

First Name _____ M.I. _____ Last Name _____
 Address _____ City _____ State _____ Zip _____
 Age _____ Sex _____ Birth Date ____/____/____ Marital Status (S M D W) Spouse's Name _____
 Social Security # _____ Occupation _____ Employer _____
 Phone (H) _____ (W) _____ (C) _____ Email _____
(Needed For Appointment Confirmation!)
 Whom may we thank for referring you to our office? _____
 Emergency Contact Name _____ Phone _____

Insurance Company _____ Phone _____
 ID # _____ Group # _____
 Insured Name _____ Insured Date of Birth _____ Insured Social Sec # _____
 Relationship to You _____ PPO or HMO? _____ Secondary Insurance? Yes ___ No ___

Assignment & Release (Insurance Patients)

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ & I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO "OC Back & Body Doctors" ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, including electronic submissions.

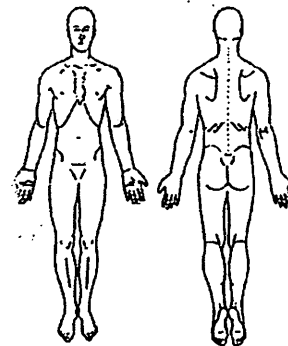
Patient Signature _____ Date _____

Patient Health Questionnaire

1. Reason for office visit? _____

 2. Is this condition due to an: ___ Auto Accident ___ Work Injury ___ Other Accident ___ Illness ___ Unknown Cause

<u>Description</u>		<u>Frequency</u>
___ Sharp Pain	___ Numb	___ Constant (76-100%)
___ Dull Pain	___ Shooting	___ Frequent (51-75%)
___ Ache	___ Gripping	___ Occasional (26-50%)
___ Weak	___ Burning	___ Intermittent (25% or Less)
___ Throbbing	___ Tingling	



Mark on the pictures where you have pain or other symptoms →

Indicate intensity of your symptoms at its **lowest and highest** level

No symptoms 0 1 2 3 4 5 6 7 8 9 10 Severe symptoms

2. Your symptoms are _____ Decreasing _____ Not Changing _____ Increasing
 3. Symptoms are worse in the ___ Morning ___ Afternoon ___ Night ___ Increases during the day ___ Same all day
 4. When did your symptoms appear? Date _____ Describe how your problem began: _____

 8. Have you had these symptoms before: ___ Yes ___ No If yes, when? _____

Patient Health Questionnaire (continued)

12. Have you seen other Doctor(s) for this condition? ___ Chiropractor ___ MD ___ Osteopath ___ P.T. ___ Other
13. Name of Doctor(s) _____ Phone () _____ Date of last treatment _____
14. What makes your problem **better**? ___ Nothing ___ Rest ___ Walking ___ Standing ___ Sitting ___ Exercise
___ Heat ___ Ice ___ Other _____
12. What makes your problem **worse**? ___ Nothing ___ Rest ___ Walking ___ Standing ___ Sitting ___ Exercise
___ Bending ___ Lifting ___ Coughing/Sneezing ___ Other _____
13. Are your complaints affecting your ability to move around? (walk, run, pick up things, swing your arms freely, move your head, wiggle your fingers) ___ Yes ___ No If yes, how? _____

12. When the problem is at its worst, explain exactly how it feels _____

16. How do your complaints affect you at:
Work (eg. Computer work, concentration levels, travel, sitting)

Home (eg. Cleaning, cooking, laundry, gardening)

Other Activities (eg. Driving, sports, playing with children, exercising)

17. Do you sleep well? Yes No
18. How many hours per night do you sleep? (Average) _____
19. Do you...
Have trouble falling asleep? Yes___ No___
Awaken in the middle of the night? Yes___ No___
Wake up feeling tired? Yes___ No___
20. Since you began suffering with this problem, what have you tried that **did not work**? (eg. Ice, Heat, Rest, Over the Counter Meds., Prescription Drugs, Stretching) _____

19. Are you interested in relieving your **symptoms only** or **correcting the cause** of your symptoms?
I want to correct the cause of my symptoms I want to receive symptom relief only
20. List all activities that this problem prevents you from doing either partially or totally, that you would like to be doing again? _____

Occupational Information

- Occupation _____ FT___ PT___ Has your work status changed due to this complaint? Yes___ No___
- Physical activities at work: ___ Sitting more than 50% of day ___ Light labor ___ Moderate labor
___ Heavy labor ___ Repeated motion
- Does your job involve lifting? ___ Pounds ___ Occasionally ___ Frequently ___ Constantly
- Additional job requirements: ___ Bending ___ Twisting ___ Stooping ___ Turning ___ Carrying ___ Walking ___ Other
- Is your job associated with potentially harmful chemicals (eg pesticides, radioactivity, solvents) _____

Health History

List all accidents and/or injuries in the past? (Even as a child) ___ Auto ___ Work ___ Other (Slip & Fall, Sports)

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (eg. Changes in job, work, residence or finances, legal problems): _____

What time of day do you feel the most energy (or the least symptoms)? _____

What time of day do you feel the worst (or your symptoms are aggravated)? _____

Do you experience any of these general symptoms regularly?

- | | | | | |
|-------------------------------------|--|-----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Nausea | <input type="checkbox"/> Itching/rash | <input type="checkbox"/> Heart Burn |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea |

Medical History

- Do you have a family physician? Yes No
Physician's Name and Telephone Number: _____
Date of Last: Physical Exam _____ Spinal X-rays _____ MRI, CT Scan, Bone Scan _____
- Have you ever been hospitalized and/or had surgery? Yes No
Date and reason for hospitalization/surgery _____

- List current health problems for which you are being treated: _____

- Current Medications (prescription or over the counter) _____
- Do you consider yourself underweight overweight just right Your weight today _____
- Have you had an unintentional weight loss or gain of 10 pounds or more in the last year? Yes No
- Do you have any allergies? ___ Yes ___ No List Allergies _____
- (Women) To your knowledge, are you pregnant? ___ Yes ___ No Due Date _____

Experience with Chiropractic

- Do you understand the term Subluxation? ___ Yes ___ No
Have you ever been adjusted by a Chiropractor before? ___ Yes ___ No
Reason for visit? _____
Doctor's Name: _____
Approximate Date of Last Visit: _____
Has any adult in your family seen a Chiropractor? ___ Yes ___ No
Has any child in your family seen a Chiropractor? ___ Yes ___ No
Where you aware that:
- Doctors of Chiropractic work with the nervous system? ___ Yes ___ No
 - The nervous system controls all bodily functions and systems? ___ Yes ___ No
 - Your symptoms account for only 10% of how your nervous system is really working? ___ Yes ___ No
 - Subluxations are often present without any symptoms or warning signs? ___ Yes ___ No

Patient's Signature _____ Date _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids / ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased Sex Drive
- Sexually transmitted disease
- Other _____
- Age of first period _____
- Date of last gynecological exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Surgical menopause
- Menopause
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Obesity
- Osteoporosis
- Pneumonia
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
Cigarettes: # / day _____
Cigars: # / day _____
- Alcohol:
Wine: # glasses / d or wk _____
Liquor: # ounces / d or wk _____
Beer: # glasses / d or wk _____
- Caffeine:
Coffee: # 6 oz cups / d _____
Tea: # 6 oz cups / d _____
Soda w/ caffeine: # cans / day _____
- Other sources _____
- Water: # glasses / d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch / carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
 dairy wheat eggs
 soy corn all gluten
- Other _____

Food Frequency

- Servings per day:
Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow / orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip breakfast
- Two meals / day
- One meal / day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

Current Supplements

- Multivitamin / mineral
- Vitamin C
- Vitamin E
- EPA / DHA
- Evening Primrose / GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please include details.

- | | | |
|--|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do our legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Have you tried any medications such as anti-inflammatory?
If yes, what kind of medication? | NO | YES |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before?
If yes: When? For how long? What kind? | NO | YES |
| 13. Have you had an MRI?
If yes: When? Who ordered it? What was it ordered for? | NO | YES |
| 14. Have you used any splint or braces or other prescribed treatment by an MD?
If yes: When? What kind? Who ordered it? | NO | YES |
| 15. If you have tried any treatment or medications, did this make your problem better?
Comment: _____ | NO | YES |

For any yes answer, rule in/out the diagnosis with these two tests:

- A) NCV/EMG tests Upper Lower Indicated Not Indicated (circle one)
- B) Vascular Test Indicated Not Indicated (circle one)