

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Age \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status ( S M D W ) Spouse's Name \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ Email \_\_\_\_\_  
(Needed For Appointment Confirmation!)  
 Whom may we thank for referring you to our office? \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
 ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_ Insured Social Sec # \_\_\_\_\_  
 Relationship to You \_\_\_\_\_ PPO or HMO? \_\_\_\_\_ Secondary Insurance? Yes \_\_\_ No \_\_\_

### Assignment & Release (Insurance Patients)

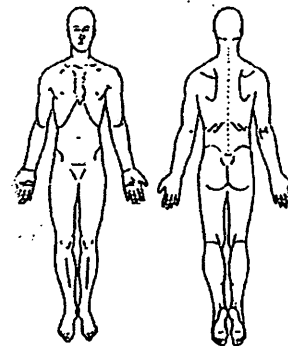
I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ & I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO "OC Back & Body Doctors" ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, including electronic submissions.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### Patient Health Questionnaire

1. Reason for office visit? \_\_\_\_\_  
 \_\_\_\_\_  
 2. Is this condition due to an: \_\_\_ Auto Accident \_\_\_ Work Injury \_\_\_ Other Accident \_\_\_ Illness \_\_\_ Unknown Cause

<u>Description</u>		<u>Frequency</u>
___ Sharp Pain	___ Numb	___ Constant (76-100%)
___ Dull Pain	___ Shooting	___ Frequent (51-75%)
___ Ache	___ Gripping	___ Occasional (26-50%)
___ Weak	___ Burning	___ Intermittent (25% or Less)
___ Throbbing	___ Tingling	



**Mark on the pictures where you have pain or other symptoms** →

Indicate intensity of your symptoms at its **lowest and highest** level

No symptoms 0 1 2 3 4 5 6 7 8 9 10 Severe symptoms

2. Your symptoms are \_\_\_ Decreasing \_\_\_ Not Changing \_\_\_ Increasing  
 3. Symptoms are worse in the \_\_\_ Morning \_\_\_ Afternoon \_\_\_ Night \_\_\_ Increases during the day \_\_\_ Same all day  
 4. When did your symptoms appear? Date \_\_\_\_\_ Describe how your problem began: \_\_\_\_\_  
 \_\_\_\_\_  
 8. Have you had these symptoms before: \_\_\_ Yes \_\_\_ No If yes, when? \_\_\_\_\_

## Patient Health Questionnaire (continued)

12. Have you seen other Doctor(s) for this condition? \_\_\_ Chiropractor \_\_\_ MD \_\_\_ Osteopath \_\_\_ P.T. \_\_\_ Other
13. Name of Doctor(s) \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Date of last treatment \_\_\_\_\_
14. What makes your problem **better**? \_\_\_ Nothing \_\_\_ Rest \_\_\_ Walking \_\_\_ Standing \_\_\_ Sitting \_\_\_ Exercise  
\_\_\_ Heat \_\_\_ Ice \_\_\_ Other \_\_\_\_\_
12. What makes your problem **worse**? \_\_\_ Nothing \_\_\_ Rest \_\_\_ Walking \_\_\_ Standing \_\_\_ Sitting \_\_\_ Exercise  
\_\_\_ Bending \_\_\_ Lifting \_\_\_ Coughing/Sneezing \_\_\_ Other \_\_\_\_\_
13. Are your complaints affecting your ability to move around? (walk, run, pick up things, swing your arms freely, move your head, wiggle your fingers) \_\_\_ Yes \_\_\_ No If yes, how? \_\_\_\_\_
12. When the problem is at its worst, explain exactly how it feels \_\_\_\_\_
16. How do your complaints affect you at:  
**Work** (eg. Computer work, concentration levels, travel, sitting)  
\_\_\_\_\_  
**Home** (eg. Cleaning, cooking, laundry, gardening)  
\_\_\_\_\_  
**Other Activities** (eg. Driving, sports, playing with children, exercising)  
\_\_\_\_\_
17. Do you sleep well?  Yes  No
18. How many hours per night do you sleep? (Average) \_\_\_\_\_
19. Do you...  
Have trouble falling asleep? Yes\_\_\_ No\_\_\_  
Awaken in the middle of the night? Yes\_\_\_ No\_\_\_  
Wake up feeling tired? Yes\_\_\_ No\_\_\_
20. Since you began suffering with this problem, what have you tried that **did not work**? (eg. Ice, Heat, Rest, Over the Counter Meds., Prescription Drugs, Stretching) \_\_\_\_\_
19. Are you interested in relieving your **symptoms only** or **correcting the cause** of your symptoms?  
I want to correct the cause of my symptoms  I want to receive symptom relief only
20. List all activities that this problem prevents you from doing either partially or totally, that you would like to be doing again? \_\_\_\_\_

## Occupational Information

- Occupation \_\_\_\_\_ FT\_\_\_ PT\_\_\_ Has your work status changed due to this complaint? Yes\_\_\_ No\_\_\_
- Physical activities at work: \_\_\_ Sitting more than 50% of day \_\_\_ Light labor \_\_\_ Moderate labor  
\_\_\_ Heavy labor \_\_\_ Repeated motion
- Does your job involve lifting? \_\_\_ Pounds \_\_\_ Occasionally \_\_\_ Frequently \_\_\_ Constantly
- Additional job requirements: \_\_\_ Bending \_\_\_ Twisting \_\_\_ Stooping \_\_\_ Turning \_\_\_ Carrying \_\_\_ Walking \_\_\_ Other
- Is your job associated with potentially harmful chemicals (eg pesticides, radioactivity, solvents) \_\_\_\_\_

## Health History

List all accidents and/or injuries in the past? (Even as a child) \_\_\_ Auto \_\_\_ Work \_\_\_ Other (Slip & Fall, Sports)

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (eg. Changes in job, work, residence or finances, legal problems): \_\_\_\_\_

What time of day do you feel the most energy (or the least symptoms)? \_\_\_\_\_

What time of day do you feel the worst (or your symptoms are aggravated)? \_\_\_\_\_

Do you experience any of these general symptoms regularly?

- |                                     |  |                                   |                                       |  |
|-------------------------------------|--|-----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Fatigue    | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic Attacks       | <input type="checkbox"/> Nausea   | <input type="checkbox"/> Itching/rash | <input type="checkbox"/> Heart Burn                |
| <input type="checkbox"/> Bloating   | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dizziness    | <input type="checkbox"/> Diarrhea                  |

## Medical History

- Do you have a family physician?  Yes  No  
Physician's Name and Telephone Number: \_\_\_\_\_  
Date of Last: Physical Exam \_\_\_\_\_ Spinal X-rays \_\_\_\_\_ MRI, CT Scan, Bone Scan \_\_\_\_\_
- Have you ever been hospitalized and/or had surgery?  Yes  No  
Date and reason for hospitalization/surgery \_\_\_\_\_  
\_\_\_\_\_
- List current health problems for which you are being treated: \_\_\_\_\_  
\_\_\_\_\_
- Current Medications (prescription or over the counter) \_\_\_\_\_
- Do you consider yourself  underweight  overweight  just right Your weight today \_\_\_\_\_
- Have you had an unintentional weight loss or gain of 10 pounds or more in the last year?  Yes  No
- Do you have any allergies? \_\_\_ Yes \_\_\_ No List Allergies \_\_\_\_\_
- (Women) To your knowledge, are you pregnant? \_\_\_ Yes \_\_\_ No Due Date \_\_\_\_\_

## Experience with Chiropractic

- Do you understand the term Subluxation? \_\_\_ Yes \_\_\_ No  
Have you ever been adjusted by a Chiropractor before? \_\_\_ Yes \_\_\_ No  
Reason for visit? \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_  
Approximate Date of Last Visit: \_\_\_\_\_  
Has any adult in your family seen a Chiropractor? \_\_\_ Yes \_\_\_ No  
Has any child in your family seen a Chiropractor? \_\_\_ Yes \_\_\_ No  
Where you aware that:
- Doctors of Chiropractic work with the nervous system? \_\_\_ Yes \_\_\_ No
  - The nervous system controls all bodily functions and systems? \_\_\_ Yes \_\_\_ No
  - Your symptoms account for only 10% of how your nervous system is really working? \_\_\_ Yes \_\_\_ No
  - Subluxations are often present without any symptoms or warning signs? \_\_\_ Yes \_\_\_ No

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

## Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

## Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids / ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased Sex Drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Surgical menopause
- Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

## Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Obesity
- Osteoporosis
- Pneumonia
- Stroke
- Suicide
- Other \_\_\_\_\_

## Health Habits

- Tobacco:  
Cigarettes: # / day \_\_\_\_\_
- Cigars: # / day \_\_\_\_\_
- Alcohol:  
Wine: # glasses / d or wk \_\_\_\_\_
- Liquor: # ounces / d or wk \_\_\_\_\_
- Beer: # glasses / d or wk \_\_\_\_\_
- Caffeine:  
Coffee: # 6 oz cups / d \_\_\_\_\_
- Tea: # 6 oz cups / d \_\_\_\_\_
- Soda w/ caffeine: # cans / day \_\_\_\_\_
- Other sources \_\_\_\_\_
- Water: # glasses / d \_\_\_\_\_

## Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

## Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch / carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:  
 dairy  wheat  eggs  
 soy  corn  all gluten
- Other \_\_\_\_\_

## Food Frequency

- Servings per day:  
Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow / orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

## Eating Habits

- Skip breakfast
- Two meals / day
- One meal / day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

## Current Supplements

- Multivitamin / mineral
- Vitamin C
- Vitamin E
- EPA / DHA
- Evening Primrose / GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

## Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

**NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

For any YES answer, please include details.

- |  |    |     |
|--|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?<br>Comment: _____                               | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?<br>Comment: _____                            | NO | YES |
| 3. Do your hands or arms fall asleep regularly?<br>Comment: _____  | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?<br>Comment: _____                            | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?<br>Comment: _____   | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?<br>Comment: _____                                | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?<br>Comment: _____                             | NO | YES |
| 8. Do our legs or feet fall asleep regularly?<br>Comment: _____  | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?<br>Comment: _____                               | NO | YES |
| 10. Do you suffer from cold hands or feet?<br>Comment: _____   | NO | YES |
| 11. Have you tried any medications such as anti-inflammatory?<br>If yes, what kind of medication?                          | NO | YES |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before?<br>If yes: When? For how long? What kind?       | NO | YES |
| 13. Have you had an MRI?<br>If yes: When? Who ordered it? What was it ordered for?   | NO | YES |
| 14. Have you used any splint or braces or other prescribed treatment by an MD?<br>If yes: When? What kind? Who ordered it? | NO | YES |
| 15. If you have tried any treatment or medications, did this make your problem better?<br>Comment: _____                   | NO | YES |

For any yes answer, rule in/out the diagnosis with these two tests:

- A) NCV/EMG tests    Upper    Lower                      Indicated    Not Indicated    (circle one)
- B) Vascular Test    Indicated    Not Indicated    (circle one)