

Confidential Patient Information

Patient Name				Today's Date	
Street Address			Birth Date		Age
					Sex <input type="radio"/> M <input type="radio"/> F
City		State	Zip		Social Security #
Marital Status <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widow		Spouse Name			# of Children
Home Phone		Work Phone		Cell Phone	
				Best place to reach you: <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell	
E-mail			Whom may we thank for referring you here?		
Occupation		Employer		Employer/Business Address	
Emergency Contact Name		Emergency Contact Phone #		Employer City, State, Zip	
May we contact your MD to coordinate care? <input type="radio"/> Yes <input type="radio"/> No		Your primary MD's first/last name & practice location			

The Reason You're Here

What is your number-one problem or the one area of greatest pain? _____

When did this problem/pain start? _____ Gradual Sudden

What do you think caused this problem? _____

How are your symptoms changing? Getting better Not changing Getting worse

What helps? _____ What makes it worse? _____

Have you had similar conditions/symptoms in the past? No Yes. If yes, when? _____

Please list any other complaints that are currently bothering you: _____

Previous Chiropractic Care

1. Have you been to a Chiropractor before? Yes No. 4. Date of last chiropractic adjustment _____

2. If yes, was it for the same problem? Yes No. 5. Has your family had chiropractic care? Yes No

3. Did you receive good results? Yes No.

Who else have you seen for this? _____

What other care have you received for this? _____

Have you had spinal x-rays taken within the last year? No Yes. If yes, was it for the same problem? Yes No

I prefer to see: Dr. Misty Gargan Dr. Andrew Shannahan No preference

Your Current Health

Please rate your overall level of health *Poor* 0 1 2 3 4 5 6 7 8 9 10 *Excellent*

Do you exercise? No Yes. What type? _____ How often? _____

Check those that apply: Smoke _____ packs/day. Alcohol _____ drinks/week. Coffee _____ cups/week.

Rate your stress: low medium high Rate your diet: healthy average poor

Are you content with your present level of health? Yes No ↓

What aspect(s) would you like to change? _____

Please check if you are currently involved in any of the following activities:

Commute / Drive In Car (_____ hrs/day) Play Video Games (_____ hrs/day) Computer Use (_____ hrs/day)

Watch Television (_____ hrs/day) Read/watch TV in Bed Sleep on stomach

Please list all medications and nutritional supplements: _____

WOMEN ONLY: Are you pregnant? No Yes, Due Date _____ Date of Last period _____

Please check if you have or have had any of the following: PMS Irregular cycle Unable to get pregnant

Your Health History

Have you been treated for any health condition in the last year? Yes No

If yes, please explain: _____

Please list any previous accidents and dates (ie. auto, work, falls, broken bones, spinal injuries, etc.): _____

Please describe any hospitalizations & surgeries (other than above): _____

If you have experienced any of the following conditions in the past, mark a **"P"** on the line provided. If you have currently experiencing any of the following conditions, please mark a **"C"** on the line provided. Check all that apply.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> heart attack | <input type="checkbox"/> knee/hip replacement | <input type="checkbox"/> fainting spells | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke | <input type="checkbox"/> dizziness | <input type="checkbox"/> sudden weight loss |
| <input type="checkbox"/> difficulty with urination | <input type="checkbox"/> glaucoma | <input type="checkbox"/> difficulty with bowel movements | <input type="checkbox"/> loss of hearing |
| <input type="checkbox"/> prostate trouble | <input type="checkbox"/> bloody stools | <input type="checkbox"/> cancer | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> anemia | <input type="checkbox"/> diverticulosis | <input type="radio"/> right <input type="radio"/> left |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> ulcers | <input type="checkbox"/> chest pain | <input type="checkbox"/> muscle weakness |
| <input type="checkbox"/> constipation | <input type="checkbox"/> loss of memory | <input type="checkbox"/> general fatigue | <input type="checkbox"/> walking problems |
| <input type="checkbox"/> nausea/morning sickness | <input type="checkbox"/> muscle cramping | <input type="checkbox"/> soreness in joints | <input type="checkbox"/> numbness |
| <input type="checkbox"/> ears ringing | <input type="checkbox"/> headache | <input type="checkbox"/> migraine | <input type="checkbox"/> jaw Pain |
| <input type="checkbox"/> gout | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> syphilis | <input type="checkbox"/> chest pain / arm pain |
| | <input type="checkbox"/> arthritis | <input type="checkbox"/> asthma | |

Please add anything else you would like the doctor to know: _____

Billing Details

If you have any insurance information, please provide the staff with your insurance card and/or forms

How will you be handling your financial account? Cash Health Insurance Auto Insurance/ Personal Injury
 Labor & Industries Medicare

Who is the primary policy holder? _____ ⇨ Their Date of Birth? _____

Who is the primary policy holder's employer? _____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorized this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____

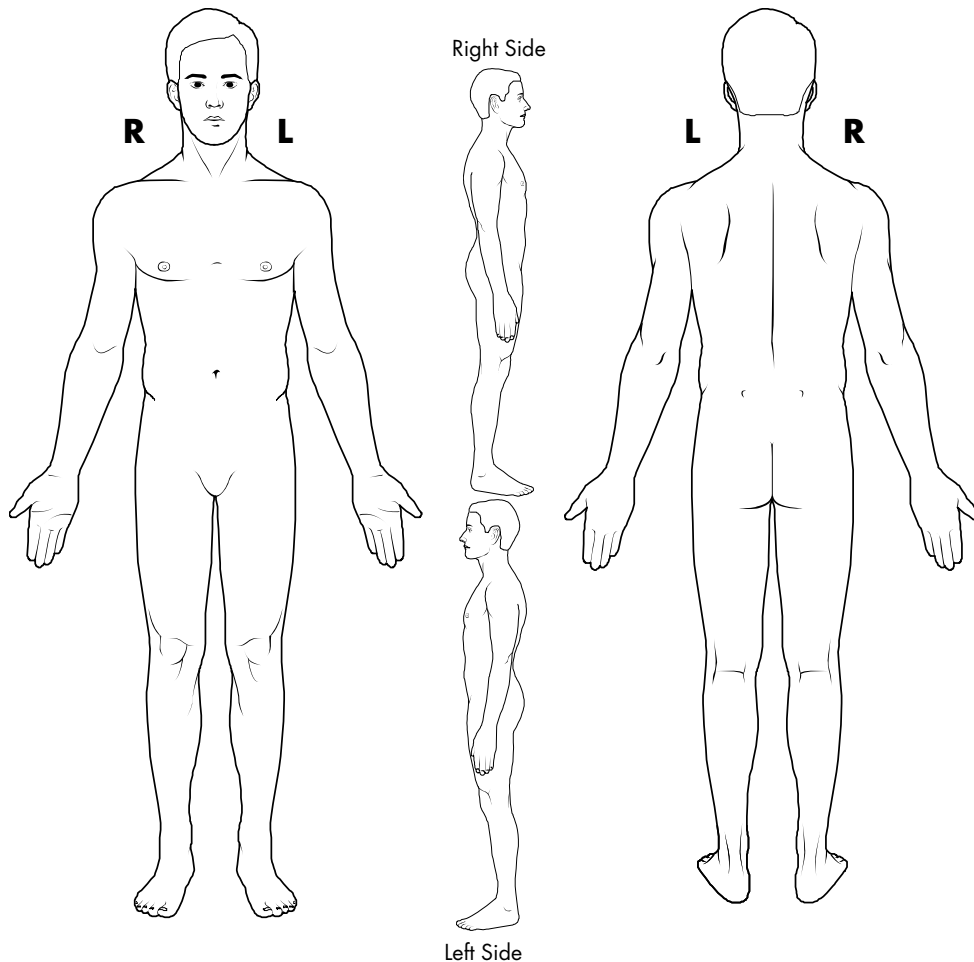
(signature of parent if patient is a minor)

Pain Drawing Quadruple Index

Name _____ Date _____

1. Mark these drawings according to where you hurt (If the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

KEY	
Stabbing	// // // // //
Burning	X X X X X X
Pins & Needles	O O O O O O
Aching	+ + + + + +
Numbness	= = = = = =

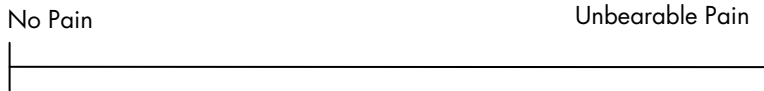


2. On the scales below, Please draw a vertical line representing your pain or discomfort.

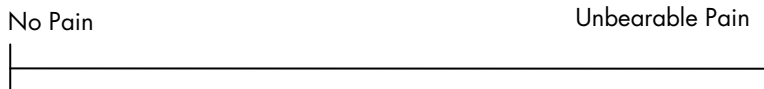
A Rate the pain you have right now:



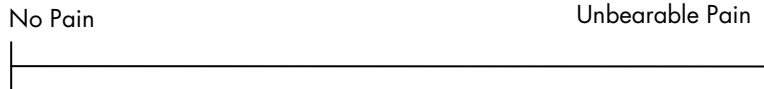
B Rate your average pain in the past week:



C Rate your pain at its best in the past week:



D Rate your worst pain in the past week:



Functional Rating Index

Name _____ Date _____

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number** which most closely describes your condition **RIGHT NOW**.

Pain Intensity

- | | | | | |
|----------|-----------|---------------|-------------|---------------------|
| 0 | 1 | 2 | 3 | 4 |
| No Pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

Recreation

- | | | | | |
|-----------------------|------------------------|------------------------|-------------------------|--------------------------|
| 0 | 1 | 2 | 3 | 4 |
| Can do All Activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities |

Sleeping

- | | | | | |
|---------------|------------------------|----------------------------|-------------------------|-------------------------|
| 0 | 1 | 2 | 3 | 4 |
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

Frequency of Pain

- | | | | | |
|----------|---------------------------------|-----------------------------------|-------------------------------|--------------------------------|
| 0 | 1 | 2 | 3 | 4 |
| No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

Personal Care (washing, dressing, etc)

- | | | | | |
|--------------------------|----------------------------|----------------------------------|-------------------------------------|-----------------------------------|
| 0 | 1 | 2 | 3 | 4 |
| No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

Lifting

- | | | | | |
|---------------------------|----------------------------------|-------------------------------------|----------------------------------|--------------------------------|
| 0 | 1 | 2 | 3 | 4 |
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

Travel (driving, etc.)

- | | | | | |
|-----------------------|-------------------------|-----------------------------|------------------------------|---------------------------|
| 0 | 1 | 2 | 3 | 4 |
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on long trips |

Walking

- | | | | | |
|-----------------------|-----------------------------|-----------------------------|-----------------------------|---------------------------------|
| 0 | 1 | 2 | 3 | 4 |
| No pain; any distance | Increased pain after 1 mile | Increased pain after ½ mile | Increased pain after ¼ mile | Increased pain with all walking |

Work

- | | | | | |
|---|----------------------------------|--------------------------|--------------------------|-------------|
| 0 | 1 | 2 | 3 | 4 |
| Can do Usual work Plus unlimited Extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

Standing

- | | | | | |
|-----------------------------|------------------------------------|-----------------------------|-----------------------------|----------------------------------|
| 0 | 1 | 2 | 3 | 4 |
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after ½ hour | Increased pain with any standing |

Doctor's use only

FRI Score: _____