Westenhaver CHIROPRACTIC

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How did you hear about us? ☐Family _____ ☐Friend_____ ☐Co-Worker_____ ☐Location ☐Yellow Pages ☐Drove By ☐Hospital ☐Insurance Plan ☐Dr._____

First:_____ M.I.____ Last:_____ Sex: M / F Date of Birth: ____/____/_____

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

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

Status: ☐Single ☐Married ☐Divorced ☐Widowed Social Security Number: _____ - _____ - _____

Spouse's name:_____ Email:_____

Emergency Contact Name(Someone Not Living with you)_____

Phone(_____)_____-_____ Relationship:_____

Current Health

What brings you into our office? _____ Use the letters BELOW to indicate the TYPE and LOCATION of your _____ sensations right now. Key: A=Ache B=Burning N=Numbness P=Pins&Needles S=Stabbing

When did this condition BEGIN? ____/____/_____

Has it ever occurred before? ☐Yes ☐No When?_____

Is the Current Condition: ☐Auto related ☐Job Related ☐Home Related ☐Slip or Fall ☐Lifting ☐Slept Wrong ☐Unknown cause ☐Other

Explain:_____

_____

Condition/Pain Started on what date: ____/____/_____

Have you seen any other doctors for THIS CONDITION? ☐Yes ☐No

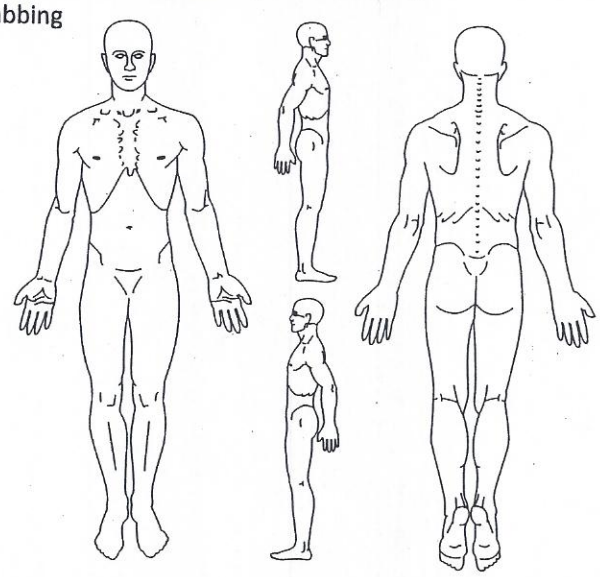
If YES, Who? _____

Have you had X-rays Taken? ☐ Yes ☐ No

Type of treatment_____ Were you satisfied with the results of your treatment? ☐Yes ☐NoExplain: _____

_____

Do you SUFFER with ANY OTHER condition than which you are now consulting us? _____



Do you wear any of the following? ☐ Heel Lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics ☐ Other_____

CMS requires providers to report both race and ethnicity

Race (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I decline to Answer

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino / I decline to Answer

Are you currently taking any medications? (please include regularly used or over the counter mdications)

Medication	For what condition?	How Long have you been taking this?

Do you have any medication allergies

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of chiropractic care)

Name: _____ Date: _____

Review of Systems-Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Please check CURRENT Conditions.

Constitutional: ☐I DENY having any of the symptoms listed below.
☐Tired ☐Fever ☐Chills ☐Weight Loss ☐Weight Gain ☐Other_____

Skin: ☐I DENY having any of the symptoms listed below.
☐ Rash ☐ Acneiform eruption ☐ Dermal and Subcutaneous growth ☐ Dermatitis
☐ Disturbances of Pigmentation ☐ Skin Lesions ☐Psoriasis ☐ Bacterium-related condition
☐ Vascular-related condition ☐ Other _____

Ears Nose Throat: ☐I DENY having any of the symptoms listed below.
☐ Nasal Congestion ☐ Post-Nasal drip ☐ Sore Throat ☐ Earache (L / R) ☐ Other_____

Cardiorespiratory: ☐I DENY having any of the symptoms listed below.
☐ Difficulty Swallowing ☐ Cough ☐ Shortness of breath ☐ Palpitations ☐ Chest pain/discomfort
☐ Other_____

Urinary: ☐I DENY having any of the symptoms listed below.
☐ Pain during urination ☐ Increased frequency of urination ☐ blood in urine ☐ Urinating >1x a night
☐ Other _____

Endocrine: ☐I DENY having any of the symptoms listed below.
☐ Easy bruising tendency ☐ Excessive sweating ☐ Sweating heavily at night ☐ Excessive thirst
☐ Temperature intolerance ☐ Other _____

Gastrointestinal: ☐I DENY having any of the symptoms listed below.
☐ Decreased Appitite ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Heartburn ☐ Blood in stool ☐ Other _____

Neuro/eyes: ☐I DENY having any of the symptoms listed below.
☐ Headache ☐ Dizziness ☐ Ringing in ears ☐ Numbness ☐ Decrease in strength ☐ Red Eyes
☐ Sleep Disturbance ☐ Depression ☐ Anxiety ☐ Other _____

Female Reproductive: ☐I DENY having any of the symptoms listed below.
☐ Unexplained vaginal bleeding ☐ Vaginal Discharge ☐ Vaginal Pain ☐ Vaginal Itching/Burning
☐ Other_____

Male Reproductive: ☐I DENY having any of the symptoms listed below.
☐ Penile Discharge ☐ Erectile Dysfunction ☐ Infertility ☐ Other _____

Psychiatric/Mental Health: ☐I DENY having any of the symptoms listed below.
☐ Anxiety ☐ Depression ☐ Trouble Sleeping ☐ Other_____

Chief Complaint – History of Present Illness (HPI)

Please Check which areas you are having problems with and rate the pain level on a scale of 0 (no pain) and 10 (extreme pain)

Location: ☐ Occiput- L / R ____ ☐ Neck- L / R ____ ☐ Traps- L / R ____ ☐ Upper back- L / R ____ ☐ Ribs- L / R ____
☐ Middle Back- L / R ____ ☐ Lower Back- L / R ____ ☐ Hips- L / R ____ ☐ SI joint- L / R ____ ☐ Shoulder- L / R ____
☐ Elbow- L / R ____ ☐ Wrist- L / R ____ ☐ Hand- L / R ____ ☐ Knee- L / R ____ ☐ Ankle- L / R ____ ☐ Foot- L / R ____

Condition: ☐ New ☐ Recurring ☐ Exacerbation ☐ Chronic ☐ Re-exam

Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Radiating
☐ Other_____

Timing: **Worse in the:** ☐ Morning ☐ Afternoon ☐ Night ☐ With Activity ☐ Constant ☐ Intermittent

Context: **Better with:** ☐ Warm Temp ☐ Cold Temp **Worse with:** ☐ Warm Temp ☐ Cold Temp ☐ Damp

Headaches: **Location:** ☐ Occipital ☐ Frontal ☐ Temporal ☐ Parietal ☐ Sinus
Quality: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Stabbing ☐ Aura ☐ No Aura
Types: ☐ Hat Band ☐ Cluster ☐ Migraine ☐ Tension ☐ Frequency_____

Modifying Factors:

Symptoms Better With: ☐ Activity ☐ Bending ☐ Cold ☐ Heat ☐ Massage ☐ Movement ☐ OTC Meds ☐ Rx Meds ☐ Rest ☐ Stretching
☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Nothing Helps ☐ Other_____

Name: ______________________________ Date: ______________

Employment:

Business name ______________________________ Phone number: ______________

Occupation: ______________________________ Work (hrs/wk): ______________

☐Full time ☐Part Time ☐Unemployed ☐Heavy labor ☐Moderate labor ☐Light Labor

Job Classification: ☐ Sed (<5lbs) ☐ Light (6-20lbs) ☐ Moderate(21-49lbs) ☐ Heavy(>50lbs)

Lifting Frequency: ☐ Constant (66-100%/day) ☐ Frequent (33-65%/day) ☐ Occasional (0-32%/day)

Lifting Postures: ☐ Torso ☐ Knee ☐ Arm ☐ High Near ☐ Off Posture

Work Activities:

☐ Working on Computer ☐ Talking on Phone ☐ Bending ☐ Climbing ☐ Kneeling ☐ Pushing
☐ Pulling ☐ Reaching ☐ Sitting ☐ Standing ☐ Twisting ☐ Walking ☐ Hand Tools ☐ Assembly

Conditions Effect on Job Performance:

☐**Mild** Painful(can do)☐**Mod** Painful(limits ability)☐**Mod/Sev** (limited duty)☐**Sev** (limited duty)☐**Sev** (Can't do limited duty)

Daily Activities: Effects on Current Condition on Performance

Bending	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Carrying Groceries	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Changing Pos Sit-Stand	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Climb Stairs	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Driving	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Ext Computer Use	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Household Chores	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Kneeling	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lifting	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Reading	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self-Care-Bathing	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self-Care-Dressing	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self-Care-Shaving	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sexual Activities	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sleep	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Long periods of Sitting	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Long periods of Standing	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Walking	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Yard Work	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

Recreational Activity: Effects of Current Condition on Performance

________	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
________	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
________	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
________	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
________	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
________	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

Past Health History

Please fill out carefully as these problems can affect your overall course of care with us.

Previous Chiropractic Care: I have not previously seen a Chiropractor OR fill in the information BELOW.

Doctor: ______________ Location: ______________ Date of Last Visit: ______________

Were you satisfied with your care? ☐Yes ☐No Why? ______________

Childhood Illness(es): LIST all health conditions ______________

Adult Illness(es): LIST all health conditions ______________

Surgery(ies) LIST all surgical procedures. Write the date of the procedure immediately afterward. ______________