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Patient Health Assessment

General Information

Patient Name_____ Date_____

Patient Address_____

City_____ State_____ Zip Code_____

Home Phone #_____ Work Phone#_____ Cell#_____

E-mail address_____ Date of Birth_____

Patient Occupation_____ Social Security#_____

Patient Employer_____

Name of Insured (if other than you) _____

Relation to Patient_____

Insured's Employer_____

Referred for Treatment by_____

Health Insurance Plan_____ Group#_____ Member ID#_____

Other Health Insurance_____

Symptom/Condition History

1) Please describe your current condition and how the problem began_____
_____

2) How long have you had this problem? _____

3) How would you describe your pain?

□ Sharp □ Soreness □ Throbbing □ Tingling □ Dull □ Stiffness

□ Spasm □ Burning □ Ache □ Weakness □ Numbness □ Shooting

4) How would you rate the intensity of your pain right now? (Circle a number)

0 1 2 3 4 5 6 7 8 9 10
(minimal) (mild) (moderate) (severe) (unbearable)

5) How often is the pain present during your waking day? (Check appropriate box)

□ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

6) Since your problem began, is your pain

□ Getting better □ Getting worse □ Staying the same

7) How did your problem begin? _____

□ Auto accident □ Work related accident □ Other type of accident

□ Gradual □ Sudden □ No specific reason

8) What makes your problem better?

□ Nothing □ Walking □ Standing □ Sitting □ Lying down □ Moving □ Rest

9) What makes your problem worse?

□ Nothing □ Walking □ Standing □ Sitting □ Lying down □ Moving □ Rest

10) Are you currently taking any medications for this condition or any other conditions?_____

11) Were you previously treated for this condition? □Yes □ No
If yes, please describe by whom □ MD/DO □Chiropractor □ Physical therapist
□ Acupuncturist □other_____

12) What were the approximate dates of treatment, the type of treatment and how did you respond to treatment?_____
_____

13) What is your physical activity at work?
□ Mostly sitting □ Light manual □ Moderate manual □ Heavy manual

14) Do you exercise?
□ No regular exercise □ 1-2 times/week □ 3-4 times/week □5-7 times/week
□ Cardiovascular □ Stretching □ Weight Machine □ Free Weights
□ Sports_____

15) What is your general stress level?
□ No stress □ Minimal stress □ Moderate Stress □ Greatly stressed

16) Do you take vitamins, herbs or nutritional supplements?
□ No □ Yes If yes, what do you take? _____

17) Is your problem affecting your ability to work or do other routine daily activities?
□ No effect □ Have some restrictions but can function
□ Need some assistance with activities □ cannot work
□ cannot function without assistance □ totally disabled

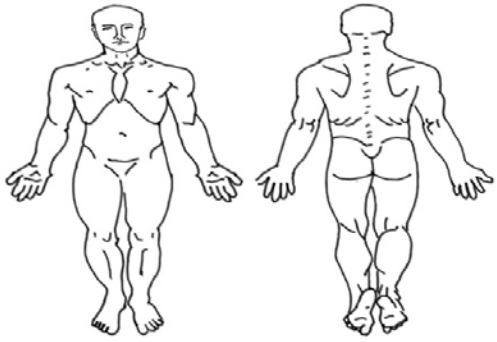
Past or Present Symptoms, Conditions or Habits

Please check the box indicating whether this applies to past or present.

Symptoms/Conditions	**Past**	**Present**
Rheumatoid arthritis	□	□
Ankylosing spondylitis	□	□
Bone fractures **	□	□
Malignancy of the spine **	□	□
Infection of the bones or joints	□	□
Myelopathy	□	□
Cauda Equina syndrome	□	□
Carotid artery problems **	□	□
Aneurysm **	□	□
Instability of joints	□	□
Benign tumors of the spine **	□	□
Osteoporosis **	□	□
Bleeding disorders	□	□
Nerve problems	□	□
Anticoagulants/blood thinning therapy	□	□
Dizziness	□	□
Drop Attacks	□	□
Double vision	□	□
Difficulty speaking	□	□
Difficulty swallowing	□	□
Nausea	□	□
Numbness	□	□
Nystagmus	□	□
Neck pain	□	□

Jaw pain	☐	☐
Headaches	☐	☐
Fainting spells	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐
Transient ischemic attacks	☐	☐
Shoulder pain	☐	☐
Arm/hand pain	☐	☐
Upper back pain	☐	☐
Lower back pain	☐	☐
Hip pain	☐	☐
Knee pain	☐	☐
Ankle/foot pain	☐	☐
Arthritis	☐	☐
Fatigue	☐	☐
Respiratory condition	☐	☐
Digestive problems	☐	☐
Kidney problems	☐	☐
Menstrual problems	☐	☐
Sinus/ allergy/ asthma conditions	☐	☐
Weight gain/loss	☐	☐
Cancer	☐	☐
Skin condition	☐	☐
Diabetes	☐	☐
Prostate problems	☐	☐
Tobacco use	☐	☐
Alcohol use	☐	☐
Caffeine use	☐	☐
Pregnancy	☐	☐
Surgery	☐	☐

Please shade in the figures below where you have pain.



Signature_____ Date_____