

CONFIDENTIAL PATIENT INFORMATION

Dear Patient: This information is considered confidential. We need this information because we care enough to want know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

PLEASE PRINT

PATIENT INFORMATION

Name _____ Maiden Name _____

Address _____ Apt _____ City _____ State _____ ZIP _____

Birthdate ____/____/____ Male ___ Female SSN ____-____-____

Phone (____) _____ Business (____) _____ Mobile (____) _____

Marital Status ___ Single ___ Married ___ Divorced ___ Legally Separated ___ Widowed

Email Address _____

Your Occupation ___ Employed at _____
___ Unemployed ___ Retired ___ Student

Who you referred to our office? ___ Patient _____ Relationship to this Patient _____

___ Our Website ___ Atlas Orthogonal Website ___ Activator Website ___ WZZM 13 Website ___ Google Search

___ Facebook ___ Twitter ___ Muskegon Chronicle Ad ___ Yellow Pages ___ Our Sign ___ BNI

___ Fibromyalgia Workshop ___ Arthritis Workshop ___ Headache Workshop ___ Health Screening

___ Physician Referral from _____

GUARANTOR INFORMATION

Name _____ Maiden Name _____

Address _____ Apt _____ City _____ State _____ ZIP _____

Birthdate ____/____/____ Male ___ Female SSN ____-____-____

Phone (____) _____ Business (____) _____ Mobile (____) _____

Marital Status ___ Single ___ Married ___ Divorced ___ Legally Separated ___ Widowed

Email Address _____

Your Occupation ___ Employed at _____
___ Unemployed ___ Retired ___ Student

Your Relationship to the Patient ___ Spouse ___ Parent ___ Step Parent ___ Grandparent ___ Legal Guardian

I AM SEEKING CARE IN THIS OFFICE FOR

- Temporary relief of symptoms
- Relief of symptoms and stabilization of the problem (Initial Intensive Care)
- Relief, stabilization and correction of the problem

Please place a check by any of the conditions listed below that you are experiencing (other conditions not listed can be written below)

MUSCULOSKELETAL SYSTEM

- Low Back Problems
- Pain Between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Walking Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Depression

NERVOUS SYSTEM

- Numbness
- Loss of Feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle Jerking
- Convulsions
- Forgetfulness
- Confusion

SPINAL CORD PRESSURE SYMPTOM

- Headaches
- Dizziness
- Blurred Vision
- Loss of Concentration
- Difficulty in Sleeping
- Nervousness
- Fatigue
- Depression
- Irritability

OTHER CONDITIONS

HEALTH COACHING

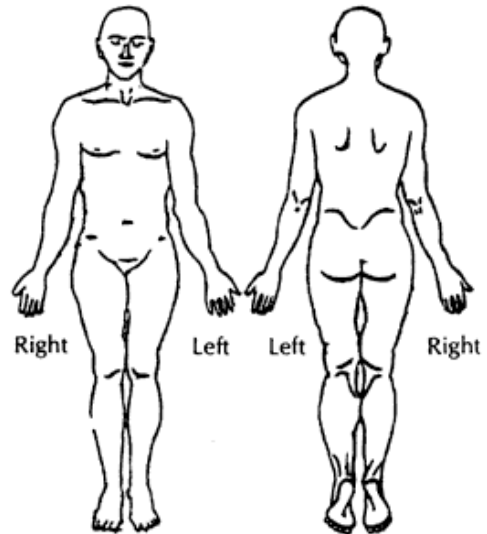
I am interested in Health Coaching

- Yes No I would like more information

SMOKING HISTORY

- Currently smoke Every day Some days
 Previously smoked Never Smoked

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION NAME	DOSE	REASON FOR MEDICATION	STARTING DATE

ALLERGIES TO MEDICATIONS? NO YES IF YES, PLEASE LIST _____

SURGICAL HISTORY

SURGERY	DATE	DOCTOR	REASON FOR SURGERY

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C

GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

O F C

GASTRO-INTESTINAL

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

O F C

CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

GENITO-UNRINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

FOR WOMEN ONLY

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes No Are you pregnant?

CHECK THE FOLLOWING CONDITION YOU HAVE HAD:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Malaria | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whooping cough |

PLEASE PRINT

What's your major complaint? _____

List surgical operation and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers
 "Pep" pills Tranquilizers Birth control pills

Others: _____

Age of mattress: _____ Comfortable Uncomfortable Do you use a bed board? _____

Are you wearing: Heal lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident: Past year Past five years Over five years Never

Describe: _____

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

HAVE YOU EVER:

Yes No

DESCRIBE BRIEFLY

- | | | | |
|---|--------------------------|--------------------------|-------|
| Been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Used a cane, crutch, or other support? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been treated for a spine or nerve disorder? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Had a fractured bone? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Been hospitalized for anything other than surgery | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

DO YOU:

- | | | | |
|--|--------------------------|--------------------------|-------|
| Now take vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Think you may need vitamins or minerals? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have an allergy to any drug? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

DATE OF LAST:

Less than 6 months

6-18 months

Over 18 months

Never

- | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Spinal examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical examination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest X-ray | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal X-ray | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental X-ray | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Urine test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HABITS

Heavy

Moderate

Light

None

- | | | | | |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IN CASE OF EMERGENCY: (Name of relative or close friend not living in you home):

NAME _____

ADDRESS: _____ PHONE: _____

General Pain Disability Index Questionnaire



2950 N. Seventh St. Suite 200 • Phoenix, AZ 85014 • 800.598.0224 • phone 602.224.0220 • fax 602.224.0230 • www.activator.com

Name (Please Print): _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

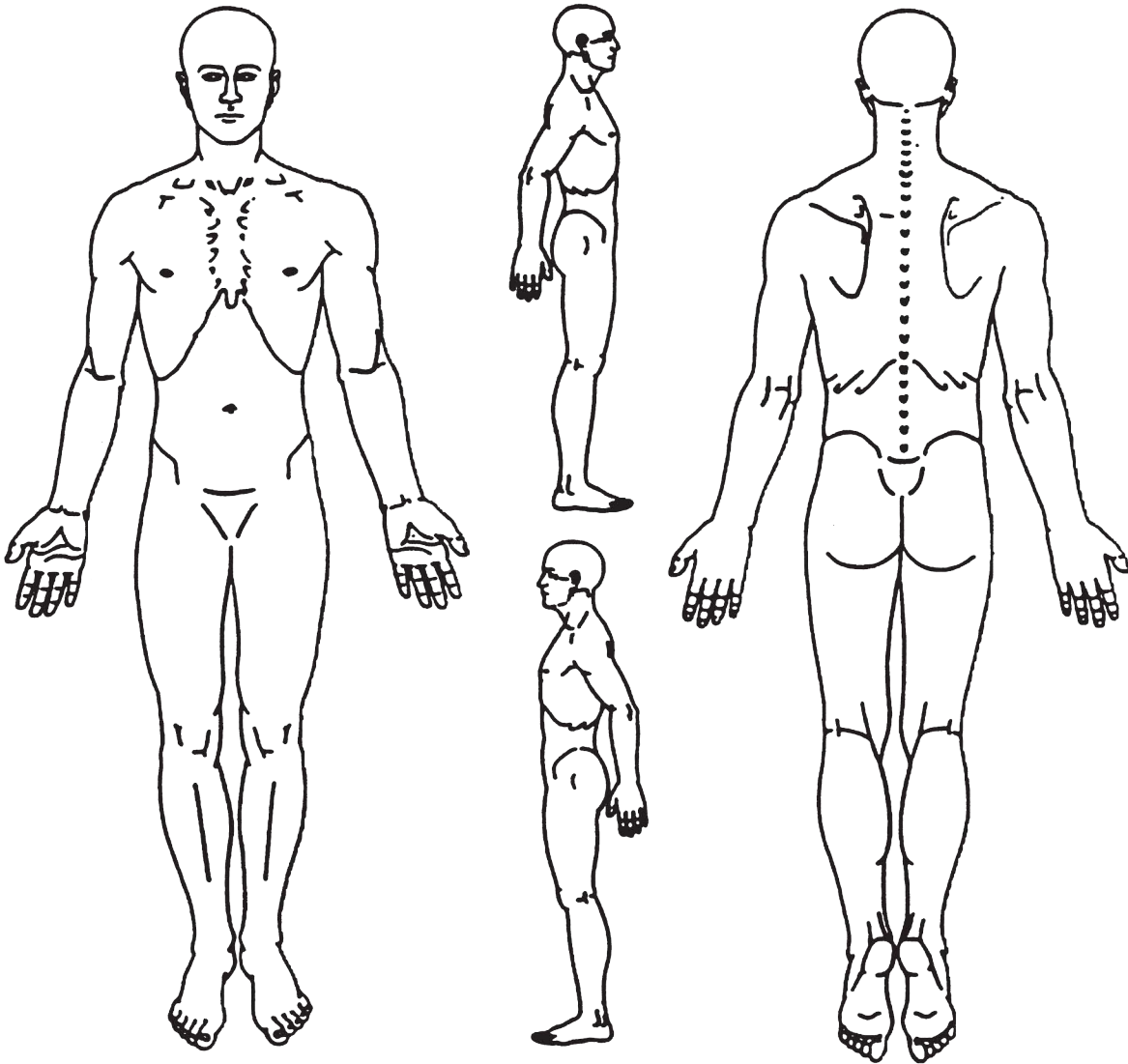
How long have you had this pain? _____ Years _____ Months _____ Weeks

Is this your first episode of this pain? _____ Yes _____ No

Use the letter below to indicate the type and location of your sensations right now

(Please remember to complete both sides of this form)

A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES S = STABBING O = OTHER



over please

FOR DOCTOR'S USE

Chief complaint (other than neck or low back pain): _____

For neck conditions use the Neck Disability Index Questionnaire; for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire.

General Pain Disability Index Questionnaire



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The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES for each of the six categories of daily living listed. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

1. Family/Home Responsibilities — This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

2. Recreation — This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

3. Social Activity — This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

4. Occupation — This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

5. Self Care — This category includes activities, which involve personal maintenance and independent daily living such as taking a shower, driving, getting dressed, etc.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

6. Life-Support Activity — This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

TOTAL SCORE: _____ SIGNATURE: _____ DATE: _____