OC Back & Body Doctors

Advanced Physical Medicine
A Natural Approach to Getting Back Your Health!

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

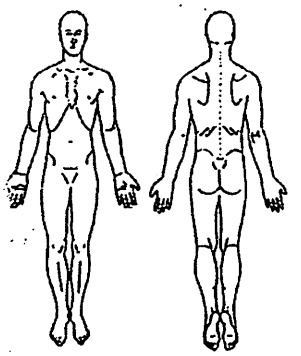
Description

____ Sharp Pain ____Numb
____ Dull Pain ____Shooting
____ Ache ____Gripping
____ Weak ____Burning
____ Throbbing ____Tingling

Frequency

____ Constant (76-100%)
____ Frequent (51-75%)
____ Occasional (26-50%)
____ Intermittent (25% or Less)

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?_____

Continued on next page

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) _____

Continued on next page

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?

☐ Fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic Attacks	☐ Nausea	☐ Itching/rash	☐ Heart Burn
☐ Bloating	☐ Headaches	☐ Vomiting	☐ Dizziness	☐ Diarrhea

Medical History

1. 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_____
2. Have you ever been hospitalized and/or had surgery? ☐ Yes ☐ No
   Date and reason for hospitalization/surgery_____
   _____
   _____
3. List current health problems for which you are being treated:_____
   _____
4. Current Medications (prescription or over the counter)_____
5. Do you consider yourself ☐ underweight ☐ overweight ☐ just right Your weight today _____
6. Have you had an unintentional weight loss or gain of 10 pounds or more in the last year? ☐ Yes ☐ No
7. Do you have any allergies? ___Yes ___No List Allergies_____
8. **(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:

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

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)