CHIROPRACTIC REGISTRATION AND HEALTH HISTORY FORM

PATIENT INFORMATION	INSURANCE INFORMATION
Patient Name:	Who is responsible for this account?
Date:	<u> </u>
Social security #:	SS# of insured
Address:	Birthdate of insured
	Relationship to patient
E-mail:	Insurance Co Policy #
Birthdate:	
() Married () Single () Divorced	Assignment and release:
() Widowed () Minor	I certify that I, and/or my dependents, have insurance
() Partnered for years	coverage with and assign directly CIMW all insurance benefits, if any, otherwise payable to
Employer/school	me for services rendered. I understand that I am
Employer address	financially responsible for all charges whether or not paid by insurance. I authorize the use for my signature on all
	insurance submissions.
Employer phone #	The above named doctor may use my health care
Spouse's name:	information and may disclose such information to the above named insurance company and their agents for the
Spouse's employer:	purpose of obtaining payment for services and
Whom may we thank for referring	determining insurance benefits or the benefits payable for related services. This consent will end when my current
you?	treatment plan is completed.
	X
	Date:
PHONE NUMBERS	ACCIDENT INFORMATION
Cell Home	Is this condition due to an accident?
Cell Home Best time to reach you	Is this condition due to an accident? () Yes () No
Cell Home Best time to reach you Emergency Contact:	Is this condition due to an accident?
Cell Home Best time to reach you Emergency Contact: Name:	Is this condition due to an accident? () Yes () No
Cell Home Best time to reach you Emergency Contact:	Is this condition due to an accident? () Yes () No
Cell Home Best time to reach you Emergency Contact: Name: Number:	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form
Cell Home Best time to reach you Emergency Contact: Name: Number:	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form
Cell Home Best time to reach you Emergency Contact: Name: Number: PATIENT C	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form
Cell Home Best time to reach you Emergency Contact: Name: Number: Reason for visit When did your symptoms appear?	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form
Cell Home Best time to reach you Emergency Contact: Name: Number: Reason for visit When did your symptoms appear? Is your condition getting worse over time?	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form
Cell Home Best time to reach you Emergency Contact: Name: Number: PATIENT C Reason for visit When did your symptoms appear? Is your condition getting worse over time? Have you seen other doctors for this complain	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION at a condition due to an accident? Description of the condition
Cell Home Best time to reach you Emergency Contact: Name: Number: Number: Reason for visit When did your symptoms appear? Is your condition getting worse over time? Have you seen other doctors for this complain Please rate the severity of your pain from 1-10	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION at? Name: 0 (10 is the worst pain)
Cell Home Best time to reach you Emergency Contact: Name: Number: Number: PATIENT C Reason for visit When did your symptoms appear? Is your condition getting worse over time? Have you seen other doctors for this complain Please rate the severity of your pain from 1-10 Is it constant or does it come and go?	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION at? Name: 0 (10 is the worst pain)
Cell Home Best time to reach you Emergency Contact: Name: Number: Number: PATIENT C Reason for visit When did your symptoms appear? Is your condition getting worse over time? Have you seen other doctors for this complain Please rate the severity of your pain from 1-10 Is it constant or does it come and go? How often do you have this pain?	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION at? Name: 0 (10 is the worst pain)
Cell Home Best time to reach you Emergency Contact: Name: Number: Number: Reason for visit When did your symptoms appear? Is your condition getting worse over time? Have you seen other doctors for this complain Please rate the severity of your pain from 1-10 is it constant or does it come and go? How often do you have this pain? Does it interfere with your: () work () sleep	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION The provided Head of the content of the cont
Cell Home Best time to reach you Emergency Contact: Name: Number: Number: PATIENT C Reason for visit When did your symptoms appear? Is your condition getting worse over time? Have you seen other doctors for this complain Please rate the severity of your pain from 1-10 Is it constant or does it come and go? How often do you have this pain?	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION The provided Head of the content of the cont
Cell Home	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION at? Name: 0 (10 is the worst pain) () daily routines () recreation itting () lying down () walking () bending
Cell Home	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION The provided Head of the content of the cont
Cell Home	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION Int? Name: O (10 is the worst pain) () daily routines () recreation itting () lying down () walking () bending HISTORY Spinal Exam
Cell Home	Is this condition due to an accident? () Yes () No If yes, please complete personal injury form CONDITION O(10 is the worst pain) () daily routines () recreation itting () lying down () walking () bending HISTORY Spinal Exam d/Urine test

Mark with an X to	indicate if you have/ha	ad any of the following. Please also mark any that
apply to immediat	e family, and indicate	the relationship to you.
AIDS/HIV ()		Hepatitis ()
Alcoholism ()		Hernia ()
Allergy Shots ()		Herniated Disc ()
Anemia ()		High Cholesterol ()
Anorexia ()		Kidney disease ()
Appendicitis ()		Liver disease ()
Arthritis ()		Migraines ()
Asthma ()		Miscarriage ()
Bleeding disorder	s()	Multiple Sclerosis ()
Breast Lump ()		Osteoporosis ()
Bronchitis ()		Pacemaker ()
Bulimia ()		Parkinsons ()
Cancer ()		Polio ()
Cataracts ()		Prostate problems ()
Chemical depend	ency ()	Prosthesis ()
Diabetes ()		Psychiatric Care ()
Emphysema ()		Stroke ()
Epilepsy ()		STD()
Fractures ()		Suicide attempts ()
Goiter ()		Thyroid problem ()
Gout ()		Tonsillitis ()
Heart Disease ()		TB ()
		Tumors ()
		Ulcers ()
		Other ()
Exercise:	Work Habits:	Other Habits:
() none	() sitting	() smoking quantity
() mild	() standing	() drinking quantity
() moderate	() light labor	() coffee/caffeine quantity
() heavy	() heavy labor	() stress reason
Pregnancy histo	ry: # of pregnancies_	# of live births
# of miscarriages	vaginal/C-section	on? are you pregnant now?
If you due date?	_	
		ajor injuries and any surgical procedures
performed:		

MEDICATIONS	ALLERGIES	SUPPLEMENTS
Please list medications, what they are for, and how long you have been taking them: 1- 2-		Please list supplements you are currently taking, where you purchased them, and the dose (if known): 1-
3-		2-
4-		3- 4-

Please tell us what your goals/expectations of your care are-	
) relief care- primary goal is to relieve your symptoms	
) corrective care- complete the correction begun in the relief care	
) stabilization- stabilize structures supporting the spine to prevent future episodes	
) wellness- promotion of optimal functioning of all bodily systems	
) other:	

QUADRUPLE VISUAL ANALOGUE SCALE

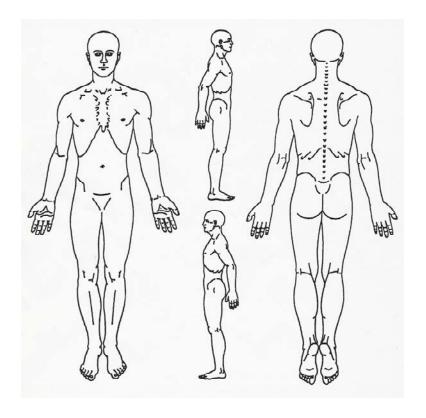
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

1.	What is	your	pain	RIGHT	NOW?	

no pain								<u>-</u>			10
	0	1	2	3	4	5	6	7	8	9	10
2. What is y	our TYP	ICAL or	AVERA	AGE pai	n?						
no pain											
no pam	0	1	2	3	4	5	6	7	8	9	10
3. What is y	our pain	level AT	TITS BE	ST (Hov	v close to	"0" doe	s your pa	ain get at	t its best)	?	
3. What is yo	our pain	level AT	TITS BE	EST (Hov	v close to	5 "0" doe	s your pa	ain get at	t its best)	9	10
no pain	0	1	2	3	4	5	6		8		10
no pain	0 t percent	1 tage of y	2 our awal	3 ke hours	4 is your p	5 pain at it	6 s best? _	7	8_%	9	10
no pain Wha	0 t percent	1 tage of y	2 our awal	3 ke hours	4 is your p	5 pain at it	6 s best? _	7	8_%	9	10

What percentage of your awake hours is your pain at its worst? ______%



A= Ache
B= Burning
D= Dullness
N= Numbness
P= Pins & Needles
R= Radiation
S- Stabbing

NAME _____ DATE_

BACK BOURNEMOUTH QUESTIONNAIRE

	E number	on EACH	scale that	best descr	ibes how	you feel.				
Over the past v	week, on a	verage, ho	w would y	ou rate yo	our back pa	ain?				
No pain	Worst pain possible									
0	1	2	3	4	5	6	7	8	9	10
Over the past v				pain inter	fered with	ı your daily	activities	s (housew	ork, washi	ng, dressing
No interference	e							Unab	le to carry	out activity
0	1	2	3	4	5	6	7	8	9	10
Over the past vactivities? No interference		much has	your back	pain inter	fered with	n your abili	ty to take			social, and
			3	4	5	6	7	8	9	10
Over the past v Not at all anxio	ous		ense, uptig	ght, irritab	le, difficu	lty in conce	entrating/r	relaxing) l Extre	nave you b	een feeling ous
Over the past $\sqrt{0}$ Over the past $\sqrt{0}$	veek, how ous 1 week, how	anxious (t	ense, uptig	ght, irritab	le, difficul	lty in conce	entrating/i	Extre 8 ic, unhapp	nave you b mely anxio 9 py) have yo	ous 10 ou been fee
Over the past vote of t	veek, how 1 week, how essed	anxious (t	ense, uptig 3 (down-in-	ght, irritab 4 -the-dump	5 ss, sad, in l	f lty in conce	7 pessimist	Extre 8 ic, unhapp Extre	nave you b mely anxio 9 py) have yo mely depro	ous 10 ou been feelessed
Over the past volume of the past	veek, how 1 veek, how essed	anxious (t	anse, uptig	ght, irritab 4 -the-dump	5 ss, sad, in l	6 low spirits,	7 pessimist	Extre 8 ic, unhapper Extre 8	py) have you be mely anxion growth anxion growth anxion growth anxion growth growth anxion growth growth anxion growth gr	ous 10 ou been feelessed 10
Over the past vote of t	veek, how veek, how essed 1 veek, how	anxious (t	anse, uptig	ght, irritab 4 -the-dump	5 ss, sad, in l	6 low spirits,	7 pessimist	Extre 8 ic, unhapp Extre 8 has affected	py) have you be mely anxious py) have you mely deprosed (or would be more than the property of	ous 10 ou been feelessed 10
Over the past volume of the past	veek, how veek, how essed 1 veek, how	anxious (t	anse, uptig 3 (down-in-	ght, irritab 4 -the-dump	5 s, sad, in l	6 low spirits,	7 pessimist 7 ne home) l	Extre 8 ic, unhapp Extre 8 has affected Have	py) have you be mely anxious py) have you mely deprosed (or would be more than the property of	ous 10 ou been feelessed 10 Id affect) youch worse
Over the past volume of the past	veek, how lous 1 week, how essed 1 week, how no worse 1	anxious (t	anse, uptig 3 (down-in- 3 felt your w	ght, irritab 4 -the-dump 4 -york (both	5 ss, sad, in l 5 inside and	6 doutside the	7 pessimist 7 ne home) l	Extre 8 ic, unhapp Extre 8 has affecte Have	py) have you be mely depressed (or wou made it m	ous 10 ou been feelessed 10 Id affect) y
Over the past v Not at all anxio Over the past v Not at all depr Over the past v Have made it v	veek, how lous 1 week, how essed 1 week, how no worse 1 week, how	anxious (t	anse, uptig 3 (down-in- 3 felt your w	ght, irritab 4 -the-dump 4 -york (both	5 ss, sad, in l 5 inside and	6 doutside the	7 pessimist 7 ne home) l	Extre 8 ic, unhapper Extre 8 has affected Have 8 pain on y	py) have you be mely depressed (or wou made it m	ous 10 ou been feeling to be been feeling and to be been feeling to be

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

k the ONE the past w ain 0	eek, on av	on EACH werage, how	scale that	best descr	ribes how y	you feel.				. Please answer AL							
the past w	1 eek, how	2			our neck pa	ain?		Wors									
0 the past wng, driving terference	eek, how		3					Wors									
the past wng, driving	eek, how		3		No pain Worst pain possible												
ng, driving terference		much hae		4	5	6	7	8	9	10							
		much has	your neck	pain inter	fered with	your daily	activities	s (housewo	ork, washii	ng, dressing, lifting,							
0								Unab	le to carry	out activity							
	1	2	3	4	5	6	7	8	9	10							
the past w ties?	eek, how	much has	your neck	pain inter	fered with	your abili	ty to take	part in rec	reational,	social, and family							
terference								Unab	le to carry	out activity							
0	1	2	3	4	5	6	7	8	9	10							
the past w		anxious (to	ense, uptig	ght, irritab	le, difficul	ty in conce	entrating/r		ave you be mely anxio	een feeling?							
0	1	2	3	4	5	6	7	8	9	10							
the past w	eek, how	depressed	(down-in	-the-dump	os, sad, in l	ow spirits,	, pessimist	ic, unhapp	oy) have yo	ou been feeling?							
t all depre	ssed							Extre	mely depre	essed							
0	1	2	3	4	5	6	7	8	9	10							
the past w	eek, how	have you	felt your v	vork (both	inside and	d outside th	ne home)	has affecte	ed (or woul	ld affect) your neck							
made it no	o worse							Have	made it m	uch worse							
0	1	2	3	4	5	6	7	8	9	10							
the past w	eek, how	much have	e you beer	able to co	ontrol (red	luce/help)	your neck	pain on y	our own?								
Over the past week, how much have you been able to control (reduce/help) your neck Completely control it								No control whatsoever									
•	1	2	3	4	5	6	7	8	9	10							
•																	
oletely con																	
			<u></u>						•								

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.