PATIENT INFORMATION

Please write clearly and answer every question

Today's Date _____

Name _____ Date of Birth _____Social Security No._____

Address_____ City _____ State _____Zip _____

Home Phone # _____ Cell Phone #_____

E-mail_____ Gender: □ Male □ Female

Marital Status: □ Married □ Single □ Divorced □ Widowed Number of children and their ages_____

Spouse's Name _____ Date of Birth_____

Your Employer _____ Spouse's Employer _____

Phone #_____ EXT. _____ Phone_____ EXT. _____

Occupation_____ Occupation _____

Address _____Address _____

City _____State ____ Zip _____ City _____ State _____ Zip _____

How did you hear about our office?_____

Who is your family physician?_____

Have you been treated by a chiropractor before? □ Yes □ No If yes, who and when?_____

Present Complaints/Symptoms:

Please list your present complaints/symptoms: _____

_____

When did your symptoms begin? _____

Have you seen other doctors for your present condition? □ Yes □ No

If yes, how did they treat it and how did you respond?_____

Is this a work related injury? □ Yes □ No Did you report it to your employer? □ Yes □ No

Is this an accidental injury? □ Yes □ No Auto Accident? □ Yes □ No

Have you seen an attorney? □ Yes □ No If yes, who _____ Phone Number _____

Please explain:_____

By signing below, I certify that all information is correct to the best of my knowledge.

Patient Signature_____ Date _____

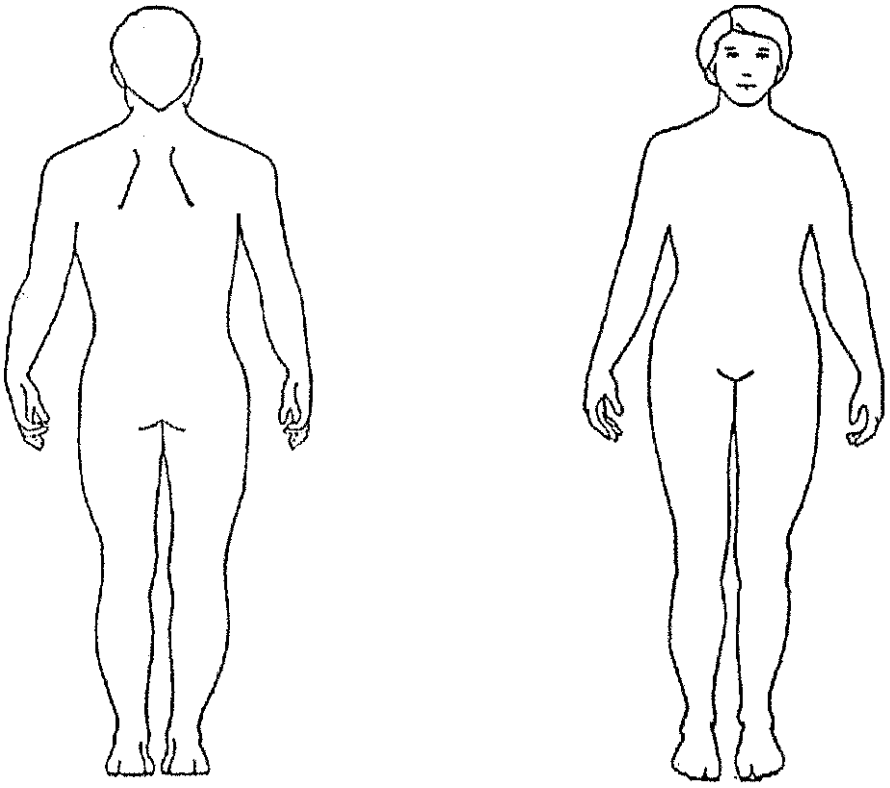
Guardian/Responsible Party's Signature _____ Date _____

AREAS OF PAIN

Name_____ Date_____

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and Stabbing = + + + +
Dull and Achy = v v v v
Pins and Needles = 0 0 0 0
Numbness = / / / /



Patient Signature _____

Please check the appropriate square to describe your present limitations in function:

Activity	Normal	Mildly Limited	Moderately Limited	Severely Limited
Lifting	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Running	☐	☐	☐	☐
Resting in Bed	☐	☐	☐	☐
Intercourse	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

Patient Name:_____ Account #_____ Date_____

Active Health Wellness Center

South Bend Neuropathy

SYMPTOM SURVEY

GENERAL SYMPTOMS:

A) Nervousness B) Irritability C) Fatigue D) Depression

E) Loss of sleep F) Tension G) PMS H) Jaw Pain

HEAD:

A) Headache Mild Moderate Severe

How often (1 2 3 4 5 6) Per day / Wk / Mo

Are They: Sharp | Dull

Are They: Constant | Intermittent

Where located: Back of Head Forehead

Temples R / L Side

Behind the Eyes

B)Light Headed C)Memory loss D) Fainting

E) Blurred vision D) Double Vision G) Sensitivity to light

H) Loss of Balance I) Hearing loss J) Ringing in ears

NECK:

A) Pain Left side Right side Both

Pain Level: Mild Moderate Severe

Pain is increased by: Forward movement

Backward movement

Rotate head right / left

Bend neck right / left

B) Stiffness C) Muscle Spasm D) Grinding / Grating sounds

SHOULDERS:

A) Pain at joint	Left	Right	Both
B) Pain across shoulder	Left	Right	Both
C) Limitation of Movement	Left	Right	Both
D) Tension	Left	Right	Both

ARMS:

A) Pain in Upper Arm	Left	Right	Both
B) Pain in Elbow	Left	Right	Both
C) Pain in Forearm	Left	Right	Both
D) Pins & Needles (arm)	Left	Right	Both
E) Pins & Needles (forearm)	Left	Right	Both
F) Numbness in Arm	Left	Right	Both
G) Numbness in Forearm	Left	Right	Both

HANDS:

A) Pain in wrist	Left	Right	Both
B) Pain in Hand	Left	Right	Both
C) Pin & Needles (Hand)	Left	Right	Both
D) Numbness (Hand)	Left	Right	Both

MIDBACK:

A) Pain Left Right Both

Pain level: Mild Moderate Severe

Pain Type: Sharp/Stabbing Dull Ache

B) Muscle Spasm Left Right Both

CHEST:

A) Deep Chest Pain Left Right Both

Pain level: Mild Moderate Severe

B) Pain around ribs Left Right Both

C) Shortness of Breath D) Irregular Heartbeat

ABDOMINAL SYMPTOMS:

A) Pain Mild Moderate Severe

B) Nervous Stomach C) Nausea D) Gas E) Constipation

F) Diarrhea G) Heartburn H) Indigestion I) Loss of Appetite

LOWBACK:

A) Upper Lumbar Pain	Left	Right	Both
B) Lower Lumbar Pain	Left	Right	Both
C) Sacro-iliac Pain	Left	Right	Both
D) Muscle Spasm	Left	Right	Both

Pain level: Mild Moderate Severe

HIPS AND LEGS:

A) Pain in Buttocks Left Right Both

Pain level: Mild Moderate Severe

B) Pain in Hip Joint Left Right Both

Pain level: Mild Moderate Severe

C) Pain down Leg Left Right Both

Location: Front Back Side

Pain Radiates to: Knee Calf Foot

D) Numbness down Leg Left Right Both

Location: Front Back Side

E) Pins & Needles (leg) Left Right Both

Location: Front Back Side

F) Knee Pain Left Right Both

G) Leg Cramps Left Right Both

FEET:

A) Ankle	Left	Right	Both
B) Swollen Ankle	Left	Right	Both
C) Foot Pain	Left	Right	Both
D) Numbness of Feet	Left	Right	Both
E) Swollen Feet	Left	Right	Both
F) Cramps	Left	Right	Both

Patient Name:_____ Account #_____ Date_____

Active Health Wellness Center

South Bend Neuropathy

SYMPTOM SURVEY Continued

EYES
- ☐ Double Vision
- ☐ Glasses
- ☐ Tearing
- ☐ Burning
- ☐ Eye Strain

EARS
- ☐ Deafness
- ☐ Discharge
- ☐ Ringing
- ☐ Excess Wax

SKIN
- ☐ Rashes
- ☐ Eruptions
- ☐ Discolorations

WEIGHT
- ☐ Gain
- ☐ Loss
- ☐ Hold the same

NOSE
- ☐ Sinusitis
- ☐ Bleeding
- ☐ Post Nasal Drip
- ☐ Obstruction

THROAT
- ☐ Soreness
- ☐ Hoarseness
- ☐ Difficulty Swallowing

HEAD
- ☐ Headaches
- ☐ Trauma
- ☐ Dizziness
- ☐ Fainting

CHEST
- ☐ Pain
- ☐ Heart Pounding
- ☐ Difficulty Breathing
- ☐ Cough up blood or sputum

MUSCULAR
- ☐ Numbness
- ☐ Joint Pain
- ☐ Varicosities
- ☐ Swelling of hands/feet

URINARY (URINATION)
- ☐ Abnormally Frequent
- ☐ Burning
- ☐ Pain
- ☐ Discolored with Pus/Blood

FEMALE (ONLY)
- ☐ Irregular Periods
- ☐ Regular Periods
- ☐ Duration of Periods
- ☐ Number of Pregnancies
- ☐ Complication during pregnancy
- ☐ Menopause

STOMACH/INTESTINES
- ☐ Poor Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Rectal Bleeding
- ☐ Irregular Stool
- ☐ Hernia
- ☐ Ulcers

HABITS
- ☐ Coffee
- ☐ Tea
- ☐ Milk
- ☐ Water
- ☐ Fruit Juices
- ☐ Exercise
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Recreational Drugs

FEMALE ONLY: Are you pregnant? _____ YES _____ NO _____ Patient Initial Here

Please list any medications or prescription drugs you are currently taking:

_____

_____

Please list any vitamins/supplements you are currently taking:

_____

_____

DIAGNOSTIC SURVEY

Have you ever been x-rayed before? _____ Facility/Location? _____
Area of Body? _____ When? _____ How many times? _____

Have you ever had an MRI or CT scan? _____ Facility/Location? _____
Area of Body? _____ When? _____ How many times? _____

Have you ever had any radiation treatments? _____ When/Where? _____
Have you ever had any chemotherapy treatments? _____ When/Where? _____

Patient Name:_____ Account #_____ Date_____

Please list any injuries such as auto accidents, concussions, fractures, etc.

_____

_____

_____

Please circle any of the following illness you have experienced

Measles	Pneumonia	Gonorrhea	Nervousness
Mumps	Pleurisy	Syphilis	Nervous Breakdown
Chicken pox	Tuberculosis	Gall Stones	"Leaking" heart
Small pox	Arthritis	Kidney Stones	Rheumatic fever
Diphtheria	Diabetes	Kidney disease	Hepatitis or Jaundice
Whooping Cough	Goiter	Cancer	Hives or Eczema
Polio	Migraine	Meningitis	Any bone or joint disease
Scarlet Fever	Anemia	Epilepsy	Low blood pressure
Hay fever	Fractures	Heart disease	High blood pressure
	Allergies	Asthma	Other

FAMILY HISTORY

Mark those which apply

	LIVING	DEAD	CANCER	TB	DIABETES	BLOOD DISEASE	ALLERGY	HEART	ARTHRITIS
FATHER									
MOTHER									
SISTERS									
BROTHERS									

Please list dates of any operations you have had:

_____	Cholecystectomy (Gall Bladder Operation)	_____	Tonsillectomy
_____	Hernalorraphy (Hernia Operation)	_____	Adenoidectomy
_____	Hemorrhoidectomy (Hemorrhoid Operation)	_____	Appendectomy
_____	Hysterectomy (Uterine Operation)	_____	Vaginal Repair
_____	Prostatectomy (Prostate Operation)	_____	Other Surgery

Patient Name:_____ Account #_____ Date_____