Richland Spine & Disc

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Patient Information

Last Name: _____ First: _____ MI: _____

Date of Birth: ____/____/_____ Age: _____ Social Security #: _____-____-_____

Cell Phone #: _____ Home Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: □Male □Female Height: _____ Weight: _____

e-mail: _____ Referred by: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone #: _____

Previous Care

Primary Care Physician_____ Have you seen him/her for this condition? □No □Yes

Address/Location: _____ Phone #: _____

Please list all other health care providers you have seen for this condition:

Name: _____ Location: _____ Phone: _____

Name: _____ Location: _____ Phone: _____

Name: _____ Location: _____ Phone: _____

Health Insurance

Insurance Company: _____ Phone #: _____

Primary Insured Last Name: _____ First: _____ MI: _____

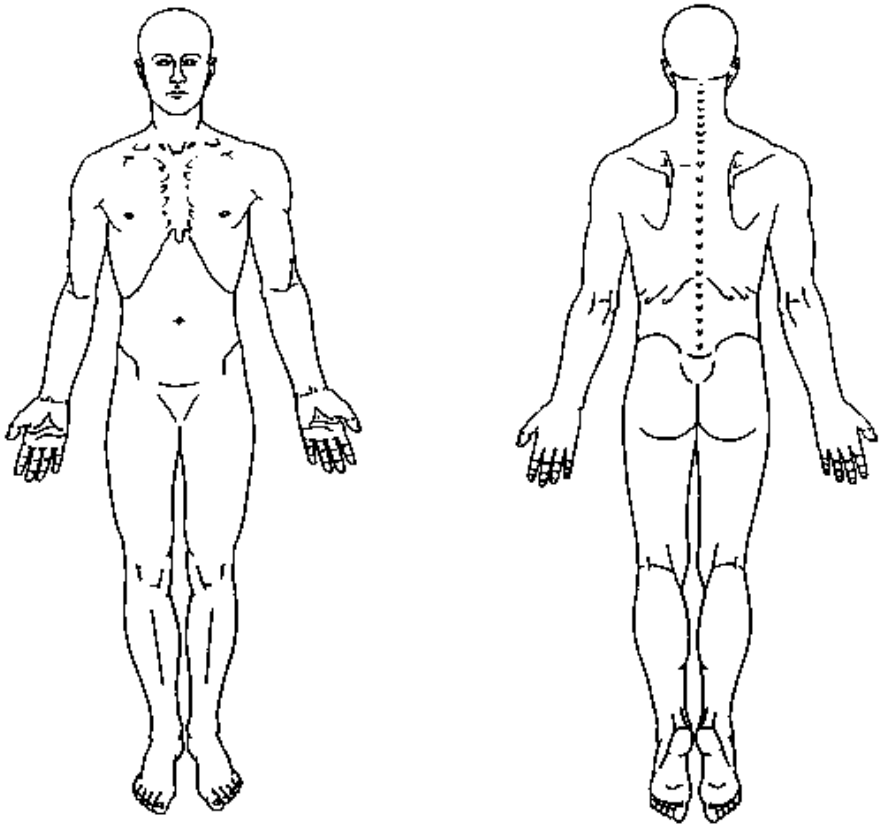
Relation to Insured: □Self □Spouse □Child □Other: _____

Subscriber ID #: _____ Group #: _____

History of Present Complaint

Patient Name:	Date:	Claim/ID#:
Is this visit related to a: □ Motor Vehicle Accident □ Work Injury □ Neither		
Reason for this visit: □ Initial Visit/New Patient □ Re-Evaluation/Continued Treatment □ New Injury		
Date of injury:	When did your symptom(s) start:	
How did your injury(s) occur:		
Please describe your injury(s) / symptom(s):		

On the picture below circle or mark area(s) of injury or complaint. Use letters to label areas of complaint.



A – Aching
B – Burning
D – Dull Pain
N – Numbness
P – Pins & Needles
S – Sharp Pain
T – Throbbing
W - Weakness

Circle the number(s) that best represent your pain or symptom level. If more than one please label.

GOOD 0 1 2 3 4 5 6 7 8 9 10 **BAD**

How often do you experience the above symptoms? □ Constantly □ Daily □ Weekly □ Monthly

Describe activities that are affected by your symptom(s): sitting, standing, walking, sleeping, driving, work…

List all other health providers you have seen for this condition:

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Health History

Patient: _____ Date: _____ Claim/ID#: _____

Have you ever had Chiropractic treatment? □ No □ Yes; when was your last treatment? _____

In the past 24 months have you had: □ X-rays □ MRI where/when: _____

Cervical Spine (Neck) - check all that apply:

- □ Neck Pain
- □ Pain into Arms/Hands
- □ Numbness/Tingling in Arms/Hands
- □ Muscle Weakness in Arms/Hands
- □ Headaches
- □ Dizziness/Lightheaded
- □ Visual Disturbances
- □ TMJ/Jaw Pain/Clicking
- □ Low Energy/Fatigue
- □ Thyroid Conditions
- □ Allergies
- □ Sinusitis

Thoracic Spine (Upper/Mid Back) - check all that apply:

- □ Upper/Mid Back Pain
- □ Chest Pain
- □ Angina/Heart Pain
- □ Heart Palpitations
- □ High Blood Pressure
- □ Shortness of Breath
- □ Difficulty Breathing
- □ Pain with Deep Inhale/Exhale
- □ Recurrent Bronchitis/Lung Infection
- □ Recurrent Acid Reflux/Heart Burn
- □ Ulcers
- □ Tired/Irritable before/after meals

Lumbar Spine (Low Back) - check all that apply:

- □ Low Back Pain
- □ Hip Pain
- □ Pain into Legs/Feet
- □ Numbness/Tingling in Legs/Feet
- □ Muscle Weakness in Legs
- □ Constipation/Diarrhea
- □ Irritable Bowel Syndrome
- □ Frequent/Difficult Urination
- □ Sexual Dysfunction
- □ Menstrual Irregularity
- □ Recurrent Bladder Infections

Health Conditions - check all that apply:

- □ HIV/AIDS
- □ **Cancer/Tumor**
- □ Diabetes
- □ **Osteoporosis/Osteopenia**
- □ **Spinal Disc Injury/Hernia/Bulge**
- □ **Stroke**
- □ Heart Disease/Attack
- □ Unexplained Weight Loss/Gain
- □ Depression
- □ Psychological Disorder
- □ Asthma
- □ Scoliosis
- □ Multiple Sclerosis
- □ Insomnia; Average hrs of sleep per night: _____
- □ **Pregnant**: date of last menstrual period:
- □ **Bone Fractures:**

List any health condition(s) not mentioned: _____

Do you have a Family History of: □ Heart Disease □ Diabetes □ Stroke □ Cancer

List date & type of <u>all</u> **Surgeries**: _____

_____

List all **Medications** presently taking: _____

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