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SHEKARRIZ FAMILY CHIROPRACTIC

Initial Health Status Form

Today's Date: _____/_____/_____

Name: _____ Birth Date: _____-_____-_____ Age: _____

Sex: M / F / Other Marital Status: Single / Married / Divorced / Widowed

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address: _____ Is it ok to send appointment reminder text messages? Yes / No

Preferred Method of Contact: Email/ Home Phone /Cell Phone Do you have Insurance: Yes / No

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

How were you referred to this office? _____

HISTORY OF COMPLAINT

Please **identify** and **number** based on the severity of the condition(s) that brought you to this office:

Headache Neck Pain Mid-Back Pain Low Back Pain Hip Pain Shoulder Pain Knee Pain

Other _____

When did the problem(s) begin? _____

How did the problem(s) begin? _____

Is your problem the result of ANY type of injury/accident? Yes No If Yes: Auto Home Other _____

If yes, please explain: _____

Current complaint level (*how do you feel today)* on a scale of 0 to 10, with 0 being no pain and 10 being Unbearable.

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Constant / Intermittent

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Constant / Intermittent

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Constant / Intermittent

Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Constant / Intermittent

Average pain intensity: last 24 hours: No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

How often do you experience your symptoms?

Intermittently (0 – 25%) Occasionally (26 – 50%) Frequently (51 – 75%) Constantly (76% - 100%)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores? No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on activities

In general, would you say your overall health right now is: Excellent Very Good Good Fair Poor

When is the problem at its worst? AM PM mid-day late PM

Have you suffered from the same or similar condition before? No Yes

If yes, how many times? _____ When was the last episode? _____

Have you tried other treatments? No Yes If yes, please state what type of treatment:

_____

How long ago? _____ Were the results: Favorable Unfavorable

Have you tried anything to make it feel better (e.g., medication, ice, heat etc.)? _____

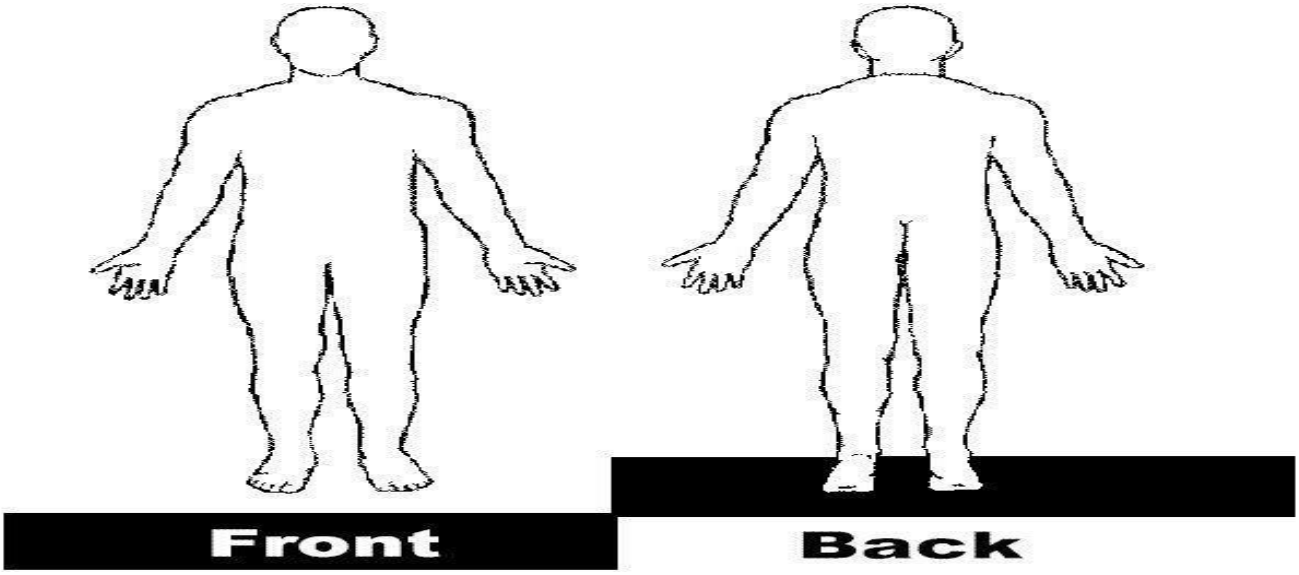
Have you tried anything to make it feel worse (e.g., laying down, walking, sitting etc.)? _____

HAVE YOU HAD SPINAL X RAYS, MRI, OR CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) Taken _____ What areas were taken? _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling



Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a C for Currently or P for the Past

_____ Alcohol/Drug Dependence

_____ Diabetes

_____ Stroke (Date) _____

_____ Recent Fever

_____ High blood pressure

_____ Numbness in Groin/Buttocks

_____ Corticosteroid Use (Cortisone, Prednisone, etc.)

_____ Taking birth control pills

_____ Numb/Tingling arms, hands, fingers

_____ Numb/Tingling legs, feet, toe

_____ Urinary Problems

_____ Visual Disturbances/Blurred or Double Vision

_____ Hip Pain

_____ Shoulder Pain

_____ Neck Pain

_____ Upper Back Pain

_____ Low Back Pain

_____ Mid Back Pain

_____ Broken Bone

_____ Sleeping Problem

_____ Menstrual Problems

_____ Menopausal problems

_____ Constipation

_____ Prostate Problems

_____ Abnormal Weight Gain or Loss

_____ Loss of Balance

_____ Digestive Problems

_____ Osteo Arthritis

_____ Scoliosis/Back Curvature

_____ Low Blood Pressure

_____ Allergies

_____ Dizziness/Fainting

_____ Cancer/Tumor

_____ Rheumatoid Arthritis

_____ Epilepsy/Seizures

_____ Currently Pregnant (# ____ weeks)

_____ Vertigo

_____ Jaw Pain/TMJ

_____ Ringing in the ears

_____ Chest Pain

_____ Impotence/Sexual Dysfunction

_____ Heartburn

_____Pain w/Cough/Sneeze

_____ Depression/Mood Changes

_____ Swollen/Painful Joints

_____ Hepatitis (A, B, C)

_____ Dislocations

_____Gall Bladder Trouble

_____ Osteoporosis

_____ Learning Disability

_____ Frequent Colds/Flu

_____ Heart Attack/Problem

_____ Asthma

_____ Kidney Trouble

_____ Tremors

_____ Disability

Other Serious Conditions: _____

SOCIAL HISTORY:

1. Smoking: Cigars Pipe Cigarette How often? Daily Weekends Occasionally Never

2. Alcoholic Beverage: How many glass/bottles? ____ Daily Weekends Occasionally Never

3. Recreational Drug use: Yes No Never Daily Weekends Occasionally Never

4. Hobbies -Recreational Activities- Exercise Regime**:** How does your present problem affect? (See ADL form)

_____

5. Sleep pattern: _____ How many hours per night? _____

PLEASE identify ALL PAST and any CURREN**T** conditions you feel may be contributing to your present problem:

	TYPE OF CARE RECEIVED TYPE OF CARE RECEIVED BY WHOM
INJURIES	1. 2. 3.
SURGERIES	1. 2. 3.
CHILDHOOD DISEASES	1. 2. 3.
ADULT DISEASES	1. 2. 3.

FAMILY HISTORY:

____ Cancer ____ Diabetes ____High Blood Pressure ____ Heart problem/Stroke ___ Rheumatoid Arthritis

Whom: grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)

Any other hereditary conditions the doctor should be aware of? No Yes

_____

List Prescription and Non-Prescription drugs you take:

_____

_____

ACTIVITIES OF LIFE:

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Write a number where applies: 1 – Painful (can do) 2 – Painful (limits) 3 – Unable to Perform

Extended computer use	Climbing upstairs	Static sitting	Sleep	Sit to Stand
Sweeping/Vacuuming	Climbing downstairs	Yard Work	Dishes	Lifting Children/Groceries
Read/Concentrate	Sexual Activities	Walking	Shaving	Washing/Bathing
Getting Dressed	Laundry	Garbage	Driving	Static standing

Other: _____

_____ _____ - _____ - _____

Patient or Authorized Person's Signature Date Completed

_____ _____ - _____ - _____

Doctor's Signature Date Form Reviewed