Leader Heights Spine, Joint & Nerve Associates

Date: _____ Chart # _____ DC # _____

Patient Information: Please print clearly and complete all sections.

Please Circle : Mr. Mrs. Ms. Miss Dr. Rev. *Marital Status* : Single Married Widowed Separated/Divorced

First Name: _____ Middle Name: _____ Last Name:_____

Nickname: _____ DOB: Month_____ Day_____ Year_____ Gender: ☐ Male ☐ Female

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

Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

☐ OK to leave a message on answering machine ☐ Do not leave message

Drivers License # _____ State Issued:_____ E-mail: _____

SS # _____ Primary Language: ___ English ___ Spanish Other:_____

Optional: Race: _____ Ethnic group: _____ Religion _____

Employer: _____ Occupation:_____ Emp. Status_____

Spouse / Parent / Legal Guardian Details:

Name: _____ Relation: _____

Address if different from patient: _____

Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

*DOB: _____ *SS # _____ *Employer _____

* Information needed if Insurance is through Spouse / Parent / Legal Guardian

Primary Pharmacy: _____

Family Dr. :_____ Phone/Address: _____

Specialist Name:_____ Phone/ Address: _____

EMERCENCY CONTACT INFORMATION:

Name: _____ Relation: _____

Address if different from patient: _____

Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Person above is authorized to receive ☐ Health records/ Treatment details ☐ Appt details ☐ Financial details

Name: _____ Relation: _____

Address if different from patient: _____

Phone: Home (_____)_____ Work (_____)_____ Cell (_____)_____

Person above is authorized to receive ☐ Health records/ Treatment details ☐ Appt details ☐ Financial details

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How did you find out about our office? ☐ Newspaper ☐ TV ☐ Radio ☐ Insurance ☐ Speaking Engagement

☐ Friend / Co-Worker: _____ ☐ Other: _____

Are your current symptoms related to a: ☐ Motor vehicle accident? ☐ Injury at work? If so, when?_____

Primary Ins. Carrier _____ Primary Insured's Name? _____ DOB_____

Secondary Ins. Carrier _____ Primary Insured's Name? _____ DOB_____

What is the reason for today's visit?

Ankle Pain	Foot Pain	Joint Pain
Arm Pain	Generalized Pain	Knee Pain
Back Pain	Groin Pain	Leg Pain
Buttock Pain	Hand Pain	Neck Pain
Chest Pain	Headache	Shoulder Pain
Facial Pain	Hip Pain	Thigh Pain

Have you ever been seen by an physician for these symptoms? ___ Yes ____ No
If Yes, who _____ Phone: _____

When did the Pain begin? _____

Please rate from (0 - 10) 0 - Pain free / 5 - Can't be ignored / 10 - Pain makes you pass out
Current level of pain _____ Worst pain level you've had _____ Pain level at its best _____

How would you describe your pain?
___ Aching ___Throbbing ___Shooting ___Stabbing ___Sharp ___Burning
___Dull ___ Tingling ___ Constant ___ Intermittent other:_____

Is your pain the result of an: ___ Illness ___ Accident ___ Injury Explain: _____
Are you presently involved in litigation or a lawsuit resulting from the accident? ____ No _____Yes
Are you being treated under Worker's compensation? ____ No ____ Yes

Please indicate if the following **increases** your pain

___ Cold	___ Heat	___Weather changes	___ Physical Activity
___ Massage	___ Pressure	___ Movement	___ Lying down
___ Sitting	___ Standing	___Urination	___ Bowel movement
___ Fatigue	___ Sneezing/ Cough	___ Stress	___ Nothing

Please indicate if the following **decreases** your pain

___ Cold	___ Heat	___Weather changes	___ Physical Activity
___ Massage	___ Pressure	___ Movement	___ Lying down
___ Sitting	___ Standing	___Urination	___ Pain Medication
___ Fatigue	___ Sneezing/ Cough	___ Rest	___ Nothing

Have you received any of the following treatments for the pain? If yes, when and did it help?

Received:			**Pain Relief:**		**Date Done:**
___Yes	___ NO	Nerve Blocks	___ Yes	___ NO	_____
___Yes	___ NO	Epidural Steroid	___ Yes	___ NO	_____
___Yes	___ NO	Spinal Stimulator	___ Yes	___ NO	_____
___Yes	___ NO	TENS unit	___ Yes	___ NO	_____
___Yes	___ NO	Physical Therapy	___ Yes	___ NO	_____
___Yes	___ NO	Traction	___ Yes	___ NO	_____
___Yes	___ NO	Acupuncture	___ Yes	___ NO	_____
___Yes	___ NO	Chiropractic Care	___ Yes	___ NO	_____
___Yes	___ NO	Psychiatric Care	___ Yes	___ NO	_____
___Yes	___ NO	Hypnosis	___ Yes	___ NO	_____
___Yes	___ NO	Bio-Feedback	___ Yes	___ NO	_____

What Medications have you used in the past to treat your pain, including non-prescription medications?
___ Over the counter ___ Non-Steroidal Anti-Inflammatory ___Pain Killers ___ Muscle Relaxants

Using a 0-10 scale (0 being non functional and 10 being fully functional) rate the below selections

___ General Activity ___ Normal Work Routine ___ Relationships with others
___ Mood ___ Sleep ___ Enjoyment of life
___ Walking Ability ___ Appetite

What are your goals?

___ Return to work ___ Improved mood ___ Increased socialization ___ Play with kids
___ Relieve pain ___Get Rid of Numbness ___ Walk ___ Sleep ___ Other

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Social History

Number of Children _____

Nature of Exercise _____

Are you concerned about the amount you drink? ___ Yes ___ No ____

Do you drink alcohol ? ___ Never ___ Daily ___ Weekly ___ 1x-2x wk ___ 3x + wk ___ Rarely

If yes, what kind _____

Do you use tobacco? ___ Yes ___ Never ___ Recently Quit ___ Quit 1yr + ___ Occasionally

Caffeine intake ___ None ___ Few times wk ___ 1-2 wk ___ 3-5 wk ___ 6 or more a wk

Do you use recreational or street drugs? ___ Never used ___ History of use ___ Current use

If yes, was it with a needle? ___ No ___ Yes

Type of job held _____ ___ Active ___ Retired / unemployed now

Job related physical activity: ___ Sedentary ___ Light ___ Moderate ___ Heavy

Nature of work: ___ Computer related ___ Prolonged Standing ___ Highly Stressful

Occupational Exposure: ___ None ___ Current ___ History of exposure

Exposure to health hazards: ___None ___ Dust ___ 2nd hand smoke ___ Paints ___ Fumes
___ Solvents ___Noise ___ other hazards

Duration of Current profession: _____ years _____ months _____ days

Stress level at work: ___ Low ___ Medium ___ High

Allergies

__ No Known Drug Allergy

___ Penicillin ___ Narcotics ___ Sulfa Drugs ___ Erythromycin ___ Cephalosponns
___ Latex ___ Iodine ___ Dyes ___ Peanuts ___ Shellfish ___ Eggs / Poultry
___ Pet Dander ___ Seasonal Allergies ___ Dust

{ _____} {_____}
{ _____} {_____}
{ _____} {_____}

Current Medications

___ No Current Medications

List of : { _____} {_____}
{ _____} {_____}
{ _____} {_____}
{ _____} {_____}
{ _____} {_____}

Past Surgical History

___ No prior surgeries

Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____
Type: _____ When: _____

Past Medical History

___ No Past Medical problems

___ AIDS or HIV+	___ Heart Disease	___ Osteoporosis
___ Hepatitis	___ Stroke	___ Tuberculosis
___ Diabetes	___ Chronic Lung Disease	___ Shingles
___ High Blood Pressure	___ Epilepsy/Seizures	___ Limb circulation
___ High Cholesterol	___ Cancer	___ Kidney Problems
___ Neuropathy	___ Gout	___ Bulging / Herniated Disk

Other: _____

Family History

___ No Known Family History

Illness:	Relation:
___ Cancer	_____
___ Diabetes	_____
___ Epilepsy	_____
___ High Blood Pressure	_____
___ Stroke	_____

Other: _____

Current review of symptoms:

Fever	___ Denies	___ Reports	Headache	___ Denies	___ Reports
Night Sweats	___ Denies	___ Reports	Dizziness	___ Denies	___ Reports
Weight loss	___ Denies	___ Reports	Double vision	___ Denies	___ Reports
			Loss of vision	___ Denies	___ Reports
Asthma	___ Denies	___ Reports	Pain in eyes	___ Denies	___ Reports
Coughing up blood	___ Denies	___ Reports	Earaches	___ Denies	___ Reports
Wheezing	___ Denies	___ Reports	Discharge from ears	___ Denies	___ Reports
			Freq. nose bleeds		
Chest pain	___ Denies	___ Reports	Sinus problems	___ Denies	___ Reports
Poor circulation	___ Denies	___ Reports	Sore throat	___ Denies	___ Reports
Blood clots	___ Denies	___ Reports	Swallowing difficulty	___ Denies	___ Reports
Irregular heart beat	___ Denies	___ Reports	Taste Difficulty	___ Denies	___ Reports
Thumping in the chest	___ Denies	___ Reports	Hoarseness	___ Denies	___ Reports
Ankle swelling	___ Denies	___ Reports	Neck pain	___ Denies	___ Reports
Feet swelling	___ Denies	___ Reports	Neck lumps	___ Denies	___ Reports
Blood in urine	___ Denies	___ Reports	Abdominal pain	___ Denies	___ Reports
Kidney stones	___ Denies	___ Reports	Indigestion	___ Denies	___ Reports
Difficulty in urination	___ Denies	___ Reports	Heart burn	___ Denies	___ Reports
Inability to control urine	___ Denies	___ Reports	Nausea/vomiting	___ Denies	___ Reports
			Vomiting of blood	___ Denies	___ Reports
Muscle pain	___ Denies	___ Reports	Freq. constipation	___ Denies	___ Reports
Shoulder pain	___ Denies	___ Reports	Freq. diarrhea	___ Denies	___ Reports
Back pain	___ Denies	___ Reports	Stomach Ulcer	___ Denies	___ Reports
Morning stiffness	___ Denies	___ Reports	Pain bowel movement	___ Denies	___ Reports
Arthritis	___ Denies	___ Reports	Chronic bloating	___ Denies	___ Reports
Swollen Joints	___ Denies	___ Reports	Blood in stool	___ Denies	___ Reports
			Hemorrhoids/piles	___ Denies	___ Reports
Excessive thirst	___ Denies	___ Reports	Jaundice	___ Denies	___ Reports
Heat / Cold intolerance	___ Denies	___ Reports			
Excessive urination	___ Denies	___ Reports	Seizures	___ Denies	___ Reports
Thyroid problem	___ Denies	___ Reports	Loss of strength	___ Denies	___ Reports
			Fainting spells	___ Denies	___ Reports
Anemia	___ Denies	___ Reports	Poor coordination	___ Denies	___ Reports
Easy bruising	___ Denies	___ Reports	Tremors	___ Denies	___ Reports
Blood Transfusions	___ Denies	___ Reports			
			Anxiety	___ Denies	___ Reports
Itching	___ Denies	___ Reports	Depression	___ Denies	___ Reports
Rashes	___ Denies	___ Reports	Mood Swings	___ Denies	___ Reports
Boils	___ Denies	___ Reports	Nervousness	___ Denies	___ Reports
Hives	___ Denies	___ Reports	Sleeping difficulty	___ Denies	___ Reports