Name_____ DOB____/____/_____ Date____/____/_____

Street Address _____

City, State, Zip Code _____ Phone _____

Have there been any changes in your insurance since your last exam? ☐ **YES** ☐ **NO**

If you checked yes, please see the front desk to update your information.

Are you taking any NEW medications or nutritional supplements since your last exam?

	No	Yes	More details of type (if applicable)	How Long?
Vitamin / Mineral Supplements	____	____	_____	_____
Herbs / Laxatives	____	____	_____	_____
Pain Meds / Muscle Relaxants	____	____	_____	_____
Sedatives/ Tranquilizers	____	____	_____	_____
Birth Control Pills	____	____	_____	_____
Hormone Replacement Therapy	____	____	_____	_____
Blood Pressure Medicine	____	____	_____	_____
Insulin	____	____	_____	_____
Other Prescribed Medicine	____	____	_____	_____
Over the Counter Products	____	____	_____	_____
Recreational Drugs	____	____	_____	_____
Tobacco	____	____	_____	_____
Alcohol	____	____	_____	_____
Coffee	____	____	_____	_____
Diet Soda / Artificial Sweeteners	____	____	_____	_____

Have you had any *recent* incidents that exacerbated your condition or increased your pain?

_____

_____

Have you had any recent diagnostic tests performed, medical diagnosis, or other health concerns since your last exam?

_____

_____

What can you currently do now that you were unable to do when you first came to the office?

_____

_____

Are there any other areas of health you would like to improve (i.e. weight, fatigue, digestion, depression, etc.)?

_____

_____

Please list any questions you have for the doctor or staff in regards to treatment plan, expectations of care, financial situation, nutritional supplements, etc.

_____

_____

Please list any friends or family members who could benefit from visiting our office regarding their physical, chemical or stress related health issues. Which clubs or organizations are you involved with that could benefit from a lecture or trigger point workshop led by the doctor?

_____

_____

AFFIDAVIT

Patient's statement "Documenting" Medical Necessity of Care, a sworn statement be "Federal" Documentation Format.

PATIENT EXACERBATION DOCUMENTATION AND UPDATE HISTORY QUESTIONAIRE:

Problem 1

Where does it hurt? □ Low Back □ Mid Back □ Neck

□ Other: _____

What date did this start? _____

What were you doing when this episode started?

_____

Please describe it: □ Achy □ Dull □ Diffuse □ Deep
□ Tightness □ Stiffness □ Pulling □ Weakness □ Heavy
□ Sharp □ Shooting □ Burning □ Stinging □ Stabbing
□ Throbbing □ Numbness □ Tingling
□ Occasional □ Intermittent □ Frequent □ Constant
□ Off & On □ Random □ Recurring

How would you rate your pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain Possible

Has this condition been getting:

□ Better □ Worse □ Stayed the same

Which activities do you experience pain when performing?

□ All Movements □ Bending over □ Climbing stairs
□ Dressing □ Driving □ Exercising □ Getting in/ out of car
□ Getting to sleep □ Grocery shopping □ Household chores
□ Lifting Objects □ Looking over shoulder □ Lying down
□ Reaching overhead □ Seated to standing
□ Showering/ bathing □ Sitting □ Standing
□ Staying Asleep □ Using computer □ Walking
□ Yard work □ Other: _____

Does anything relieve or lessen the pain?

□ Nothing □ Chiropractic adjustments □ cold pack
□ Exercise □ Hot pack □ Massage □ Physical Therapy
□ Over-the-counter meds □ Prescription meds □ Rest
□ Stretching □ OTHER_____

Does the pain radiate or travel anywhere?

□ _____

When is this pain the worst?

□ Morning □ During the day □ At Night □ Constant

Is this a result of an accident?

Work: □ Yes □ No Auto: □ Yes □ No

Problem 2

Where does it hurt? □ Low Back □ Mid Back □ Neck

□ Other: _____

What date did this start? _____

What were you doing when this episode started?

_____

Please describe it: □ Achy □ Dull □ Diffuse □ Deep
□ Tightness □ Stiffness □ Pulling □ Weakness □ Heavy
□ Sharp □ Shooting □ Burning □ Stinging □ Stabbing
□ Throbbing □ Numbness □ Tingling
□ Occasional □ Intermittent □ Frequent □ Constant
□ Off & On □ Random □ Recurring

How would you rate your pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain Possible

Has this condition been getting:

□ Better □ Worse □ Stayed the same

Which activities do you experience pain when performing?

□ All Movements □ Bending over □ Climbing stairs
□ Dressing □ Driving □ Exercising □ Getting in/ out of car
□ Getting to sleep □ Grocery shopping □ Household chores
□ Lifting Objects □ Looking over shoulder □ Lying down
□ Reaching overhead □ Seated to standing
□ Showering/ bathing □ Sitting □ Standing
□ Staying Asleep □ Using computer □ Walking
□ Yard work □ Other: _____

Does anything relieve or lessen the pain?

□ Nothing □ Chiropractic adjustments □ cold pack
□ Exercise □ Hot pack □ Massage □ Physical Therapy
□ Over-the-counter meds □ Prescription meds □ Rest
□ Stretching □ OTHER_____

Does the pain radiate or travel anywhere?

□ _____

When is this pain the worst?

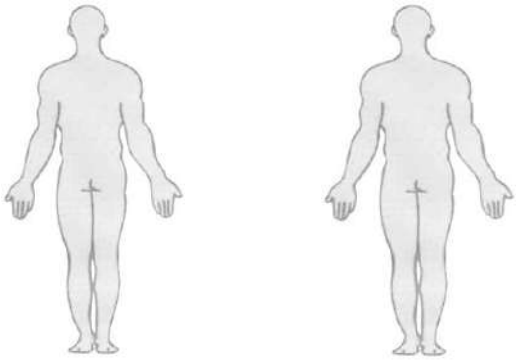
□ Morning □ During the day □ At Night □ Constant

Is this a result of an accident?

Work: □ Yes □ No Auto: □ Yes □ No

Mark an X on the picture where you continue to have pain, numbness or tingling.

Problem 1 **Problem 2**



_____

Signature

_____

Printed Name

_____

Date

Functional Rating Index

In order to properly assess your condition, we must understand how much your main problem has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; no restrictions	Mild Pain; no restrictions	Moderate Pain; need to go slowly	Moderate Pain; need some assistance	Severe pain; need 100% assistance

Travel (driving, etc.)

0	1	2	3	4
No Pain on long trips	Mild Pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe pain on short trips

Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

Lifting

0	1	2	3	4
No Pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after one hour	Increased pain after 1/2 hour	Increased pain with any standing

Printed Name: _____ **Date:** _____

Signed Name: _____

Appointment Reminders

If you would like a reminder of your future appointments please select an option below with contact information and phone carrier.

Circle preference: 2 hours before or One day before or Other

- ☐ **Email: _____**

- ☐ **Text: _____ Phone Carrier _____**

- ☐ **Decline**