Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to call and ask for help. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Laser Therapy and Chiropractic care.

About this Patient

First Name _____

Last Name _____

Cell Phone _____

Birthday _____

Marital Status

◯ Married ◯ Single ◯ Widow
◯ Divorce ◯ Other

Gender

◯ Female ◯ Male

Email _____

Street Address _____

City _____

State/Province _____

Zip Code _____

Reason for this Visit

Is the purpose of this appointment related to:

◯ Job ◯ Sports ◯ Auto
◯ Fall ◯ Chronic Discomfort ◯ Home Injury
◯ Other

If job related, have you made a report of your accident to your employer?

◯ Yes ◯ No

What type of complaint?

☐ an acute ☐ a chronic ☐ a recurring ☐ a sub-acute

Where is chief complaint? _____

What was date of onset of this condition? _____

GIVE DETAILS: Mechanism of injury or condition

◯ OTHER
◯ after a long drive
◯ after a slip
◯ after performing household chores
◯ after a prolonged or chronic illness
◯ without a known origin
◯ after a long flight
◯ after lifting an object
◯ after performing yardwork
◯ after a fall
◯ after a poor night's sleep
◯ after over-arching or reaching
◯ after sitting in one place too long

Frequency of pain?

- ◯ OTHER
- ◯ Constant (100% of the time)
- ◯ Frequent (< 75% but > 50% of the time)
- ◯ Occasional (< 50% but > 25% of the time)
- ◯ Intermittent (less than 25% of the time)
- ◯ On and off
- ◯ Random
- ◯ Recurring

What is quality of discomfort?

- ☐ OTHER
- ☐ discomfort
- ☐ aching
- ☐ annoying
- ☐ burning
- ☐ deep
- ☐ diffuse
- ☐ dull
- ☐ heavy
- ☐ intolerable
- ☐ pulling
- ☐ sharp
- ☐ shock like
- ☐ stabbing
- ☐ stiffness
- ☐ throbbing
- ☐ tightness
- ☐ tingling

If the discomfort radiates, where does travel to? Otherwise, choose NON-RADIATING.

- ☐ non-radiating
- ☐ radiating to front of left chest
- ☐ radiating to front of right chest
- ☐ radiating to front of left abdomen/groin
- ☐ radiating to front of right abdomen/groin
- ☐ radiating to front of left thigh
- ☐ radiating to front of left lower leg
- ☐ radiating to top of left foot
- ☐ radiating to front of left shoulder
- ☐ radiating to front of left upper arm
- ☐ radiating to front of left lower arm
- ☐ radiating to front of left hand
- ☐ radiating to front of left face
- ☐ radiating to front of right thigh
- ☐ radiating to front of right lower leg
- ☐ radiating to top of right foot
- ☐ radiating to front of right shoulder
- ☐ radiating to front of right upper arm
- ☐ radiating to front of right lower arm
- ☐ radiating to front of right hand
- ☐ radiating to front of right face
- ☐ radiating to back of left thigh
- ☐ radiating to back of left lower leg
- ☐ radiating to bottom of left foot
- ☐ radiating to back of left shoulder
- ☐ radiating to back of left upper arm
- ☐ radiating to back of left lower arm
- ☐ radiating to back of left hand
- ☐ radiating to back of left side of head
- ☐ radiating to back of right thigh
- ☐ radiating to back of right lower leg
- ☐ radiating to bottom of right foot
- ☐ radiating to back of right shoulder
- ☐ radiating to back of right upper arm
- ☐ radiating to back of right lower arm
- ☐ radiating to back of right hand
- ☐ radiating to back of right side of head

Is complaint getting better, worse or staying the same?

- ◯ improved
- ◯ stayed the same
- ◯ worsened
- ◯ relief which lasted for awhile

How much pain do you have?

- ◯ 1/10
- ◯ 2/10
- ◯ 3/10
- ◯ 4/10
- ◯ 5/10
- ◯ 6/10
- ◯ 7/10
- ◯ 8/10
- ◯ 9/10
- ◯ 10/10

Symptom relieved by?

- ☐ OTHER
- ☐ chiropractic adjustment
- ☐ cold packs
- ☐ exercise
- ☐ heat packs
- ☐ massage
- ☐ nothing
- ☐ over the counter medication
- ☐ physical therapy
- ☐ prescription medication
- ☐ re-direct attention
- ☐ rest
- ☐ stretching
- ☐ work

What aggravates the symptoms?

- [ ] OTHER
- [ ] -
- [ ] caring for family
- [ ] computer use
- [ ] daily child or pet care
- [ ] getting in or out of car
- [ ] grocery shopping
- [ ] lying down
- [ ] reading
- [ ] sitting
- [ ] stretching
- [ ] walking
- [ ] none
- [ ] almost any movement
- [ ] carrying
- [ ] concentrating
- [ ] driving
- [ ] getting out of bed
- [ ] household chores
- [ ] pulling
- [ ] repetitive motions
- [ ] squatting
- [ ] talking on the telephone
- [ ] working
- [ ] none reported
- [ ] bathing
- [ ] changing positions
- [ ] cooking
- [ ] eating
- [ ] getting up from lying down
- [ ] lifting
- [ ] pushing
- [ ] resting
- [ ] standing
- [ ] turning
- [ ] yard work
- [ ] unknown action
- [ ] bending
- [ ] climbing stairs
- [ ] coughing and sneezing
- [ ] falling or staying asleep
- [ ] getting up from sitting
- [ ] looking over shoulder
- [ ] reaching
- [ ] running
- [ ] stress
- [ ] twisting

Any past episodes of this complaint?

- ◯ OTHER
- ◯ confirms
- ◯ denies

Has patient received any past care for this complaint?

- [ ] OTHER
- [ ] Chiropractic care
- [ ] medical care
- [ ] occupational therapy
- [ ] prescribed medications
- [ ] nothing
- [ ] Craniosacral therapy
- [ ] Naturopathic therapy
- [ ] Osteopathic medicine
- [ ] physical therapy
- [ ] Acupuncture
- [ ] injection therapy
- [ ] nutritional supplements
- [ ] over-the-counter medications
- [ ] surgery

Have any recent diagnostic images or tests been performed?

- ◯ OTHER
- ◯ Yes
- ◯ No

Activity of daily living most affected

- [ ] OTHER
- [ ] homemaking
- [ ] sitting
- [ ] standing
- [ ] None
- [ ] lifting
- [ ] sleeping
- [ ] traveling and/or driving
- [ ] employment
- [ ] personal care (washing, dressing, etc.)
- [ ] social life
- [ ] walking

What does patient have difficulty performing due to this specific complaint? (Choose all the apply)

- [ ] OTHER
- [ ] concentrating
- [ ] getting in/out of car
- [ ] lifting objects
- [ ] rising out of chair or bed
- [ ] staying asleep
- [ ] bending over
- [ ] dressing self
- [ ] getting to sleep
- [ ] looking over shoulder
- [ ] showering or bathing
- [ ] using a computer
- [ ] caring for family
- [ ] driving car
- [ ] grocery shopping
- [ ] lying down
- [ ] sitting
- [ ] walking
- [ ] climbing stairs
- [ ] exercising
- [ ] performing household chores
- [ ] reaching overhead
- [ ] standing
- [ ] participating in yard work

What were the patient's specific therapeutic goals?

- [ ] to have no functional limitations
- [ ] to be able to lift w/o pain
- [ ] to relieve pain
- [ ] to return to work without limitation
- [ ] ability to transfer from device to bed w/o pain
- [ ] to sleep throughout the night w/o pain
- [ ] to improve strength
- [ ] to walk on all terrain without limitation
- [ ] to walk without need of assistive device
- [ ] ability to transfer sitting to standing w/o pain
- [ ] to decrease swelling
- [ ] to improve overall flexibility
- [ ] to able to hunt without limitation
- [ ] ability to transfer supine to sitting w/o pain
- [ ] ability to transfer sitting to supine w/o pain
- [ ] to improve all ranges of motion w/o pain
- [ ] to decrease stiffness
- [ ] to return to sport activity without limitation
- [ ] ability to transfer from bed to device w/o pain
- [ ] ability to transfer standing to sitting w/o pain

Are you?

◯ Male ◯ Female

FOR WOMEN ONLY:

Are you pregnant?

◯ OTHER ◯ Yes ◯ No

Are you nursing?

◯ OTHER ◯ Yes ◯ No

Are you taking birth control?

◯ OTHER ◯ Yes ◯ No

Do you experience painful periods?

◯ OTHER ◯ Yes ◯ No

Do you have irregular cycles?

◯ OTHER ◯ Yes ◯ No

Do you have breast implants?

◯ OTHER ◯ Yes ◯ No

Do you perform a regular self breast examination?

◯ OTHER ◯ Yes ◯ No

Do you take HRT?

◯ OTHER ◯ Yes ◯ No

Do you take oral contraceptives?

◯ OTHER ◯ Yes ◯ No

Date of Last PAP/pelvic Exam?

◯ OTHER ◯ Approximate Year:
◯ Have never had a PAP or pelvic exam. ◯ None reported

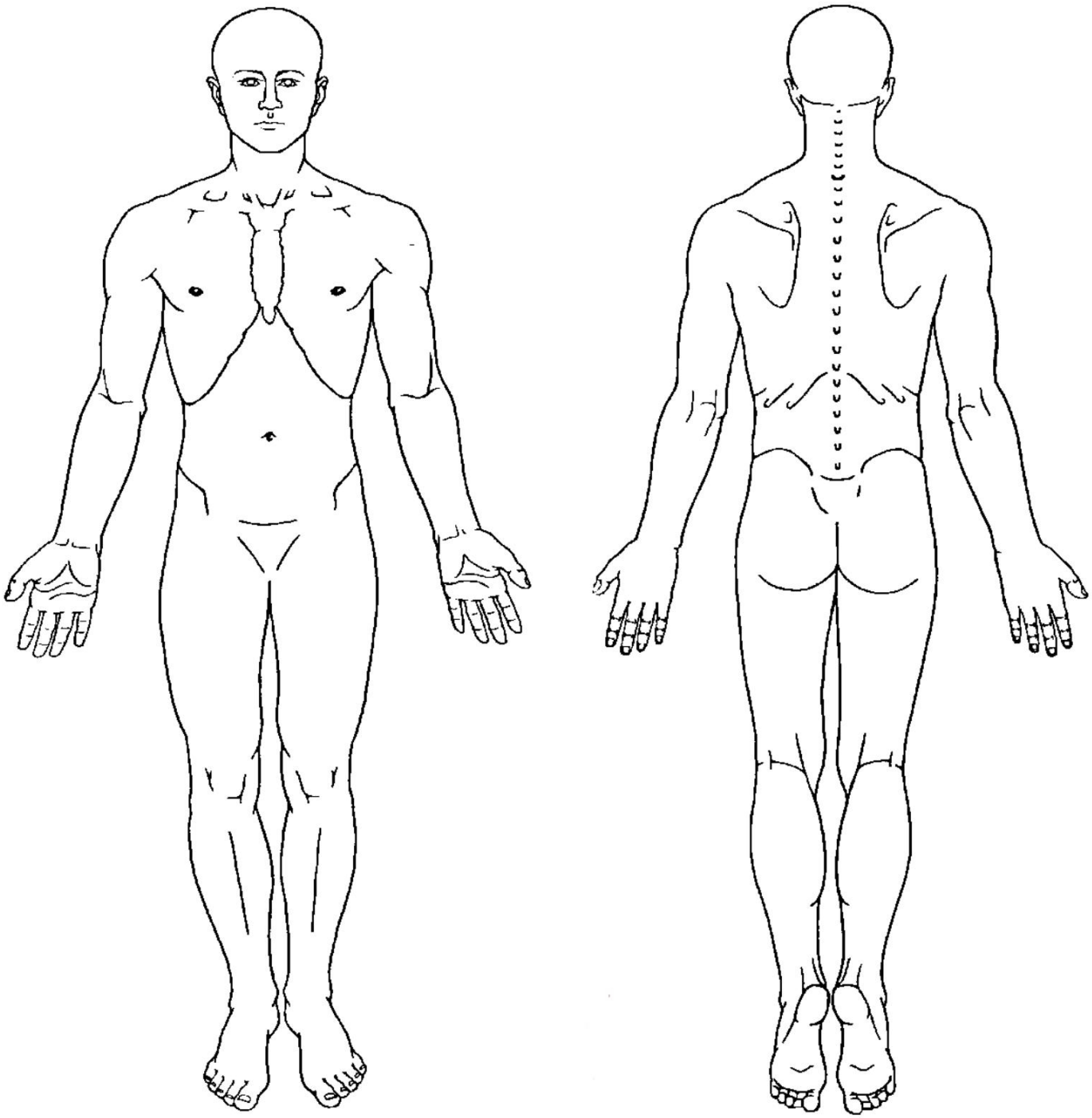
Date of Last Mammogram?

◯ OTHER ◯ Appoximate year:
◯ Have never had a mammogram. ◯ None reported

Date of LMP?

◯ Approximately: ◯ Has not begun menstruation.
◯ No longer menstruates due to menopause. ◯ No longer menstruates due to surgery or HRT.
◯ OTHER ◯ None reported

Mark your Pain Point



Who should receive bills for payment on your account?

- ☐ Patient
- ☐ Spouse
- ☐ Parent
- ☐ Workers Comp
- ☐ Medicare
- ☐ Personal Health Insurance
- ☐ Auto Insurance

Emergency Contact

First Name _____

Last Name _____

Relationship

Work Phone **Home Phone**

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself . I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Insurance Company

Policy # **Group #**

Address

Phone Number

ABOUT THE INSURED PERSON

First Name **Last Name**

Date of Birth **Relation**

Missed Appointments

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of treatments and at-home instructions is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. Reminder texts are provided to help you save the date. If you need to re-schedule an appointment, please call our office and arrange for a make-up appointment. We would prefer the make up appointment to be within the same week.

Thank you for your understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Signature

Date Signed

_____

Printed Name

_____

Email

_____