ADVANCED HEALTH CHIROPRACTIC AND MASSAGE

Patient Information Today's Date: ___________________

Name ____ Age ______ Gender: M F (Pregnant: Yes No)

Home Address ____ Home Phone ______________________________

City, State, Zip ______________________________________ Cell Phone ______________________________

Email Address ____

Birth date _______________________ Social Security Number ________________ Marital Status: S M D W P

Occupation, Employer ______________________________________How many people in your household? ________

Emergency Contact ____ Phone _________________________________

How were you referred to this office? ____

Who is your Primary Care Doctor? ____

Is This Visit Related To A: Work Injury Car Collision Injury Home Injury Non-Injury Symptoms Gradual Onset Other

Experience with Chiropractic **DO YOU HAVE P.I.P.?** Yes No Not Sure

Have you seen a Chiropractor before? □Yes □No Who? ____

Reason for visit(s) with previous provider: ____

Did your previous provider take x-rays? □Yes: Year ______ □No What was the diagnosis? _________________________________

Did they recommend a specific course of treatment? □Yes □No

Did they recommend a home health care program? □Yes □No If yes, what? _________________________________

How long were you treated? _________________________ Last treatment date: _________________________

How did you respond? ____________________________________ Have you ever had Massage Therapy Treatments? Yes No

Health & Lifestyle

Do you exercise? □Yes □No How often? ______ day(s) per week; Do You Play An Instrument:_______________________

What are your current Hobbies? ____

Do you smoke? □Yes □No How much/how often? ____

Do you drink alcohol? □Yes □ No How much/how often? ____

Do you drink coffee? □Yes □No How much/how often?____

How much water do you drink daily? ________ cups (1 cup = 8oz)

Do you take supplements? □Yes □No Please list: ____

Do you sleep on your: □ Back □ Side □ Stomach

Health History

Indicate whether **F**ather, **M**other, **S**ister, **B**rother, or **S**elf has been diagnosed with the following:

___ **STROKE**	___ Diabetes	___ Neurological Problems	___ Lung Disease	___ Lumbago
___ Heart Disease	___ Circulatory Problems	___ Whooping Cough	___ Heat Murmur	___ Eczema/Psoriasis
___ Cancer	___ Broken Bones/Fractures	___ Pneumonia/Bronchitis	___ Osteoporosis	___ Varicose Veins
___ High Blood Pressure	___ Paralysis	___ Arthritis	___ Rheumatic Fever	___ Small Pox
___ Liver Disease	___ Metal Implants	___ Infectious Disease	___ Gall Bladder	___ Measles
___ Migraine Headaches	___ Appendectomy	___ Tonsillectomy	___ Hernia	___Pleurisy
___ Kidney Disease	___ Polio	___ Tuberculosis	___ Anemia	___ Mumps
___ Epilepsy/Seizures	___ Chicken Pox/Shingles	___ Blood Sugar Problems	___ Influenza	___Thyroid Problems

___ Other: ____

Injury History

List ALL past **Auto Collisions**, Month/Year, type of collision (rear-end, side impact) and if care was given.

1.____

2.____

List ALL **Worker's Compensation** claims, Injured Body Regions, Month/Year, and what type of care received.

1. ____

2. ____

List ALL past **Hospitalizations and Surgeries** (including augmentation), Month/Year, and type of injury.

1. ____

2. ____

3. ____

Please list all **medications** you are currently taking:____

1. Injury Information

Date of Injury	Date: Time:
Name of Employer at Time of Injury	
Address of Employer	
Job Title	Title: Length of time employed (months/yrs)

Have you notified your employer about your injury?	Yes □ □ No
Has your employer notified their workers' compensation insurance carrier?	Yes □ □ No
Have you filled out an injured worker's claim form?	Yes □ □ No
Do you have an attorney representing you for this work-related injury?	Yes □ □ No
If yes, provide name/address/telephone:	
Have you missed any time off work?	Yes □ □ No
If yes, please indicate the dates you have been off work: From: ____________ To: _______________	
What is your job description?	
How many hours did you work in a typical day?	
How many hours did you work in a typical week?	

2. Worker's Compensation Insurance Information

Name of Insurance Carrier	
Address of Insurance Carrier	
Claims Adjusters Information	Name: Telephone:
Claim Number	

3. Job Duties at Time of Injury (Check column that applies to the frequency of a specific activity at your job)	**Never** (0 Hours)	**Occasionally** (1-15x/hr) (Up to 3 hrs)		**Frequently** (16-60 x/hr) (3-6 hrs a day)		**Constant** (More than 60 x/hr) (6-8 hrs a day)	
Bending head and neck							
Twisting head and neck							
Bending Waist							
Twisting Waist							
Lifting less than 25 pounds							
Lifting heavier than 25 pounds							
Bending while lifting							
Reaching above the level of your head							
Reaching above the level of your shoulder							
Carrying objects in hand							
Gripping or fingering objects left hand							
Gripping or fingering objects right hand							
Fine movement with fingers							
Handwriting							
Pushing and pulling with left hand							
Pushing and pulling with right hand							
Keyboarding on computer							
Heavy or power use of hands							
Crawling							
Crouching or squatting							
Walking							
Kneeling							
Standing							
Climbing							
Sitting while driving a vehicle							
Sitting (other than driving)							

4. Symptom Information

Did anyone Witness?
□ Co-Worker □ __________________
□ Supervisor □ __________________

When did you first notice pain or symptoms?
□ Immediately □ Within 24 Hours
□ Within 1-7 Days □ Other

Was any part of your head hit?

Forehead	Yes □ □ No
Back of head	Yes □ □ No
Left side of head	Yes □ □ No
Right Side of head	Yes □ □ No
Top of head	Yes □ □ No

Other: ________________________________

Did you lose consciousness?	Yes □ □ No
Did you black out?	Yes □ □ No
Have you lost any memories prior to your injury?	Yes □ □ No
Immediately after did you feel an altered state of awareness, dazed, confused, shock, or anger?	Yes □ □ No
Has your memory been different since your injury?	Yes □ □ No
Did you have a lump or bruise on a part of your head?	Yes □ □ No
Have you had any head injuries in your past?	Yes □ □ No

Please Explain:

Where did you go after the accident?
□ Home □ Work □ ER □ Private Doctor

How did you get there?
□ Drove Self □ Police □ Ambulance □ Somebody Else

Were XRAYS taken? Yes □ □ No **Was lab work done? Yes □ □ No**

Body parts XRAYed? ____

What lab work? ____

The XRAYS revealed: ____

Did you have an MRI or CT Scan? Yes □ □ No

Treatments: □ **Cervical Collar** □ **Ice** □ **Other:** ________________________

Medications: ____

Follow-Up Instructions: ____

Check off your symptoms right after and a few days following:

□ Headaches	□ Dizziness	□ Loss of Concentration
□ Neck pain	□ Nausea	□ Reduce3d Drive/Motivation
□ Neck Stiffness	□ Confusion	□ Reduced Tolerance to Alcohol
□ Fainting	□ Fatigue	□ Absence of ability to Anticipate
□ Ringing in Ears	□ Tension	□ Difficulty Finishing Task
□ Loss of Smell	□ Irritability	□ Abnormal Levels of Anxiety
□ Poor Memory	□ Inflexibility	□ Impaired Sexual Function
□ More Assertive	□ LanguageDifficulty	□ Difficulty handling multiple tasks
□ Forgetful	□ Personal Change	□ Less Diplomatic than Normal
□ Anger Outbursts	□ Head Tremors	□ Reduced Attention Span
□ Depression	□ Mood Swings	□ Indefference to other People
□ Mid Back Pain	□ Cold Hands	□ More Shallow Relationships
□ Low Back Pain	□ Cold Feet	□ Difficulty with Problem Solving
□ Nervousness	□ Diarrhea	□ Less Mental Stamina
□ Loss of Taste	□ Depression	□ Performance Inconsistencies
□ Toe Numbness	□ Anxious	□ Verbal Learning Problems
□ Constipation	□ Chest Pain	□ Slower Reaction Times
□ Fatigue	□ Impaired Judgement	□ Sleeping Problems
□ Blackouts	□ Blurry Vision	□ Shortness of Breath
□ Loss of Balance		□ Need Reminders
□ Pain behind eyes		

□ Others: ____

5. Please describe, to the best of your knowledge, exactly what happened minutes before your injury until you arrived home. Including body positioning, surroundings, work conditions, who helped, etc.

____
____
____
____
____
____
____
____
____
____
____
____

Please draw a picture of the surroundings as it applies to your injury.

Is This Visit Related To A: **Work Injury** **Car Collision Injury** **Home Injury** **Non-Injury Symptoms** **Gradual Onset** **Other**

Patient Name:

What brought you in to see us today?

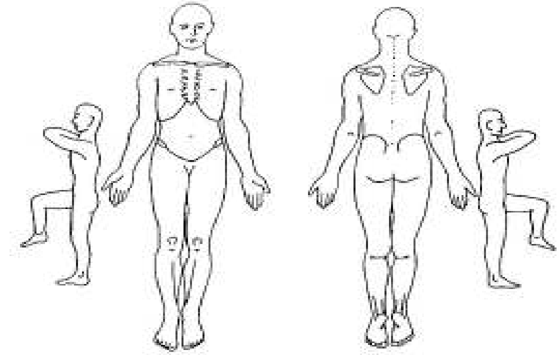
How did you hurt yourself?

When did the symptoms begin?

On the picture below, use the **indicated marks** to show areas where you have, at any time, experienced:

Indicator Marks:

Pain:	**XXXX**
Numbness:	**////**
Tingling:	****



Please indicate your pain from 0-10; with 10 being the worst pain and 0 being no pain.
Circle all that Apply

Neck ____/10; At Worst ____/10; At Best ____/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain: Burning Numbness
Stabbing Dull Sharp
Throbbing Tight Aching
Tingling Tender

How Often is Pain during Waking Hours?
Intermittent (0-25%) Frequent (51-75%)
Occasional (26-50%) Constant (76-100%)

Are you experiencing Headaches? Yes □ □ No
If yes how often?

Are you experiencing pain down your arms? Yes □ □ No
If yes, Left Arm or Right Arm or Both

How do the following motions affect your pain?

	No Change	Relieves	Increased
Looking Up	□	□	□
Looking Down	□	□	□
Right Head Rotation	□	□	□
Left Head Rotation	□	□	□

Mid-Back ___/10; At Worst ___/10; At Best ____/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain: Burning Numbness
Stabbing Dull Sharp
Throbbing Tight Aching
Tingling Tender

How Often is Pain during Waking Hours?
Intermittent (0-25%) Frequent (51-75%)
Occasional (26-50%) Constant (76-100%)

Do you get pain with breathing? Yes □ □ No
If Yes, Where? ____________

Does your pain wrap around your ribs? Yes □ □ No
If Yes, Where? ____________

How many hours per day do you sit in a chair? ______ hrs
How many hours per day are you at a computer? ______ hrs

Low-Back ___/10; At Worst __/10; At Best ___/10

Is the pain on the: **Left** **Right** **Center**

Type of Pain: Burning Numbness
Stabbing Dull Sharp
Throbbing Tight Aching
Tingling Tender

How Often is Pain during Waking Hours?
Intermittent (0-25%) Frequent (51-75%)
Occasional (26-50%) Constant (76-100%)

Do you have pain with coughing, sneezing or going to the bathroom? Yes □ □ No
If Yes, Where? ____________

Do you have pain in butt or down the leg? Yes □ □ No

How do the following motions affect your pain?

	No Change	Relieves	Increased
Sitting	□	□	□
Walking	□	□	□
Standing	□	□	□
Lying Down	□	□	□
Lifting	□	□	□
Bending	□	□	□

Patient Initials: ____________ Date: ______________

List of Extremities:

Shoulder	TMJ/Jaw	Knee
Elbow	Ribs	Ankle
Wrist	Hand	Foot

Please indicate Right or Left by Circling R or L

Extremity: **R L**________________________ ___/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

Extremity: **R L**________________________ ___/10

Type of Pain:	Burning	Numbness
Stabbing	Dull	Sharp
Throbbing	Tight	Aching
Tingling	Tender	

How Often is Pain during Waking Hours?

Intermittent (0-25%)	Frequent (51-75%)
Occasional (26-50%)	Constant (76-100%)

What have you done to try to relieve the pain?

Heat	Ice	Stretching	Nothing Helps
Rest	Medicine	Massage	Other:

Have you seen another professional for this condition?

Medical Doctor: ____________________

Chiropractor: ____________________

Physical Therapist: ____________________

Other:

Prior Similar Symptoms

□ I have NOT had prior symptoms similar to my current complaints

□ My current complaints DID exsist before, but have not been bothering me.

□ My current complaints ALREADY existed and were worsened.

Has your History contributed to your current symptoms?

□ My history HAS contributed to my current symptoms.

□ My history HAS NOT contributed to my current symptoms.

□ I'm NOT SURE if my history has contributed.

Circle the TOP 3 activities which are most affected by your pain. Circling an activity does not necessarily mean you are unable to perform it, it simply means your pain affects the activity, even just your enjoyment.

Walking	Sitting	Showering	Jogging	Standing	Dishes
Reading	Driving	Sex	Shaving	Gym	Chores
Working	Swimming	Sleeping	Bending	Dressing	Gardening

Please mark each that apply to your Daily Activities:

□ Stays at home most of the time due to the problem

□ Changes position frequently to try and get comfortable

□ Walks more slowly than usual because of the problem

□ Does not do jobs about the house because of the problem

□ Has to use handrails to get up the stairs

□ Has to lie down and rest frequently due to the problem

□ Has to hold onto something to sit or stand from a chair

□ Has to get other people to do things for you

□ Has difficulty getting dressed due to the problem

□ Can only stand for short periods due to the problem

□ Has difficulty bending or kneeling due to the problem

□ Has difficulty turning over in bed due to the problem

□ Has a loss of appetite due to the problem

□ Can only walk short distances because of the problem

□ Has difficulty sleeping because of the problem

□ Has to get dressed with someone's help

□ Has to sit most of the day because of the problem

□ Has more irritable because of the problem

□ Stays in bed most of the day because of the problem

How often do you have to stop activities to sit or lie down to control your pain?

□ All Day

□ Several times a day

□ Occasionally

□ Approx Once per day

□ Never

Patient Initials: _____________ Date: _______________

Patient Name:

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.

2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which Dr. Robinson checks for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I authorize and agree to allow the doctor and his designated staff to work with my case, my spine and the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I intend this consent to apply to all my present and future chiropractic care.

Patient Printed Name: ____ Date: _________________________

Patient Signature: ____