

Genesis Chiropractic And Rehabilitation Patient History Form

Is this visit due to an auto or workman's comp accident? NO YES

(If yes, please inform the front desk of this if you haven't already.)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Date of Birth: _____ Gender: Male Female Social Security #: _____ - _____ - _____

Race: American Indian Asian Black or African American Native Islander White Decline

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline Preferred Language: _____

Are you Pregnant? Yes No Number of Children: _____ Marital Status: _____

Primary Care Physician Name: _____ Clinic Name/Location: _____

Who may we thank for referring you to our office? _____

Have you had x-rays, MRI, or CT scans completed? (if yes) When/Where/Area of body: _____

Do you consume caffeine?	Never	< 3 Drinks/day	3-6 Drinks/day	>6 Drinks/day		
Do you consume alcohol?	Never	Casual Drinker	Moderate Drinker	Heavy Drinker		
Do you smoke?	Never	Current Smoke	Former Smoker			
Do you use drugs?	Never	Recreational	Addiction	Former Addict		
Do you exercise?	Never	Daily	Weekly	Walks	Runs	Swims

List ALL Allergies (Medications/Food/Environmental) : _____

List ALL Surgeries (DATES INCLUDED): _____

List ALL Medical History conditions: _____

List ALL Medications/Vitamins you are taking (DATE STARTED) _____

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Name: _____ Date: _____

Family Health History: Please write down any/all medical histories below that apply to the following family members.

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Son: _____

Daughter: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Please circle which daily living activities are bothered due to your current pain.

Please use the key below to help describe the symptoms that occur during these activities.

If the following is left blank it will be written in your notes that your pain is **not** affecting your Activities of Daily Living.

NT- NOT AFFECTED (Activity causes NO pain)	D- Difficult/Painful
AF- AFFECTED (Activity causes pain)	NA- Needs assistance
W- Pain is bothersome at work.	

Dressing _____ Grooming _____ Walking _____ Sleeping _____

Sitting _____ Standing _____ Driving _____ Lifting _____

Childcare _____ In/out of bed _____ Sitting to standing _____

Climbing Stairs _____ Other(_____) _____ Other(_____) _____

Housework (list activities) _____ Exercise (list activities) _____

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For the following, please only fill out/circle what applies.

NECK PAIN	<u>Rate Pain</u> 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)	How did pain start?
Date Started: _____	<u>Side</u> Left/Center/Right	Have you had similar pain before? (when)
Is the pain... →	Constant 100-75% of time	Frequently 75-50% of time
	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain... →	Sharp	Shooting
	Stabbing	Achy
	Dull	Throbbing
	Tingling	Numb
	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses
	Afternoon	Evening
	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses
	Afternoon	Evening
	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching
	Ice	Medication
	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing
	Twisting	Movement
	Walking	Other:

UPPER/MID BACK PAIN	<u>Rate Pain</u> 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)	How did pain start?
Date Started: _____	<u>Side</u> Left/Center/Right	Have you had similar pain before? (when)
Is the pain... →	Constant 100-75% of time	Frequently 75-50% of time
	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain... →	Sharp	Shooting
	Stabbing	Achy
	Dull	Throbbing
	Tingling	Numb
	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses
	Afternoon	Evening
	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses
	Afternoon	Evening
	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching
	Ice	Medication
	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing
	Twisting	Movement
	Walking	Other:

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Name: _____ Date: _____

LOW BACK PAIN	<u>Rate Pain</u> 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)	How did pain start?
Date Started: _____	<u>Side</u> Left/Center/Right	Have you had similar pain before? (when)
Is the pain... →	Constant 100-75% of time	Frequently 75-50% of time
	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain... →	Sharp	Shooting
	Stabbing	Achy
	Dull	Throbbing
	Tingling	Numb
	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses
	Afternoon	Evening
	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses
	Afternoon	Evening
	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching
	Ice	Medication
	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing
	Twisting	Movement
	Walking	Other:

OTHER:	<u>Rate Pain</u> 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe)	How did pain start?
Date Started: _____	<u>Side</u> Left/Center/Right	Have you had similar pain before? (when)
Is the pain... →	Constant 100-75% of time	Frequently 75-50% of time
	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain... →	Sharp	Shooting
	Stabbing	Achy
	Dull	Throbbing
	Tingling	Numb
	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses
	Afternoon	Evening
	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses
	Afternoon	Evening
	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching
	Ice	Medication
	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing
	Twisting	Movement
	Walking	Other:

PERSONAL INJURY QUESTIONNAIRE

Name: _____ Date of accident: _____ Time: _____ A.M./P.M.

Description of accident:

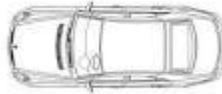
Driving Role: _____ Passenger in the back seat _____ Passenger in the front seat
_____ Driver of a motorcycle _____ Driver with both hands on the wheel
_____ Driver with left hand on the wheel _____ Driver with right hand on the wheel

Vehicle Status: _____ Accelerating _____ At a stop light _____ Attempting to stop
_____ Changing Lanes _____ Driving down the road _____ Driving in parking lot
_____ Moving _____ Moving at moderate speed _____ Moving in reverse
_____ Parked _____ Sliding out of control _____ Slowing down
_____ Speeding _____ Spinning out of control (weather related)
_____ Stopped _____ Turning

Please circle the impact area of the vehicle:

Front

Back



Lighting Conditions: _____ Dawn _____ Dusk _____ Full Daylight _____ Night

Road Conditions: _____ Damp _____ Dry _____ Ice Covered
_____ Nasty _____ Snow Covered _____ Wet

Visibility: _____ Excellent _____ Fair _____ Good _____ Poor

Opposing Vehicle Type: _____ Compact Car _____ Full Size Car _____ Large Pickup Truck
_____ Large SUV _____ Motorcycle _____ Other _____
_____ Semi _____ Small SUV _____ Small Truck

Opposing Vehicle Speed: _____ MPH

Your Vehicle Speed: _____ MPH

Headrest Position: _____ High _____ Low _____ Middle _____ Unknown

Admitted to the Hospital? Yes No
If yes when? At time of accident At a later time
Transportation to hospital? Ambulance Life Flight
 Police Car Private Transportation

Bracing Status: Was unable to brace for impact w/my hands/feet/knees
 Was aware that the accident was impending, but unable to brace
 Was not aware that the accident was impending

Problems: By being thrown from the vehicle By the seat belt
 Hit the other passenger Hit the back of the front seat
 Hit the console Hit the dashboard
 Hit the door Hit the roof of the car
 Hit the steering wheel Hit the window
 Hit the windshield

Injury Locations: Back of head Back of neck Chest
 Fingers on left hand Fingers on right hand Face
 Forehead Front of neck Left Arm
 Left elbow Left hand Left hip
 Left knee Left leg Left shin
 Left shoulder Left Wrist Low back
 Mid back Nose Right Arm
 Right elbow Right hand Right hip
 Right knee Right leg Right shin
 Right shoulder Right wrist Side of head
 Side of neck Upper back

Compromised By: Brightness Darkness Fog
 Rain Snow Traffic

Feelings After the accident: Angry Disoriented Dizzy
 Nauseous Scared Unconscious
 Upset Weak

Patient Signature: _____ **Date:** _____