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)**_____

_____

_____

Genesis Chiropractic And Rehabilitation Patient History Form

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)_____

Genesis Chiropractic And Rehabilitation Patient History Form

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

NECK PAIN **Date Started**:_____	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **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 **Date Started**:_____	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **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:

Genesis Chiropractic And Rehabilitation Patient History Form

Name:_____ Date:_____

LOW BACK PAIN **Date Started**:_____	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **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: _____ **Date Started**:_____	**Rate Pain** 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) **Side** Left/Center/Right	**How did pain start?** **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 QUESTIONAIRE

Name:_____Date of accident:_____Time:_____A.M./P.M.

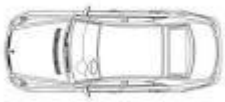
Description of accident:
_____
_____
_____
_____

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: _____