



Doctor _____ Account # _____

PATIENT INFORMATION

Date: _____

Last Name _____ First Name _____ Date of Birth _____ / _____ / _____ Age _____ Social Security Number _____ () _____

Address _____ City _____ State _____ Zip _____ Telephone Number _____ () _____

E-Mail Address _____ Emergency Contact Name & Phone Number _____ Cell Phone Number _____

Male Female Single Divorced Widowed Married (spouse's name) _____ No. of children _____ () _____

Occupation _____ Employer Name _____ Work Phone Number _____

Who referred you to our office?

Insurance Company Name: _____
 Policy # _____

Check all that apply now:

<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Pain in ears L / R	<input type="checkbox"/>	Pain in feet L / R
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Neck Stiffness	<input type="checkbox"/>	Mid Back Stiffness	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Shoulder pain L / R	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Grating in neck	<input type="checkbox"/>	Shoulder Tightness L / R	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Muscle spasms in the neck	<input type="checkbox"/>	Rib pain L / R	<input type="checkbox"/>	Loss of balance
<input type="checkbox"/>	Arm pain L / R	<input type="checkbox"/>	Pain in side L / R	<input type="checkbox"/>	Loss of taste
<input type="checkbox"/>	Arm numbness L / R	<input type="checkbox"/>	Chest pain L / R	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Elbow pain L / R	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	Wrist pain L / R	<input type="checkbox"/>	Low back Stiffness	<input type="checkbox"/>	Sleeping Trouble
<input type="checkbox"/>	Cold hands L / R	<input type="checkbox"/>	Hip pain L / R	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Numbness in hands L / R	<input type="checkbox"/>	Pain in legs L / R	<input type="checkbox"/>	Painful joints
<input type="checkbox"/>	Head feels heavy	<input type="checkbox"/>	Leg Numbness L / R	<input type="checkbox"/>	Swollen joints
<input type="checkbox"/>	Twitching of the face	<input type="checkbox"/>	Knee pain L / R	<input type="checkbox"/>	Menstrual irregularity

Do you have any other symptoms not listed above?

- 1) Is the pain worse in the . . . morning evening after normal activity after increased activity
- 2) Does the pain interfere with: Work or Activities of Daily Living (sleeping, sitting, standing, lifting, etc.)
- 3) Have you had Chiropractic care before? No Yes When: _____ Where: _____
- 4) Is it possible that you are pregnant? No Yes
- 5) Are you currently taking any medications? No Yes, if yes please indicate below.
 Name: _____ For: _____ Name: _____ For: _____
 Name: _____ For: _____ Name: _____ For: _____

PAST HISTORY

- 6) Please indicate if you are here for care due to: an auto accident an on-the-job injury or a personal injury
 Date of your injury? _____ Did you file a claim? Yes No Was a police report made? Yes No
- 7) Have you ever had any injuries, accidents, or falls (even if you think you were not hurt at the time)? No Yes, if yes please indicate below:
 When? Month _____ Year _____ Type of injury: _____
 When? Month _____ Year _____ Type of injury: _____
 When? Month _____ Year _____ Type of injury: _____
- 8) Have you ever had surgery? No Yes When? Month _____ Year _____ Type of surgery? _____
 When? Month _____ Year _____ Type of surgery? _____



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- 8) Have you ever had surgery? No Yes When? Month _____ Year _____ Type of surgery? _____
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SUBJECTIVE FINDINGS

PAIN CLASSIFICATION

CERVICAL: Mild Moderate Severe
 Sharp Stabbing Intermittent Constant

THORACIC: Mild Moderate Severe
 Sharp Stabbing Intermittent Constant

LUMBAR: Mild Moderate Severe
 Sharp Stabbing Intermittent Constant

PELVIC: Mild Moderate Severe
 Sharp Stabbing Intermittent Constant

RANGE OF MOTION	CERVICAL				LUMBAR			
	+	-	RESULT	NORM	+	-	RESULT	NORM
Flexion				45				90
Extension				45				30
Lateral Flexion				45R				30R
Lateral Flexion				45L				30L
Rotation				80R				30R
Rotation				80L				30L

ROM Reference National Boards & Life University

OBJECTIVE FINDINGS

CERVICAL: Muscle Spasms _____ L R Fixations _____ ROM

THORACIC: Muscle Spasms _____ L R Fixations _____ ROM

LUMBAR: Muscle Spasms _____ L R Fixations _____ ROM

PELVIS: Muscle Spasms _____ L R Fixations _____ ROM

AREAS OF TENDERNESS

CERVICAL: L R

DORSAL: L R

LUMBAR: L R

PELVIS: L R

POSTURAL DISTORTION

HEAD TILT: L R

Shoulder High On: L R

Ilium High On: L R

Forward Head Carriage: L R

ORTHOPEDIC TESTS

	L	R	B	N
Linder's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foraminal Compression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soto-Hall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Valsalva	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kemp's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lasegue's ___L ___R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Braggard's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hibb's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fabere-Patrick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apley's Scratch Test (shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apley's Scratch Test (knee)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Height _____ Ambulatory Yes No

Weight _____ Antalgia Yes No

Blood Pressure _____ Pulse _____

X-ray Report & Spinal Analysis

<input type="checkbox"/> At	<input type="checkbox"/> 1L	Osteophytic Changes	C	T	L
<input type="checkbox"/> Ax	<input type="checkbox"/> 2	Degeneration	C	T	L
<input type="checkbox"/> 3	<input type="checkbox"/> 3	Loss of Lordotic Curve	C	L	
<input type="checkbox"/> 4	<input type="checkbox"/> 4	Spina Bifida	C	T	L
<input type="checkbox"/> 5	<input type="checkbox"/> 5	Sacralization	L	R	
<input type="checkbox"/> 6		Lumbarization	L	R	
<input type="checkbox"/> 7		Neuroforaminal Stenosis	C	T	L
<input type="checkbox"/> 1D	L. Ilium	Scoliosis (Lateral Curve)	C	T	L
<input type="checkbox"/> 2	<input type="checkbox"/> PI		L	R	L R
<input type="checkbox"/> 3	<input type="checkbox"/> As	Spondylolisthesis	Grade: _____		
<input type="checkbox"/> 4	<input type="checkbox"/> In	Retrolisthesis	Grade: _____		
<input type="checkbox"/> 5	<input type="checkbox"/> Ex				
<input type="checkbox"/> 6		Compression Fracture _____			
<input type="checkbox"/> 7	R. Ilium				
<input type="checkbox"/> 8	<input type="checkbox"/> PI	Osteoporosis	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
<input type="checkbox"/> 9	<input type="checkbox"/> As				
<input type="checkbox"/> 10	<input type="checkbox"/> In	Spinal Fusion	<input type="checkbox"/> congenital	<input type="checkbox"/> surgical	
<input type="checkbox"/> 11	<input type="checkbox"/> Ex				
<input type="checkbox"/> 12					

COMMENTS

	Subluxation	Connective Tissue	Nerve Tissue	Bio Mechanical	Symptoms
1					
2					
3					
4					

Extremity	Connective Tissue	Symptom

CORRECTIVE CARE PLAN

Daily visits for _____ weeks

3 visits per week for _____ weeks

2 visits per week for _____ weeks

1 visit per week for _____ weeks

1 visit every 2 weeks

1 visit per month

M T W Th F Sa Su

Doctor Signature: _____

Date: _____