PATIENT INFORMATION

Date: _____ Patient ID: _____

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City _____ State/Zip _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

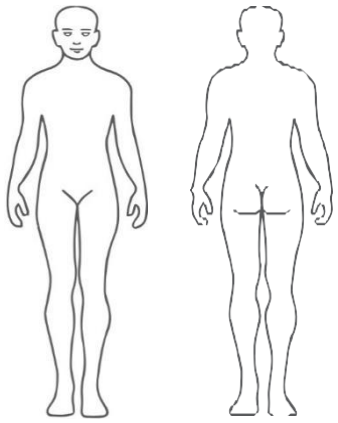
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp

☐ Tingling ☐ Shooting

☐ Stiffness ☐ Burning

☐ Dull ☐ Throbbing

☐ Aching ☐ Stabbing

☐ Cramping ☐ Swelling

☐ Nagging ☐ Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (Check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Household chores	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Self-care	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Lifting/Carrying	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Sit	☐	☐	☐	☐	Yard work	☐	☐	☐	☐
Stand	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10

NOT COMMITED — VERY COMMITED

Name: _____ DOB: _____ Date: _____ Pt. ID: _____

PATIENT WELLNESS ASSESSMENT

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONGTERM _____

CHILDREN & PREGNANCY

How many children do you have? _____ Are you currently pregnant? ☐ No ☐ Yes, I am due _____

Children(s) ages? _____ Number of past pregnancies? _____

Children*(s) health concerns? _____ Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside anv condition that vou have or have had. ☐ None

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Lymphatic Issues
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Stroke
- ☐ TMJ Issues
- ☐ Urinary Issues
- ☐ Osteoporosis
- ☐ Other _____
- ☐ NONE

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list) ☐ None	MEDICATIONS (list) ☐ None	SUPPLEMENTS (list) ☐ None

Name: _____ DOB: _____ Date: _____ Pt. ID: _____

HISTORY OF CONCERN(S)

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  - 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity?
  - 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
  - When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (Circle one)
    - How did the symptom begin? _____
  - What makes the symptom worse? (Circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
  - What makes the symptom better? (Circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Any other information? _____

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  - 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity?
  - 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
  - When did the symptom begin? _____
    - Did the symptom begin suddenly or gradually? (Circle one)
    - How did the symptom begin? _____
  - What makes the symptom worse? (Circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
  - What makes the symptom better? (Circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Any other information? _____

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ADDITIONAL INFORMATION

Auto Collision(s): ☐ None ☐ Yes, please describe: _____

_____

Work Injury: ☐ None ☐ Yes, please describe _____

_____

Sports Injury: ☐ None ☐ Yes, please describe _____

_____

Falls: ☐ None ☐ Yes, please describe _____

_____

Surgeries: ☐ Yes, please describe_____

_____

Other: _____

_____

_____

PATIENT AUTHORIZATION

I hereby authorize payment to be made directly to Beaverton Family Chiropractic, PC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Beaverton Family Chiropractic, PC for any and all services I receive at this office.

I acknowledge that I've had the opportunity to read the office HIPPA policy.

_____ _____ _____ - _____ - _____

Patient or Authorized Person's Signature | Patient Initials | Date Completed

FOR DOCTOR'S USE ONLY

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____