JESTER FAMILY CHIROPRACTIC, P.C.

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, completely and accurately. THANK YOU.

Date ________________________ Home Phone______________________ Cell/Work Phone________________________

Name____SSN_____________________________________

Street_________________________________ City______________________________ Zip Code____________________

Age _______ Birth Date________________ Heard about our office through / referred by: ____________________________

Have you ever been to a Chiropractor? Y / N Last Adjustment Date: _______________ Last X-ray Date: ______________

Occupation ___________________ Employer ________________________ Satisfaction with Career: great okay unhappy

Please List Present Complaints and Date of Onset:

1. ____ 2. ____

3. ____ 4. ____

Please use the following symbols on the pain diagram to accurately describe your condition.

PPP Where you experience Pain

NNN Where you experience Numbness

TTT Where you experience Tingling

BBB Where you experience Burning

CCC Where you experience Cramping

Specify Which Side of the Body:

Head: ____________________________________
Neck: ____________________________________
Shoulders: ________________________________
Arms: ____________________________________
Hands: ___________________________________
Upper Back: _______________________________
Mid Back: ________________________________
Low Back: ________________________________
Buttocks: ________________________________
Thigh: ___________________________________
Calves: __________________________________
Knees: ___________________________________
Feet: ____________________________________

Complaint History- Please read carefully and fill out completely:

1. How long have you had this condition? ________________________________ Date of Onset: _________________
2. Since your problem began is the pain: getting worse / getting better / staying the same
3. How would you rate the intensity of your pain? (Circle the appropriate number)

   0 1 2 3 4 5 6 7 8 9 10

   (No pain) (Moderate pain) (Terrible pain)
4. Pain radiates or travels? NO. YES. Describe where: ____
5. How often is the pain present? Constant (81-100%) Frequent (51-80%) Occasional (26-50%) Infrequent (>25%)
6. Can you go to sleep without problems? Yes / No Do you wake with pain? Yes / No Where? _________________
7. How did your problem begin? gradual / sudden / no specific reason / auto accident / work related accident
8. Describe feeling: dull / sharp / aching / shooting / spasm / throbbing / burning / numbing / tingling / sore
9. **Actions affecting this pain:** **(B) Brings on** **(A) Aggravates** **(R) Relieves**

in the morning	(B) (A) (R)	in the afternoon	(B) (A) (R)	bending forward	(B) (A) (R)
bending back	(B) (A) (R)	bending left	(B) (A) (R)	bending right	(B) (A) (R)
twisting right	(B) (A) (R)	twisting left	(B) (A) (R)	coughing	(B) (A) (R)

sneezing	(B) (A) (R)	straining	(B) (A) (R)	standing	(B) (A) (R)
lifting	(B) (A) (R)	sitting	(B) (A) (R)	heat	(B) (A) (R)
cold	(B) (A) (R)	resting	(B) (A) (R)	other ________________	(B) (A) (R)
medications	(B) (A) (R)	lying	(B) (A) (R)	other ________________	(B) (A) (R)

10. What is your physical activity at work? computer work / mostly sitting / light / moderate / heavy manual labor
11. What is your present mental and emotional stress level? none / minimal / moderate / greatly stressed
12. Is your problem affecting your ability to work or perform daily activities? no effect / some effect / greatly effected
13. Have you lost time from work, school or social activities? Yes / No
14. Can you perform physical work activities? Yes / No If No, why? pain / weakness / stress / other _______________
15. If it is affecting your daily living, what areas are affected? seeing / tasting / smelling / eating / hearing / bathing / grooming / dressing / reading / typing / writing / grasping / holding / pinching / standing / leaning / walking / stooping / squatting / climbing / kneeling / bending / twisting / carrying / lifting / pushing / pulling / reaching / lifting / pushing / pulling / reaching / sitting / driving / plane travel / sports / exercise / loss of sexual drive / reclining / restful sleep / insomnia / using the toilet / loss of concentration / nervous / irritable / change in personality / tactile feeling / other _________________
16. Is there anything about your nervous system or spine that we should know about? ________________________________
17. What exercise do you do and how much? ____
18. What did you have for breakfast, lunch and dinner yesterday? ____
19. How many glasses of water do you drink each day? ____
20. Do you smoke or use tobacco? presently / past / never How much and how long? ______________________________
21. How many hours of sleep do you get each night? __________ Quality of your sleep? great / okay / poor
22. What is your level of commitment to your self, your life and well being? high / medium / low
23. What do you hope to accomplish by seeking care in this office? pain relief / spinal correction / better health & wellness

List other doctors consulted for present complaints and injuries:

Name: __________________________________ What kind of doctor? _______________ When ______________________

Diagnosis: ____ Treatment/ x-rays: _________________________

How long did you see the doctor? __________________________ How frequently? __________________________

Result: ____

Present family doctor ________________________________ Last exam date: _________ Reason for Visit: ______________

What surgeries have you had? Type: ____date: ___________________________

Type: ____ Outcome Results:_____________ date: ____________

List former serious accidents and falls: (auto, work, home, leisure, sports, other) What / When / Treatments / Results:

____

List broken bones: What / When / Remarks: ____

List medications / diet supplements you take or have taken: ____

What / Frequency / Dosage / Side Effects / Prescribing Doctor: ____

Assignment of Benefits: I hereby irrevocably instruct and direct my insurance company to pay JESTER FAMILY CHIROPRACTIC, PC directly. For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. I also authorize the release of any health information pertinent to my case to any insurance company, Health Care Financing Administration or its agents, or attorney involved in this case. I authorize the doctor to initiate a complaint to the insurance Commissioner for any reason on my behalf.

I understand all the information on this form and I answered it true and correct to the best of my ability.

______________________________	______________________________	______________
Signature	Print Name	Date