



Welcome and thank you for choosing ChiroPlus Complementary Healthcare. Before your first appointment, please complete this form. You may bring it with you to your appointment, or fax it to us at 920/294-3238.

Before we get started, who referred you to us or how did you hear about us?

\_\_\_\_\_

**About You**

FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

NICKNAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: Male Female

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ HOME PHONE: (\_\_\_\_) \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

MARITAL STATUS (CIRCLE ONE): Minor Single Married Divorced Separated Widowed

DO YOU HAVE CHILDREN? Yes No IF YES, WHAT ARE THEIR AGES? \_\_\_\_\_

WHAT IS YOUR EDUCATIONAL LEVEL (CIRCLE ONE)? Some high school High school graduate College Graduate School

IF COLLEGE/GRAD SCHOOL, HOW MANY YEARS? \_\_\_\_\_ EMPLOYER NAME: \_\_\_\_\_

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY? NAME: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

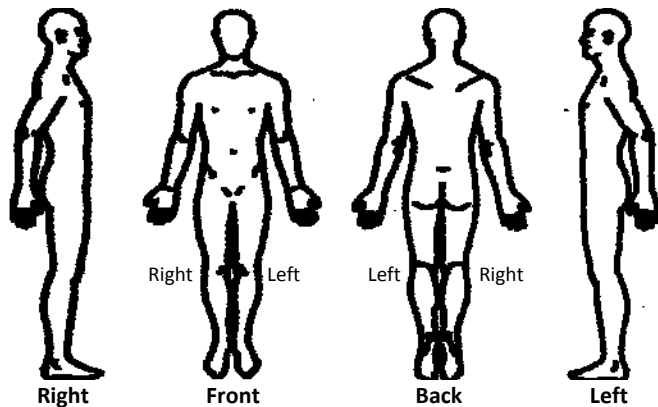
WORK PHONE: (\_\_\_\_) \_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_

**Health History**

REASON FOR TODAY'S VISIT: \_\_\_\_\_

ARE YOU IN PAIN? YES NO

USING THE ADJACENT BODY CHARTS, PLEASE CIRCLE ALL AFFECTED AREAS:



DID YOUR INJURY OCCUR DURING (CIRCLE ONE): Work Sports/Play Auto Accident Routine/Household Activity

PLEASE EXPLAIN WHAT HAPPENED: \_\_\_\_\_

\_\_\_\_\_

IS YOUR CONDITION GETTING WORSE? YES NO IS YOUR CONDITION INTERFERING WITH YOUR WORK?  YOUR SLEEP?

YOUR SOCIAL LIFE?  IF SO, HOW? \_\_\_\_\_

HAS THIS OR SOMETHING SIMILAR HAPPENED IN THE PAST? YES NO IF YES, PLEASE EXPLAIN: \_\_\_\_\_

HAVE YOU BEEN TREATED BY A MEDICAL DOCTOR FOR THIS CONDITION? YES NO

HAVE YOU BEEN TREATED BY A CHIROPRACTOR FOR THIS CONDITION IN THE PAST? YES NO

**PAST MEDICAL HISTORY:**

ACCIDENTS: \_\_\_\_\_

FRACTURES: \_\_\_\_\_

SURGERY: \_\_\_\_\_

HOSPITALIZATION: \_\_\_\_\_

ALLERGIES? \_\_\_\_\_

**REVIEW OF SYSTEMS: DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES, MEDICAL CONDITIONS OR PROCEDURES?**

Heart Attack/Stroke	Fatigue	Stomach/digestion	Hepatitis
Fibromyalgia	Alcohol/Drug Abuse	Venereal Disease	Glaucoma
Shingles	Cancer	Neck Pain	Severe/Frequent Headaches
High/Low Blood Pressure	Prostate problems	Rheumatic Fever	Artificial Bones/Joints/Implants
Ulcers/Colitis	Fainting/Seizures/Epilepsy	Sinus Problems	Mitral Valve Prolapse
Difficulty Breathing	Menstrual problems	Lower Back Problems	HIR+/AIDS/ARC
Anemia/Diabetes	Kidney Problems	Tuberculosis	Arthritis
Anxiety/Depression			

**MEDICATIONS (PLEASE LIST NAME AND DOSAGE, INCLUDING VITAMINS AND SUPPLEMENTS):**

MEDICATION/VITAMIN/SUPPLEMENT NAME	DOSAGE	MEDICATION/VITAMIN/SUPPLEMENT NAME	DOSAGE

**Social History:**

DO YOU EXERCISE? Yes No WHAT TYPE? \_\_\_\_\_

HOW OFTEN? \_\_\_\_\_ HOURS PER WEEK: \_\_\_\_\_

DO YOU USE TOBACCO? Yes No HOW MUCH? \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_

DO YOU DRINK ALCOHOL? Yes No HOW OFTEN? \_\_\_\_\_ TIMES PER WEEK: \_\_\_\_\_

**Family History:**

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING? PLEASE NOTE IF MOTHER, FATHER, SISTER, BROTHER, GRANDPARENTS.

	Family member
Cancer	
Heart disease	
Neurological problems	
Stroke	
Diabetes	
Tuberculosis	
Other	

## Insurance Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Insurance Company Name: \_\_\_\_\_

Are you the Policy Holder? *Yes No* **If "YES", STOP. IF "NO" PLEASE COMPLETE THE FOLLOWING:**

1. Insured's Name: \_\_\_\_\_
2. Insured's Date of Birth: \_\_\_\_\_
3. Insured's Employer: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_

1. Insured's Name: \_\_\_\_\_
2. Insured's Date of Birth: \_\_\_\_\_
3. Insured's Employer: \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize the payment of insurance benefits to the Chiropractor. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that this is not a guarantee of benefits and that I am responsible for all costs of chiropractic treatment, regardless of insurance coverage.

\_\_\_\_\_  
(Signature of Insured Person)

\_\_\_\_\_  
(Date)

***For office use only below***

**VERIFICATION OF BENEFITS**

Diagnosis or Chief Complaint: \_\_\_\_\_

In Plan Benefits: \_\_\_\_\_

Out of Plan Benefits: \_\_\_\_\_

Date of first visit		Modalities	
Effective Date		Does separate deductible apply to modalities	
Deductible – Family		Massage Therapy	
Deductible -Individual		X-rays	
Calendar Year – Other		Out of Pocket max	
Amount already met		Maximum visits per year	
Services covered at		Maximum amount per year	
Amount of co-payment			

Send claims to: \_\_\_\_\_

Notes: \_\_\_\_\_

Name of benefits contacts: \_\_\_\_\_ Phone: \_\_\_\_\_

Verified By: \_\_\_\_\_ Date: \_\_\_\_\_



# Automobile Accident Questionnaire

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_

Describe the events leading up to your accident? \_\_\_\_\_

Select from the following list any body parts that struck an object at the point of impact:

Head	Face	Chest	Neck	Back
Right Shoulder	Left Shoulder	Right Arm	Left Arm	Right Leg
Left Leg	Right Knee	Left Knee	Other	

Select the objects that were struck:

Windshield	Headrest	Dashboard	Steering Column
Door Frame	Back of Seat	Rear View Mirror	Seat Broke
Jarred or Thrown	Cannot remember	Rendered unconscious	Other

If you have been treated by any other physicians for neck or back problems, please explain: \_\_\_\_\_

If applicable, indicate any pains or abnormal sensations you experienced immediately following the impact:

Headache	"Saw stars"	Semi-conscious state	Right neck pain
Left neck pain	Right mid-back pain	Left mid-back pain	Right low back pain
Left low back pain	Right lower extremity	Left lower extremity	Right upper extremity pain
Left upper extremity pain	Other		

Indicate any action you took immediately following the accident:

Went home and took it easy	Went about normal	Went to physician	Went to hospital
Doctored yourself thinking pain would go away	Other		

If you were hospitalized after the accident, indicate method of delivery to hospital:

Ambulance	Drove	Driven by	Went home and taken later or drove yourself to
-----------	-------	-----------	--

Name of Hospital: \_\_\_\_\_ City/State: \_\_\_\_\_

Were you seen in the Emergency Room? Yes No Length of Stay: \_\_\_\_\_ Name of Physician: \_\_\_\_\_

Indicate any procedure performed at the hospital, including the emergency room:

Examination	X-Rays	Prescription	Injection	Complete bed rest
Stitches	Therapy	Cervical collar	Wounds dressed	Other

What was the name of the first physician you consulted? \_\_\_\_\_

Select from the following list the type of physician this was:

Family Physician	Chiropractor	Orthopedist	Osteopath
Neurologist	Walk-in Clinic	Other	

Comments: \_\_\_\_\_

Do you have an attorney? Yes No If yes, please provide his/her name, address and phone number: \_\_\_\_\_

# PATIENT SPECIFIC FUNCTIONAL AND PAIN SCALES (PSFS)

Name \_\_\_\_\_

Date \_\_\_\_\_

In your visits here we want to know what 3 activities in your life you are unable to do or having the most difficulty with as a result of your chief problem (\_\_\_\_\_).

Please list 3 activities you are unable to perform or having the most difficulty with because of your chief problem.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## Activity #1

(Point to one number):

Able to perform activity without difficulty	0	1	2	3	4	5	6	7	8	9	10	Unable to perform the activity
---	---	---	---	---	---	---	---	---	---	---	----	-----------------------------------

## Activity #2

(Point to one number):

Able to perform activity without difficulty	0	1	2	3	4	5	6	7	8	9	10	Unable to perform the activity
---	---	---	---	---	---	---	---	---	---	---	----	-----------------------------------

## Activity #3

(Point to one number):

Able to perform activity without difficulty	0	1	2	3	4	5	6	7	8	9	10	Unable to perform the activity
---	---	---	---	---	---	---	---	---	---	---	----	-----------------------------------

Our goal is to work together with you to “problem-solve” ways to return you to the activities which **you have told us** you are either unable to perform or are giving you the most difficulty since this problem began.

\_\_\_\_\_  
Signature

Chatman AB, Hyams SP, Neel JM, Binkley JM, Stratford PW, Schomberg A, Stabler M. The patient-specific functional scale: Measurement properties in patients with knee dysfunction. Phys Ther 1997;77:820-829.

# The Revised Bournemouth Questionnaire

NAME \_\_\_\_\_ DATE \_\_\_\_\_ AGE \_\_\_\_\_

The following scales have been designed to find out about your pain and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

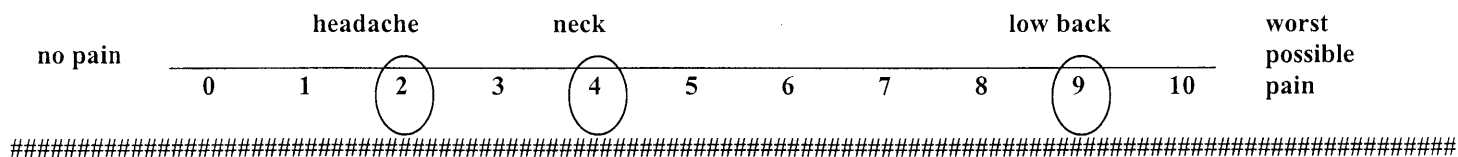
1. Over the past week, on average, how would you rate your pain?  
No pain Worst pain possible  
0      1      2      3      4      5      6      7      8      9      10
  
2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?  
No interference Unable to carry out activity  
0      1      2      3      4      5      6      7      8      9      10
  
3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities?  
No interference Unable to carry out activity  
0      1      2      3      4      5      6      7      8      9      10
  
4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?  
Not at all anxious Extremely anxious  
0      1      2      3      4      5      6      7      8      9      10
  
5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?  
Not at all depressed Extremely depressed  
0      1      2      3      4      5      6      7      8      9      10
  
6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your pain?  
0      1      2      3      4      5      6      7      8      9      10
  
7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?  
Completely control it No control whatsoever  
0      1      2      3      4      5      6      7      8      9      10

# QUADRUPLE VISUAL ANALOGUE SCALE

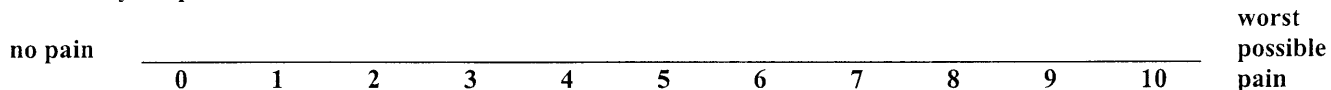
**INSTRUCTIONS:** Please circle the number that best describes the question being asked.

**NOTE:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

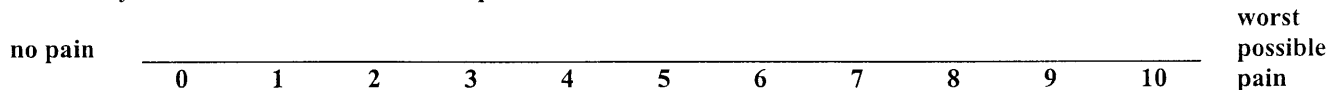
**EXAMPLE:**



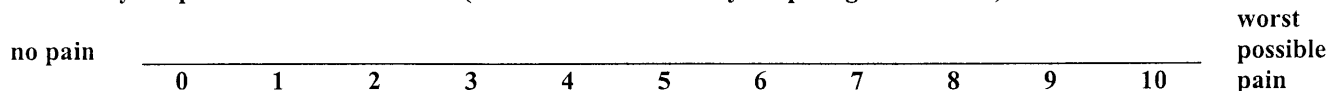
1. What is your pain **RIGHT NOW**?



2. What is your **TYPICAL** or **AVERAGE** pain?

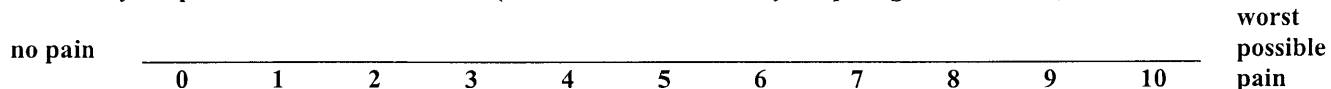


3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



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)?



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)