

PATIENT INFORMATION

NAME _____ M / F
ADDRESS _____ AGE _____ BIRTHDAY _____
CITY _____ STATE _____ ZIP _____ EMAIL: _____
PHONE: HOME _____ CELL _____ WORK _____
MARITAL STATUS _____ NUMBER & AGES OF CHILDREN _____
EMPLOYER _____ TYPE OF WORK _____
HOW DID YOU HEAR OF US? (PLEASE CHECK ALL THAT APPLY) NEWSPAPER PHONE BOOK INTERNET SEARCH WEBSITE
 CHAMBER OF COMMERCE REFERRAL: WHO MAY WE THANK? _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____
BEST PHONE TO REACH HIM/HER: _____ CELL / HOME / WORK

PURPOSE OF THIS VISIT

IS IT RELATED TO? (PLEASE CIRCLE ONE) AUTO ACCIDENT / WORK INJURY / NOT RELATED
REASON FOR THIS VISIT (PLEASE DESCRIBE) _____
WHEN DID IT BEGIN? _____ HOW DID IT HAPPEN? _____
HAVE YOU HAD THIS CONDITION BEFORE? NO IF YES, WHEN? _____
WHAT TREATMENT HAVE YOU TRIED? _____
HOW DID YOU RESPOND? _____
WHAT MAKES IT WORSE? _____ BETTER? _____
WHO IS YOUR MEDICAL DOCTOR OR PRIMARY PHYSICIAN? _____
WOULD YOU LIKE US TO SHARE OUR FINDINGS WITH HIM/HER? YES NO

PRIOR EXPERIENCE WITH CHIROPRACTIC

HAVE YOU SEEN A CHIROPRACTOR BEFORE? NO YES WHEN WAS THE LAST TIME? _____
HOW DID YOU RESPOND? GOT BETTER / NO CHANGE / GOT WORSE / OTHER _____
ARE YOU AWARE OF ANY POOR POSTURAL HABITS? (DESCRIBE) _____

.....
DOCTOR'S NOTES: _____

PATIENT NAME _____

DATE _____

PLEASE MARK ANYTHING YOU EXPERIENCE NOW OR HAVE IN THE PAST SIX (6) MONTHS.

NECK RELATED:

- | | | |
|--|---|---|
| <input type="checkbox"/> NECK PAIN / STIFFNESS | <input type="checkbox"/> CARPAL TUNNEL | <input type="checkbox"/> TMJ / JAW PAIN OR CLICKING |
| <input type="checkbox"/> HEADACHE / MIGRAINE | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> ALLERGIES / HAY FEVER |
| <input type="checkbox"/> NUMB / TINGLING IN ARMS / HANDS | <input type="checkbox"/> LOW ENERGY / FATIGUE | <input type="checkbox"/> SINUSITIS |
| <input type="checkbox"/> PAIN IN ARMS / HANDS | <input type="checkbox"/> HEARING DISTURBANCES | <input type="checkbox"/> RECURRENT COLDS / FLU |
| <input type="checkbox"/> COLDNESS IN HANDS | <input type="checkbox"/> VISUAL DISTURBANCES | <input type="checkbox"/> LOW THYROID |
| <input type="checkbox"/> WEAKNESS IN GRIP | <input type="checkbox"/> DIZZINESS | |

MID-BACK RELATED:

- | | | |
|---|--|---|
| <input type="checkbox"/> PAIN BETWEEN SHOULDER BLADES | <input type="checkbox"/> HEART MURMURS | <input type="checkbox"/> NAUSEA |
| <input type="checkbox"/> MID-BACK PAIN / STIFFNESS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> PAIN IN RIBS / CHEST | <input type="checkbox"/> HYPOGLYCEMIA | <input type="checkbox"/> ASTHMA / WHEEZING |
| <input type="checkbox"/> TENSION IN SHOULDERS | <input type="checkbox"/> HEART ATTACKS / ANGINA | <input type="checkbox"/> LUNG INFECTIONS / BRONCHITIS |
| <input type="checkbox"/> INDIGESTION / HEARTBURN | <input type="checkbox"/> HEART PALPITATIONS | <input type="checkbox"/> PAIN ON DEEP BREATHING |
| <input type="checkbox"/> REFLUX | <input type="checkbox"/> RAPID HEART BEAT | |
| <input type="checkbox"/> ULCERS / GASTRITIS | <input type="checkbox"/> TIRED OR IRRITABLE AFTER EATING OR IF HAVEN'T EATEN FOR A WHILE | |

LOW BACK RELATED:

- | | | |
|--|--|--|
| <input type="checkbox"/> LOW BACK PAIN / STIFFNESS | <input type="checkbox"/> INJURIES IN HIPS / KNEES / ANKLES | <input type="checkbox"/> CONSTIPATION |
| <input type="checkbox"/> PAIN IN HIPS / LEGS / FEET | <input type="checkbox"/> MUSCLE CRAMPS IN LEGS / FEET | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> NUMBNESS / TINGLING IN LEGS / FEET | <input type="checkbox"/> BLADDER INFECTIONS | <input type="checkbox"/> IRRITABLE BOWEL |
| <input type="checkbox"/> COLDNESS IN FEET | <input type="checkbox"/> FREQUENT / DIFFICULTY URINATING | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> WEAKNESS IN LEGS | <input type="checkbox"/> SEXUAL DYSFUNCTION | |
| <input type="checkbox"/> MENSTRUAL IRREGULARITIES / CRAMPING | | |

ANY CONDITION NOT LISTED ABOVE _____

ANY MEDICATIONS YOU ARE CURRENTLY TAKING (PRESCRIBED OR OVER THE COUNTER) _____

LIST ALL SURGERIES WITH DATES _____

LIST FALLS, ACCIDENTS, OR INJURIES WITH DATES _____

DOCTOR'S NOTES: _____

PATIENT NAME _____

DATE _____

HEALTH HABITS

ON AVERAGE HOW MUCH DO YOU:

DRINK:

WATER? _____	ENERGY DRINKS? _____
SODA? _____	BOTTLED JUICE? _____
COFFEE? _____	TEA (ICED OR HOT)? _____
ALCOHOL? _____	

HOW WOULD YOU DESCRIBE YOUR EATING HABITS? GREAT / AVERAGE / POOR / TOO MUCH SUGAR

HOW MUCH TIME DO YOU SPEND SITTING EACH DAY? (DESK, TV, COMPUTER, DRIVING) _____

WHAT VITAMINS, MINERALS, HERBS, DO YOU TAKE? _____

HOW OFTEN DO YOU EXERCISE? ...WHAT ACTIVITIES? _____

SLEEP ON YOUR... STOMACH SIDE BACK? HOW MANY HOURS OF RESTFUL SLEEP PER NIGHT (AVERAGE)? _____

DO YOU SMOKE? YES NO DON'T NOW BUT USED TO HOW MUCH? _____

FAMILY HISTORY

MOTHER'S SIDE OF FAMILY:

MOTHER	<input type="checkbox"/> DIABETES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OTHER _____
GRANDMOTHER:	<input type="checkbox"/> DIABETES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OTHER _____
GRANDFATHER:	<input type="checkbox"/> DIABETES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OTHER _____
AUNTS/UNCLES:	<input type="checkbox"/> DIABETES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OTHER _____

FATHER'S SIDE OF FAMILY:

FATHER	<input type="checkbox"/> DIABETES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OTHER _____
GRANDMOTHER:	<input type="checkbox"/> DIABETES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OTHER _____
GRANDFATHER:	<input type="checkbox"/> DIABETES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OTHER _____
AUNTS/UNCLES:	<input type="checkbox"/> DIABETES	<input type="checkbox"/> CANCER	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> OTHER _____

BROTHERS : DIABETES CANCER HEART DISEASE OTHER _____

SISTERS: DIABETES CANCER HEART DISEASE OTHER _____

DOCTOR'S NOTES: _____



Acknowledgement of Notice of Privacy Practices

Privacy Officer: Jennifer Cohen, S.T.

I hereby acknowledge that a copy of the Notice of Privacy Practices for the above listed chiropractic office is available to me upon request. A complete copy may be found at the office website, www.backbonerestored.com or in printed copy.

Printed Name: _____

Signed Name: _____ Date: _____

If signed on behalf of the patient please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of incompetent patient

Name of Patient: _____

*******For Office Use Only Below This Line*******

Complete the following only if the patient refuses to sign the acknowledgement:

Efforts to obtain signature: _____

Reasons for Refusal: _____

Person Attempting to Collect Signature: _____

ROLAND-MORRIS LOW BACK PAIN QUESTIONNAIRE

Patient Name: _____ Date: _____

Claim #: _____

When your back or leg hurts, you may find it difficult to do some of the things you normally do. Please mark with a cross only the sentences that describe you today.

- 01. [] I stay at home most of the time because of my back and/or leg pain.
- 02. [] I walk more slowly than usual because of my back and/or leg pain.
- 03. [] Because of my back and/or leg pain, I am not doing any jobs that I usually do around the house.
- 04. [] Because of my back and/or leg pain, I use a handrail to get upstairs.
- 05. [] Because of my back and/or leg pain, I lie down to rest more often.
- 06. [] Because of my back and/or leg pain, I have to hold onto something to get out of an easy chair.
- 07. [] Because of my back and/or leg pain, I try to get other people to do things for me.
- 08. [] I get dressed more slowly than usual because of my back and/or leg pain.
- 09. [] I stand up only for short periods of time because of my back and/or leg pain.
- 10. [] Because of my back and/or leg pain, I try not to bend or kneel down.
- 11. [] I find it difficult to get out of a chair because of my back and/or leg pain.
- 12. [] My back is painful almost all of the time.
- 13. [] I find it difficult to turn over in bed because of my back and/or leg pain.
- 14. [] I have trouble putting on my socks (or stockings) because of pain in my back and/or leg pain.
- 15. [] I sleep less well because of my back and/or leg pain.
- 16. [] I avoid heavy jobs around the house because of my back and/or leg pain.
- 17. [] Because of back and/or leg pain, I am more irritable and bad tempered with people than usual.
- 18. [] Because of my back and/or leg pain, I go upstairs more slowly than usual.
- 19. [] I change positions frequently to try to get my back and /or leg comfortable.
- 20. [] My appetite is not very good because of my back and/or leg pain.
- 21. [] I can only walk short distances because of my back and/or leg pain.
- 22. [] Because of my back and/or leg pain, I get dressed with the help of someone else.
- 23. [] I sit down for most of the day because of my back and/or leg pain.
- 24. [] I stay in bed most of the time because of my back and/or leg pain.

AUTO COLLISION QUESTIONNAIRE

NAME _____ DATE _____

DATE OF ACCIDENT _____ AT _____ AM / PM

LOCATION OF ACCIDENT _____

WHERE WAS THE IMPACT ON YOUR VEHICLE? REAR LEFT SIDE RIGHT SIDE FRONT

WAS THERE MORE THAN ONE (1) IMPACT? YES NO IF YES, PLEASE DESCRIBE? _____

WAS YOUR VEHICLE **MOVING** OR **STOPPED** PRIOR TO THE COLLISION? (CIRCLE ONE)

WERE YOU AWARE OF/PREPARED FOR THE COLLISION? YES NO

WHAT WAS YOUR POSITION IN THE VEHICLE? DRIVER FRONT SEAT PASSENGER REAR SEAT PASSENGER

IF YOU WERE THE DRIVER, WAS YOUR FOOT ON THE **BRAKE** OR **ACCELERATOR** PEDAL? (CIRCLE ONE)

WAS ANYONE ELSE IN THE VEHICLE WITH YOU? NO DRIVER FRONT SEAT PASSENGER REAR SEAT PASSENGER

DID YOU HAVE ON YOUR SEATBELT? YES NO

DID THE AIRBAG DEPLOY? YES NO

WHAT DIRECTION WAS YOUR HEAD POSITIONED PRIOR TO COLLISION? _____

DID YOU STRIKE ANY OBJECTS IN THE CABIN? YES NO IF YES, PLEASE DESCRIBE? _____

DO YOU HAVE AN ATTORNEY? NAME _____ PHONE _____

YOUR INSURANCE COMPANY _____ PHONE _____

CLAIM # _____

OTHER PERSON'S INSURANCE _____ PHONE _____

CLAIM # _____