Patient Information and History

Please fill out COMPLETELY. If something does not apply to you, simply write N/A in the space provided. Please Print Legibly.

Name_____ Date of Birth _____

SSN Number _____ Gender M F Status M S W D # Children _____

Possibility of Pregnancy? Y N Email address _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ OK to text? Y N Cell phone provider_____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

Medical Doctor Name _____ Phone Number _____

Spouse /Parent Name _____ Date of Birth _____

Emergency Contact Name _____ Phone _____

History Of Present Illness

What problem causes you to come to the office? _____

What caused this condition? _____

When did this start? _____ How often does the pain occur? Occasional, Frequent, Constant

How bad is this pain? Circle the one that applies. Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Throbbing, Nagging,

Burning, Deep, Stinging, Pressure-like _____

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

List past or current medications, including over the counter that you are taking? _____

_____

Other Problem

What other pain do you have? _____

What caused this pain? _____

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain. Cramping, Aching, Dull, Sharp, Shooting, Throbbing, Nagging,

Burning, Deep, Stinging, Pressure-like

How often does the pain occur? Occasional, Frequent, Constant

Allergies

Please list any allergies below including allergies to medications. _____

_____

Family History

Please tell us about the health of you grandparents, parents, and siblings. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living Deceased	Heart disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease
Paternal Grandfather	L D Cause							
Paternal Grandmother	L D Cause							
Maternal Grandfather	L D Cause							
Maternal Grandmother	L D Cause							
Father	L D Cause							
Mother	L D Cause							
Sibling M F	L D Cause							
Sibling M F	L D Cause							
Sibling M F	L D Cause							

Social History

Do you Drink alcohol Y N Do you use tobacco Y N Do you use recreational drugs Y N

Past Medical History

Have you had any illnesses in the past? _____

_____

Have you had any injuries? _____

_____

Have you been hospitalized? _____

_____

Have you had any surgeries?

_____

_____

BODY PRESSURE POINT MAP

XXXX = TRIGGER POINT LOCATION

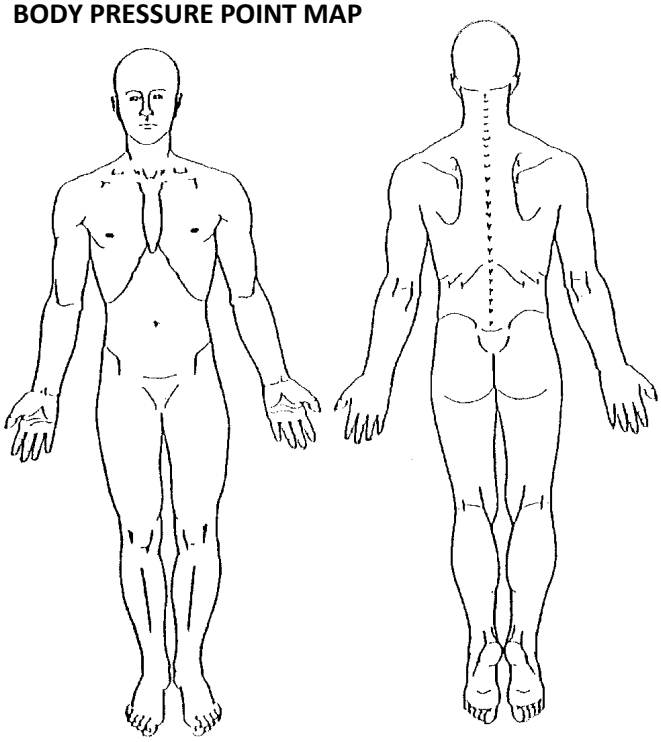
H/A = HEADACHE

---→----→ = RADIATING PAIN

(NN & TT) = NUMBNESS AND TINGLING

= BURNING

= JOINT PAIN



Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which control and regulates your entire body. Please darken the circle beside any condition that applies.

1. Musculoskeletal

○ Osteoporosis	○Arthritis	○ Neck Pain	○ Back Problems	○Hip disorders	○ Foot/ankle Pain	**NONE**○
○ Knee Injuries	○Scoliosis	○ TMJ issues	○ Shoulder problems	○Poor posture	○ Elbow/wrist pain	

2. Neurological

○ Anxiety	○Depression	○ Headache	○ Pins and needles	○Dizziness	○ Numbness	**NONE**○

3. Cardiovascular

○ High blood pressure	○Low blood pressure	○ High cholesterol	○ Poor circulation	○Angina	○ Excessive bruising	**NONE**○

4. Respiratory

○ Asthma	○Apnea	○ Emphysema	○ Shortness of breath	○ Hay fever	○ Pneumonia	**NONE**○

5. Digestive

○ Anorexia or bulimia	○Ulcer	○ Food sensitivities	○ Heartburn	○Constipation	○ Diarrhea	**NONE**○

6. Sensory

○ Blurred vision	○ Ringing in ears	○ Hearing loss	○ Chronic ear infection	○Loss of smell	○ Loss of taste	**NONE**○

7. Skin

○ Skin cancer	○Psoriasis	○ Eczema	○ Acne	○Hair loss	○ Rash	**NONE**○

8. Endocrine

○Thyroid issues	○Immune disorders	○Frequent infection	○ Hypoglycemia	○Swollen glands	○ Low energy	**NONE**○

9. Genitourinary

○ Kidney stones	○Infertility	○ Bedwetting	○ Prostate issues	○Erectile dysfunction	○ PMS symptoms	**NONE**○

10. Constitutional

○ Fainting	○ Low libido	○Poor appetite	○ Fatigue	○Weakness	○Sudden weight gain/loss (circle one)	**NONE**○

Oswestry Neck Pain Disability Questionnaire (Complete only if you have Neck Pain)

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE that most applies to you.** We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE, CHOICE THAT BEST DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain very severe at the moment
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight neck pain.
- ☐ I can read as much as I want to with moderate neck pain.
- ☐ I cannot read as much as I want to because of moderate neck pain.
- ☐ I cannot read as much as I want to because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Section 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time.

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of degree of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 – Driving

- ☐ I can drive any car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain I the neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe pain I my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hour sleepless).
- ☐ My sleep is moderately disturbed (2-3 hour sleepless).
- ☐ My sleep is greatly disturbed (3-5 hour sleepless).
- ☐ My sleep is completely disturbed (5-7 hour sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all of my recreational activities with no neck pain at all.
- ☐ I am able to engage in all of my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of pain in my neck.
- ☐ I cannot do any recreational activities at all.

Score: _____

Oswestry Low Back Pain Disability Questionnaire (Complete only if you have Low Back Pain)

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE that most applies to you.** We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE, CHOICE THAT BEST DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 – Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9 – Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.

Score: _____

Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices of Function First.

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Medical Information Release Form

Release of Information

I authorize the release of information including the diagnosis, records;
Examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child (ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____
If unable to reach me:
[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Assignment of Benefits

I certify that I (or my dependent) have insurance coverage and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

_____
Patient Name (print)

_____ Date _____
Patient/Guardian Signature

Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments/acupuncture and other therapy procedures to be performed on myself or on (child under 18) _____ by the doctor. I also consent to the procedures performed by his trained staff assistants under direct instruction and supervision.

I have had an opportunity to discuss with the doctor or other office personnel the nature and purpose of chiropractic adjustments/acupuncture and other therapy procedures. I understand that the practice of neither chiropractic/acupuncture nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee of results has been made to, nor relied upon by, me, and I wish to rely on the doctor to exercise judgment during the course of the procedures which he feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic/acupuncture procedures is very low, anyone undergoing chiropractic adjustments/acupuncture, physical therapy services or joint manipulation procedures should know of possible complications, which have been alleged. These include, but are not limited to; burns, fractures, disc injuries, strokes, dislocations, sprains, increase or worsening of symptoms and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although our clinic uses sterile disposable needles and maintains a clean safe environment.

I have read or have had read to me the above Consent. I have also had the opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

_____
Patient Name (print)

_____ Date _____
Patient/Guardian Signature