PATIENT REGISTRATION

Please complete this form as fully as possible to assist us in your evaluation and treatment. Please read each question carefully and answer to the best of your ability. This information is part of your medical record and is governed by our Privacy Practices Policy.

PERSONAL INFORMATION

Last Name: _____First Name: _____ Middle Initial: _____

Sex: ___Male ___Female Date of Birth: _____Social Security #: _____

Height: _____Weight: _____ Race: _____

Circle Marital Status: Married Single Divorced Widowed Separated Domestic Partner

Address: _____City: _____State: ___ Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

May we leave messages on your answering machine? Yes / No

May we send text reminders to your cell phone? Yes / No

Email Address: _____

What is your preferred method of communication? _____

Personal Representative: _____ Phone: _____

Address: _____City: _____State: ___ Zip: _____

Emergency Contact Name: _____Relationship: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Address: _____City: _____State: ___ Zip: _____

Do you have an **Advance Medical Directive**? Yes / No If so, please bring a copy to the office.

Employer: _____Phone: _____Occupation: _____

Address: _____City: _____State: ___ Zip: _____

Primary Care Physician: _____ Phone: _____

Address: _____City: _____State: ___ Zip: _____

Referring Physician: _____ Phone: _____

Address: _____City: _____State: ___ Zip: _____

Have you seen any other healthcare provider in the past 60 days? Yes / No

If yes, who? _____

The following individual is authorized to pick up prescriptions on my behalf:

Contact Name: _____Relationship: _____

PATIENT QUESTIONNAIRE

PAIN HISTORY

Reason for Your Visit. Briefly describe your pain: _____

_____

Duration. When did your current pain problem begin (date)? _____

Onset. Under what circumstances did your pain first begin?

___Accident at work, date: _____ ___Following surgery

___Accident at home ___Following an illness

___Auto accident ___Unknown

___Sports injury ___Other: _____

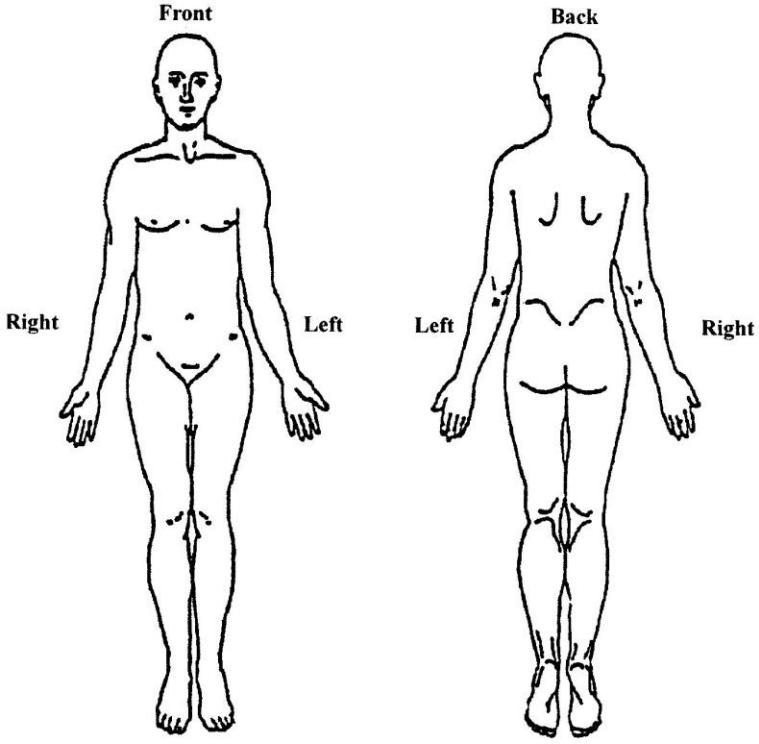
Briefly describe the circumstance(s) you checked: _____

Describe the speed of onset of your pain: ___Sudden/abrupt ___Gradual

Severity. On a scale of 1 to 10, grade your pain. At its worst: _____ At its best: _____ At this moment: _____

0 = no hurt | 1-2 hurts a little bit | 3-4 hurts a little more | 5-6 hurts even more | 7-8 hurts a whole lot | 9-10 hurts

Location. Mark on the drawings the areas where you feel pain:



Frequency.

How often do you have this pain?
___Occasionally
___Constantly
___Daily
___Weekly
___Monthly

What time of day is your pain worst?
___Morning
___Afternoon
___Evening
___Night

What time of day is your pain the least?
___Morning
___Afternoon
___Evening
___Night

PAIN HISTORY - CONTINUED

The questions below refer only to your current pain problem.

Character. Circle the words that best describe what your pain feels like:

Aching Gnawing Throbbing Stabbing Sharp Dull Burning
Other: _____

Cause. Circle the words that best describe the context/cause of your pain:

Unknown Sitting Standing Walking Bending Twisting Lifting
A-traumatic Fall Overuse Work injury Home injury Auto injury Assault
Other: _____

Alleviating Factors. Circle the words that best describe what makes your pain better:

Nothing Sitting Standing Walking Stretching Exercise Position change
Lying down Heat Ice Brace Wheelchair TENS unit Chiropractic care
OTC medications/narcotics Other:_____

Aggravating Factors. Circle the words that best describe what makes your pain worse:

Unknown Sitting/driving Standing Walking Bending Twisting Lifting
Carrying Pushing Pulling Exercise Weight bearing Lying down Getting out of bed
Upstairs Downstairs Sit-to-stand Computer use Changing clothes Previous surgery
Cough/sneeze Cold weather Damp weather Other: _____

Associated Signs and Symptoms. Circle the words that best describe your associated signs and symptoms:

Weakness Numbness Tingling Swelling Redness Warmth Radiation into limbs
Catching Locking Buckling Grinding Instability Popping/clicking
Fever Chills Rash Weight loss Bladder/bowel dysfunction
Other: _____

Diagnostic Testing. Circle the tests performed for this problem, if any, and state the approximate dates:

X-ray film CT scan MRI Myelogram Bone scan EMG Blood tests
Date: _____ Date: _____ Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Previous Treatment.

NSAIDs: How long? _____ Outcome? _____
Physical therapy: How long? _____ Outcome? _____
Home exercise: How long? _____ Outcome? _____
Chiropractic care L-spine: How long? _____ Outcome? _____

Effects on Activities of Daily Living. Circle the areas of your life that have been adversely affected by your pain:

Sleep Appetite Relationships Work Finances Physical activity
Use of alcohol Use of recreational drugs Other:_____

PAST SURGICAL HISTORY

Please list all prior surgeries and hospitalizations:

Date (month/year):	Procedure/illness:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY

Please circle any of the following medical conditions you have had or presently have:

COPD	Arthritis	Hernia
Diabetes	Asthma	High cholesterol
GERD (reflux, frequent heartburn)	Cancer	High blood pressure
Hepatitis	Depression	Kidney disease
Addiction/substance abuse	Migraines	Mental illness
Anxiety	Heart disease	Renal disease
	Memory loss	Thyroid disease

Other: _____

FAMILY MEDICAL HISTORY

Please circle any of the following medical conditions any of your BLOOD relatives have had or presently have, and indicate the relationship and whether the relationship is PATERNAL or MATERNAL:

DIAGNOSIS	RELATIONSHIP TO YOU	PATERNAL OR MATERNAL
COPD		
Diabetes		
Addiction/substance abuse		
Arthritis		
Asthma		
Bleeding disorder		
Cancer		
Chronic pain		
Depression/mental illness		
Heart disease		
High blood pressure		
Kidney disease		
Stroke		
Thyroid disease		
Other		

MEDICATIONS

Pharmacy Name and Location: _____ **Phone:** _____

Are you currently taking any **PRESCRIPTION MEDICATIONS**? Yes / No
If yes, list all prescription medications, over-the-counter medications, vitamins, and herbal supplements:

MEDICATION	DOSAGE	TIMES PER DAY	HAVE YOU HAD THIS PRESCRIPTION FILLED IN THE PAST 60 DAYS?
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Please list any other **PAIN MEDICATIONS** you have used in the **PAST**, including over-the-counter medications:

MEDICATION	DOSAGE	TIMES PER DAY	EFFECTIVENESS

Are you currently taking **BLOOD THINNERS** (i.e., PLAVIX, Coumadin, Warfarin, Heparin, or Aspirin)? Yes / No
If yes, please list:_____

ALLERGIES

Please list all **MEDICATIONS** you are allergic or intolerant to and your reaction:

MEDICATION	REACTION

Please list any other allergy or intolerance that might be pertinent (i.e., latex, Iodine, shellfish, or contrast dye):
_____

SOCIAL HISTORY

Personal and Marital Status.
Do you live alone? Yes / No Describe your home: Single level Multi-level

Circle the word that best describes your current marital status:
Married Single Divorced Widowed Domestic Partner

If married, how is your marriage? Good Average Fair Poor

How many children do you have? _____ How many children are living with you? _____

Do you take care of other family members? Yes / No

Education.
What is the highest level of education you have finished? _____

Employment.
Are you currently working? Yes / No

If you are not working, has pain forced you to stop working? Yes / No

Previous / current occupation: _____

Are you being treated under Workers Compensation? Yes / No

Are you currently receiving disability benefits? Yes / No

Habits.
Circle the word that best describes your general stress level: Low Medium High

Circle the word that best describes your exercise level: None Occasionally Moderately Heavily

Are you involved in sporting activities? Yes / No List activities: _____

Circle the word that best describes your diet:
Regular Vegetarian Vegan Gluten free Carbohydrate Specific carbohydrate

Do you drink caffeinated drinks? Yes / No How many drinks per day? _____

Do you drink alcoholic beverages? Yes / No How often? Occasionally Moderately Heavily

Do you smoke? Yes / No How often? Occasionally Moderately Heavily
Number packs per day: _____ Number of years smoking: _____

Do you use recreational/street drugs? Yes / No How often? Rarely Occasionally Often
If yes, please list: _____

PSYCHOSOCIAL HISTORY

Circle the word that best describes how your pain makes you feel:
Depressed Angry Frustrated Helpless/hopeless Loss of interest in hobbies/activities

Have you ever been treated for depression? Yes / No When? _____

Have you ever been treated for emotional/behavioral disorders? Yes / No

Do you currently have ACTIVE suicidal thoughts? Yes / No Do you have a history of suicidal attempts? Yes / No

Do you have a history of alcohol abuse? Yes / No Do family members have a history of alcohol abuse? Yes / No

Do you have a history of drug abuse? Yes / No Circle, if applicable: Marijuana Cocaine Amphetamines

Do you have any immediate family members with a history of drug abuse? Yes / No

SYSTEMS REVIEW

Please circle below if you are experiencing or have recently experienced any of the following:

Constitutional:
Weight gain (___lbs)
Weight loss (___lbs)
Exercise intolerance
Chills
Fever
Night sweats

Eyes / Ears / Nose:
Dry eyes
Irritation
Vision change
Difficulty hearing
Frequent nosebleeds
Sinus pressure/drainage

Mouth / Throat:
Teeth abnormalities
Bleeding gums
Mouth ulcer
Dry mouth
Mouth breathing
Snoring
Oral abnormalities
Sore throat

Cardiovascular:
Chest pain on exertion
Arm pain on exertion
Palpitations
Known heart murmur
Light-headed on standing

Respiratory:
Cough
Coughing up blood
Wheezing
Shortness of breath, when walking
Shortness of breath, when lying
Sleep apnea

Gastrointestinal:
Change in appetite
Abdominal pain
Nausea/vomiting
Vomiting blood
Diarrhea
Constipation
Black/bloody stools

Genitourinary:
Difficulty urinating
Increased urinary frequency
Urinary loss of control
Incomplete emptying
Blood in urine

Musculoskeletal:
Muscle aches
Muscle weakness
Joint pain
Back pain
Swelling in the extremities

Integumentary (skin / breast):
Dry skin
Itching
Rash
Jaundice
Abnormal mole
Growths/lesions

Neurological:
Frequent or severe headaches
Migraines
Numbness
Weakness
Dizziness
Seizures
Loss of consciousness
Restless legs

Psychiatric:
Sleep disturbances
Restless sleep
Feeling unsafe in relationships
Depression
Confusion
Alcohol abuse

Endocrine:
Fatigue
Increased thirst
Cold intolerance
Hair loss
Increased hair growth

Hematologic / Lymphatic:
Swollen glands
Easy bruising
Excessive bleeding

Allergic / Immunologic:
Runny nose
Sinus pressure
Itching
Hives
Frequent sneezing

PAIN'S EFFECT ON ACTIVITIES OF DAILY LIVING

Circle ONE number in each section that best describes how your pain has affected your everyday life:

Section 1 – Pain Intensity
1 I have no pain at the moment.
2 The pain is very mild at the moment.
3 The pain is moderate at the moment.
4 The pain is fairly severe at the moment.
5 The pain is very severe at the moment.
6 The pain is the worst imaginable at the moment.

Section 2 – Personal Care
1 I can look after myself normally without extra pain.
2 I can look after myself, but it is very painful.
3 It is painful to look after myself, and I am slow and careful.
4 I need some help but can manage most of my personal care.
5 I need help every day in most aspects of self-care.
6 I do not get dressed, I wash with difficulty, and I stay in bed.

Section 3 – Lifting
1 I can lift heavy weights without pain.
2 I can lift heavy weights, but it gives me extra pain.
3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
4 Pain prevents me from lifting weights, but I can manage light to medium weights if they are conveniently positioned.
5 I can lift only very light weights.
6 I cannot lift or carry anything at all.

Section 4 – Walking
1 Pain does not prevent me from walking any distance.
2 Pain prevents me from walking more than 1 mile.
3 Pain prevents me from walking more than ¼ mile.
4 Pain prevents me from walking more than 100 yards.
5 I can walk only using a stick or crutches.
6 I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
1 I can sit in any chair as long as I like.
2 I can sit in my favorite chair as long as I like.
3 Pain prevents me from sitting more than 1 hour.
4 Pain prevents me from sitting more than ½ hour.
5 Pain prevents me from sitting more than 10 minutes.
6 Pain prevents me from sitting at all.

Section 6 – Standing
1 I can stand as long as I want without extra pain.
2 I can stand as long as I want, but it causes extra pain.
3 Pain prevents me from standing more than 1 hour.
4 Pain prevents me from standing more than ½ hour.
5 Pain prevents me from standing more than10 minutes.
6 Pain prevents me from standing at all.

Section 7 – Sleeping
1 My sleep is never disturbed by extra pain.
2 My sleep is occasionally disturbed by extra pain.
3 Because of pain, I have less than 6 hours of sleep.
4 Because of pain, I have less than 4 hours of sleep.
5 Because of pain, I have less than 2 hours of sleep.
6 Pain prevents me from sleeping at all.

Section 8 – Sex Life (if applicable)
1 My sex life is normal and without extra pain.
2 My sex life is normal but causes some extra pain.
3 My sex life is somewhat normal but is very painful.
4 My sex life is severely restricted by pain.
5 My sex life is absent because of pain.
6 Pain prevents any sex life at all.

Section 9 – Social Life
1 My social life is normal and is without pain.
2 My social life is normal but increases the degree of pain.
3 Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. sports).
4 Pain has restricted my social life, and I don't go out often.
5 Pain has restricted my social life to my home.
6 I have no social life because of pain.

Section 10 – Traveling
1 I can travel anywhere without extra pain.
2 I can travel anywhere, but it gives me extra pain.
3 Pain is bad, but I manage journeys over 2 hours.
4 Pain restricts me to journeys of less than 1 hour.
5 Pain restricts me to short journeys less than 30 minutes.
6 Pain prevents me from traveling except to receive treatment.

TOTAL: _____

In signing this document, I hereby acknowledge that the information that I have provided is true and accurate to the best of my knowledge. Falsification of this information may be grounds for discharge from this practice. I understand that this information will be used by the company's pain management specialists in developing a comprehensive treatment plan.

Name of Patient: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Name of Personal Representative (if applicable): _____Relationship: _____

Signature of Personal Representative: _____ Date: _____