



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: (____) _____

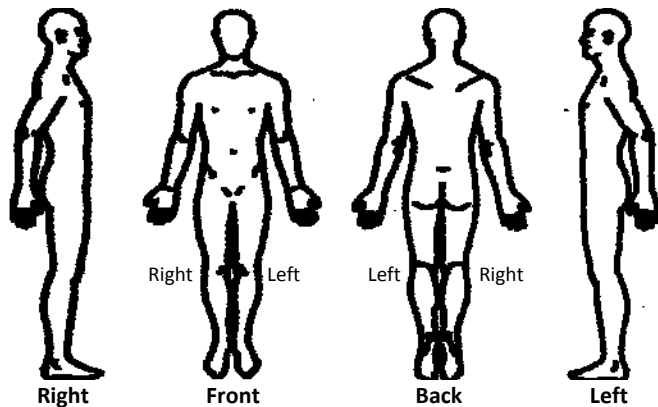
WORK PHONE: (____) _____ RELATIONSHIP TO YOU: _____

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: _____



Worker's Compensation Form

Patient's Name _____ **Date** _____

Date of Injury _____ **Hour** ____ **AM/PM**

Was injury reported to employer? No Yes Name of person reported injury to: _____

Have you lost time from work? No Yes If Yes, how much time lost? _____

Have you returned to work since this injury? No Yes If Yes, Date _____

Check appropriate box

FULL TIME REGULAR DUTY <input type="checkbox"/>	FULL TIME LIGHT DUTY <input type="checkbox"/>
PART TIME REGULAR DUTY <input type="checkbox"/>	PART TIME LIGHT DUTY <input type="checkbox"/>

Length of time worked there prior to accident? _____

Have you been treated by another doctor for this accident? No Yes, Name of Doctor _____

In your own words, please describe how the accident happened: _____

Since the injury, are you: Improved Unchanged Getting Worse

Have you had Physical Therapy: No Yes If Yes, how often _____

Does Physical Therapy help? No Yes

Prior to this injury, have you ever had any of the physical complaints similar to what you have now?

No Don't Know Yes, describe: _____

Were these similar complaints the result of a previous injury? No Yes If Yes, please provide details of previous injuries: _____

Have you had a previous Worker's Compensation Injury? No Yes If Yes, Date(s) of previous injuries: _____

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

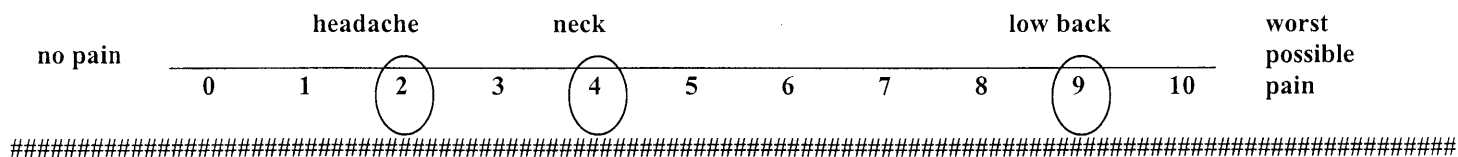
7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?
Completely control it No control whatsoever
0 1 2 3 4 5 6 7 8 9 10

QUADRUPLE VISUAL ANALOGUE SCALE

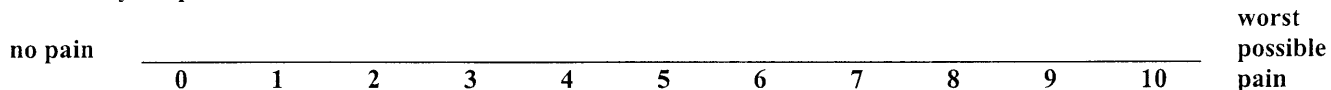
INSTRUCTIONS: Please circle the number that best describes the question being asked.

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.

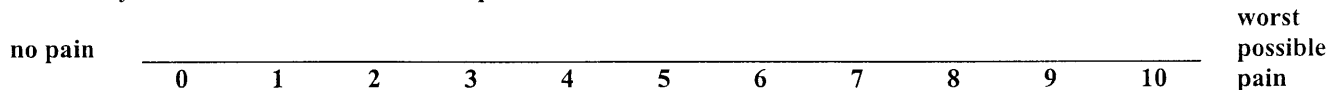
EXAMPLE:



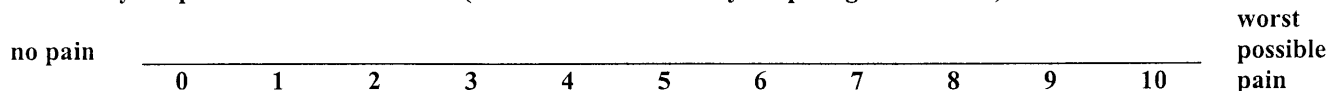
1. What is your pain **RIGHT NOW**?



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

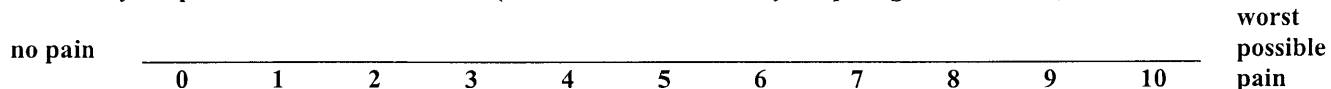


3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



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)