ringing in Ears)	☐ Discharge ☐ Headaches ☐ Nose Bleeds ☐ TMJ	☐ Dizziness ☐ Hearing Loss ☐ PND (Post Nasal Drip)	☐ Ear Drainage ☐ History of Head Injury ☐ Rhinorrhea (Runny Nose)
Respiration: ☐ None	☐ Asthma	☐ Cough	☐ Coughing up Blood	☐ Shortness of Breath (SOB)	☐ Sputum Production	☐ Wheezing
Cardio: ☐ None	☐ Angina ☐ Palpitations	☐ Chest Pain ☐ PND	☐ Claudication ☐ SOB with Exertion	☐ Heart Murmur ☐ Swelling of Legs	☐ Heart Problems ☐ Ulcers	☐ Orthopnea ☐ Varicose Veins
Gastro: ☐ None	☐ Abdominal Pain ☐ Heartburn ☐ Regurgitation	☐ Belching ☐ Hemorrhoids ☐ Stool Caliber	☐ Black Tarry Stools ☐ Indigestion ☐ Stool Color	☐ Constipation ☐ Jaundice ☐ Stool Consistency	☐ Diarrhea ☐ Nausea ☐ Vomiting	☐ Difficulty Swallowing ☐ Rectal Bleeding ☐ Vomiting Blood
Female: ☐ None	☐ Breast Lumps/Pain ☐ Vaginal Bleeding	☐ Burning Urination ☐ Vaginal Discharge	☐ Cramps	☐ Frequent Urination	☐ Irregular Menstruation	☐ Urine Retention
Male: ☐ None	☐ Burning Urination	☐ Erectile Dysfunction	☐ Frequent Urination	☐ Hesitancy/Dribbling	☐ Prostate	☐ Urine Retention
Endocrine: ☐ None	☐ Cold Intolerance ☐ Goiter	☐ Diabetes ☐ Hair Loss	☐ Excessive Appetite ☐ Heat Intolerance	☐ Excessive Hunger ☐ Unusual Hair Growth	☐ Excessive Thirst ☐ Voice Changes	☐ Frequent Urination
Skin: ☐ None	☐ Changes in Nail Texture ☐ Itching	☐ Changes in Skin Color ☐ Paresthesias	☐ Hair Growth ☐ Pruritis	☐ Hair Loss ☐ Rash	☐ History of Skin Disorders ☐ Skin Lesions/Ulcers	☐ Hives ☐ Varicosities
Nervous: ☐ None	☐ Dizziness ☐ Numbness ☐ Tremor	☐ Facial Weakness ☐ Seizures ☐ Unsteadiness of Gait	☐ Headache ☐ Sleep Disturbance	☐ Limb Weakness ☐ Slurred Speech	☐ Loss of Consciousness ☐ Stress	☐ Loss of Memory ☐ Strokes
Psychologic: ☐ None	☐ Anhedonia ☐ Depression	☐ Anxiety ☐ Insomnia	☐ Appetite ☐ Memory Loss	☐ Behavioral Change ☐ Mood Change	☐ Bipolar	☐ Confusion
Allergy: ☐ None	☐ Anaphalaxis	☐ Food Intolerance	☐ Itching	☐ Nasal Congestion	☐ Sneezing	
Hematology: ☐ None	☐ Anemia ☐ Lymph Node Swelling	☐ Bleeding	☐ Blood Clotting	☐ Blood Transfusions	☐ Bruising	☐ Fatigue

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PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course o

Childhood Illness:
☐ None
☐ ADD ☐ Allergies/Hayfever ☐ Asthma ☐ Atopic Dermatitis ☐ Cerebral Palsy
☐ Depression ☐ Diabetes ☐ Fetal Drug Exposure ☐ Food Allergies ☐ Headaches
☐ Measles ☐ Mumps ☐ Rash ☐ Seizure Disorder ☐ Sickle Cell Anem
☐ Unusual Childhood Illnesses

Adult Illnesses:
☐ None
☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chicken Pox
☐ CVA (Stroke) ☐ Depression ☐ Diabetes (Insulin Dep) ☐ Diabetes (NIDDM - Noninsulin) ☐ Eye Problems
☐ Hepatitis ☐ Hypertension ☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease
☐ Seizures ☐ Similar Symptoms ☐ STD's ☐ Suicide Attempts ☐ Thyroid Problem

Surgeries:
☐ None
☐ Angioplasty ☐ Appendectomy ☐ Caesarean Section ☐ Cardiac Catheterization ☐ Carpal Tunnel R
☐ Cosmetic ☐ D&C ☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hysterectomy
☐ Joint Replacement ☐ Laminectomy ☐ Mastectomy ☐ Pacemaker Insertion ☐ Spinal Fusion
☐ Gallbladder
☐ Other _____

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SOCIAL HISTORY

Alcohol: ☐ None ☐ Beer ☐ Liquor ☐ Social Consumption

Diet:
☐ High Fat Diet ☐ High Fiber ☐ High Protein ☐ High Salt Intake
☐ Low Calorie Intake ☐ Low Carbohydrate ☐ Low Fiber ☐ Low Salt

Education: Level or Degree Attained: _____

Substance: ☐ Denies Any ☐ Denies IV Drugs Not Used Since _____

Tobacco: Type _____ Amount _____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ☐ Yes ☐ No If yes, please explain _____

_____

Any other conditions you feel we should know about, even if unrelated?

_____

_____

_____

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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