Patient Name:____ Date_____________________

Address ____

Cell Phone __________________ Work Phone___________________ Home Phone ______________________

Email ____________________________________

Employer ______________________________________ Address_____________________________________

Spouse's Employer ______________________________________ Address______________________________

PLEASE PROVIDE THE FOLLOWING INFORMATION

My present symptoms are:____

Recent falls:____

Recent surgery:____

Recent accidents:____

Last physical:________________________________ Last adjustment:_________________________________

Since I last saw you, I have been seen by Dr(s):____

For:____

Patient's comments:____

Payment is expected at time of visit

Person responsible for payment_________________________________ Address________________________

Relationship_________________________________ Phone__________________________

Are you insured? Yes No Company:____

Sign____ SS#________________

3904 Meadowdale Blvd
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Dominion Chiropractic Clinic

In the past 5 years:

Major Illnesses______________________________

Surgeries/Date of procedure(s) ______________________________

Hospitalization/Date______________________________

Allergies______________________________

Current medications (dosage and frequency)

____

____

____

Previous injury, trauma, or auto accidents

____

____

Any broken bones______________________________

FAMILY HISTORY	Major Illnesses	Date of Death	Cause
MOTHER	____________	____________	____________
FATHER	____________	____________	____________
SIBLINGS	____________	____________	____________
	____________	____________	____________

Smoking Status ☐ Non-smoker ☐Current smoker ☐Former smoker

Alcohol Use ☐None ☐Casual ☐Moderate ☐Heavy ☐Drinks beer ☐Drinks wine

Recreational Drug Use ☐None ☐Recreational ☐Addiction

Caffeine Intake ☐ None ☐<3 drinks/day ☐3-6 drinks/day ☐>6 drinks/day

Exercise ☐Never ☐Daily ☐Weekly ☐Walks ☐Runs ☐Swims

Race______________ Ethnicity______________ Language______________

Signature______________________________ Date______________

Dominion Chiropractic Clinic
Patient Name ____ Date_________________________

New Patient History Form
Please list your primary complaint for symptom 1. If you have a secondary complaint to address, use symptom 2.

Symptom 1 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________________
  - Did the symptom begin ☐suddenly or ☐gradually?
  - How did the symptom begin? ____
- What makes the symptom worse?☐Bending neck forward ☐bending neck backward ☐tilting head to left ☐tilting head to right ☐turning head to left ☐turning head to right ☐bending forward at waist ☐bending backward at waist ☐tilting left at waist ☐tilting right at waist ☐twisting left at waist ☐twisting right at waist ☐sitting ☐standing ☐getting up from seated position ☐lifting ☐any movement ☐driving ☐walking ☐running ☐nothing ☐other ____
- What makes the symptom better? ☐rest ☐ice ☐heat ☐stretching ☐exercise ☐massage ☐pain medication ☐muscle relaxers ☐nothing ☐ other ____________________________________
- Describe the quality of the symptom: ☐sharp ☐dull ☐achy ☐burning ☐throbbing ☐piercing ☐stabbing ☐deep ☐nagging ☐shooting ☐ stinging ☐other _____________________
- Does the symptom radiate to another part of your body? ☐No ☐Yes If yes, where ___________________________
- Is the symptom worse at certain times of the day or night? ☐morning ☐afternoon ☐evening ☐night ☐unaffected by time of day

Symptom 2 ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time that you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin ☐suddenly or ☐gradually?
  - How did the symptom begin? ____
- What makes the symptom worse?☐Bending neck forward ☐bending neck backward ☐tilting head to left ☐tilting head to right ☐turning head to left ☐turning head to right ☐bending forward at waist ☐bending backward at waist ☐tilting left at waist ☐tilting right at waist ☐twisting left at waist ☐twisting right at waist ☐sitting ☐standing ☐getting up from seated position ☐lifting ☐any movement ☐driving ☐walking ☐running ☐nothing ☐other _____________________________________
- What makes the symptom better? ☐rest ☐ice ☐heat ☐stretching ☐exercise ☐massage ☐pain medication ☐muscle relaxers ☐nothing ☐ other _________________________________
- Describe the quality of the symptom: ☐sharp ☐dull ☐achy ☐burning ☐throbbing ☐piercing ☐stabbing ☐deep ☐nagging ☐shooting ☐ stinging ☐other _______________________
- Does the symptom radiate to another part of your body? ☐No ☐Yes If yes, where _________________________
- Is the symptom worse at certain times of the day or night? ☐morning ☐afternoon ☐evening ☐night ☐unaffected by time of day

Dominion Chiropractic Clinic

Name ____ Date_________________

Functional Rating Index

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

Item	0	1	2	3	4
1. **Pain Intensity**	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
2. **Sleeping**	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
3. **Personal Care** (washing, dressing, etc)	No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
4. **Travel** (driving, etc)	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
5. **Work**	Can do usual work plus unlimited extra work	Can do usual work with no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
6. **Recreation**	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
7. **Frequency of pain**	No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day
8. **Lifting**	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9. **Walking**	No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking
10. **Standing**	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Patient's signature____ Date__________________________

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