

Patient History

Medicare Policy Notice

IMPORTANT: In compliance with Medicare standards and practices, this office is unable to provide treatment to Medicare beneficiaries. If you are a Medicare beneficiary, please notify the front desk immediately.

☐ I acknowledge that I have read and understood the Medicare Policy stated above:

Patient Signature: _____

MANDATORY COMPLETION REQUIREMENT: To ensure the highest standard of care and accurate diagnosis, a thorough and complete patient history is required. Please provide detailed responses for all questions. If a question is not applicable, please indicate this by writing "N/A." Failure to complete this form thoroughly may necessitate the rescheduling of your appointment.

Red Flag Screen

Please answer the following honestly.

1. Are you currently experiencing fever, chills, unexplained weight loss, night sweats, or severe nighttime pain that prevents sleep? ☐ Yes ☐ No
2. Have you experienced any recent, sudden change in bowel or bladder control? ☐ Yes ☐ No
3. Are you experiencing sudden, severe numbness in your inner thighs/groin ("saddle area")? ☐ Yes ☐ No
4. Have you experienced any recent significant trauma or falls (within the last 6 months)? ☐ Yes ☐ No
5. Are you experiencing any sudden, significant loss of coordination or balance? ☐ Yes ☐ No

If you answered "Yes" to any of the above, please provide details: _____

Neurological Screen(are you experiencing any of the following symptoms?)

- ☐ **Balance:** Loss of balance?
- ☐ **Eyes:** Blurred or loss of vision?
- ☐ **Face:** Face drooping?
- ☐ **Arms:** Arm weakness?
- ☐ **Speech:** Speech difficulty?

If you checked any of the above, please provide details: _____

Are you currently seeking or have you sought medical care for any of the symptoms checked above? ☐ Yes ☐ No.

If yes, please provide your doctor's name, contact information, and the result of treatment: _____

Current Complaint Assessment

What is your Primary reason for coming in today: _____

When did this *initially* begin? _____

How did it occur? ☐ Injury/Fall ☐ Lifting ☐ Repetitive Motion

☐ Gradual Onset ☐ Unknown ☐ Other: _____

Prior Treatments: ☐ Chiropractic ☐ Medication ☐ Physical Therapy

☐ Surgery ☐ Injections ☐ Massage ☐ None ☐ Other: _____

Rate the severity of your pain on a scale of 1 to 10:

1 (least) – 10 (worst) 1 -- 2 -- 3 -- 4 -- 5 -- 6 -- 7 -- 8 -- 9 – 10

Is your primary complaint.....☐ constant ☐ come and go

Please indicate the location of the pain on the figures

(Please use 'P' for Primary Complaint and 'S' for Secondary Complaint):->

Do you have a Secondary complaint: _____

When did this *initially* begin? _____

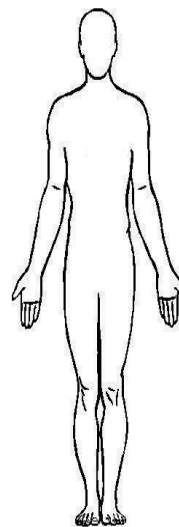
How did it occur? ☐ Injury/Fall ☐ Lifting ☐ Repetitive Motion

☐ Gradual Onset ☐ Unknown ☐ Other: _____

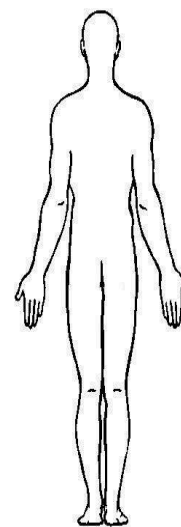
Is your secondary complaint.....☐ constant ☐ come and go

Rate the severity of your pain on a scale of 1 to 10:

1 (least) – 10 (worst) 1 -- 2 -- 3 -- 4 -- 5 -- 6 -- 7 -- 8 -- 9 – 10



Front



Back

Detailed Analysis of Primary Complaint

Pain Quality: ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Stabbing ☐ Radiating ☐ Other: _____

Aggravating/Relieving Factors: ☐ Sitting ☐ Standing ☐ Walking ☐ Twisting ☐ Bending ☐ Sleep ☐ Other: _____

Functional Limitations (Please indicate how your pain affects these activities, if at all):

Sleeping: ☐ No Impact ☐ Mild ☐ Moderate ☐ Severe

- Please explain further and how long has this been an issue: _____

Sitting: ☐ No Impact ☐ Mild ☐ Moderate ☐ Severe

- Please explain further and how long has this been an issue: _____

Standing: ☐ No Impact ☐ Mild ☐ Moderate ☐ Severe

- Please explain further and how long has this been an issue: _____

Walking: ☐ No Impact ☐ Mild ☐ Moderate ☐ Severe

- Please explain further and how long has this been an issue: _____

Lifting/Carrying: ☐ No Impact ☐ Mild ☐ Moderate ☐ Severe

- Please explain further and how long has this been an issue: _____

Daily Chores/Work: ☐ No Impact ☐ Mild ☐ Moderate ☐ Severe

- Please explain further and how long has this been an issue: _____

Exercise/Hobbies: ☐ No Impact ☐ Mild ☐ Moderate ☐ Severe

- Please explain further and how long has this been an issue: _____

Other: _____

Social/Lifestyle

Tobacco/Nicotine use: ☐ Yes ☐ No

Exercise Frequency: ☐ Daily ☐ Weekly ☐ Sedentary

Work Environment: ☐ Desk/Computer ☐ Physical/Manual Labor ☐ Other: _____

Do you have any known allergies (especially to topical creams, oils, or latex)? ☐ No ☐ Yes, please specify:

Is there a possibility of pregnancy? ☐ No ☐ Yes ☐ N/A

Chronic Health & Wellness Concerns

- ☐ Neck Pain ☐ Back Pain ☐ Shoulder Pain
☐ Hip Pain ☐ Dizziness ☐ Headaches/Migraines
☐ Numbness/Tingling ☐ Other: _____

Health History

History of broken bones? (If yes, please explain below)

☐ No, I certify that to the best of my knowledge I do not have a history of broken bones.

History of surgeries? (If yes, please explain below)

☐ No, I certify that to the best of my knowledge I do not have a history of surgeries.

History of hospitalizations? (If yes, please explain below)

☐ No, I certify that to the best of my knowledge I do not have a history of hospitalizations.

History of any of the following:(If yes, please explain below)

- ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ High Cholesterol ☐ Thyroid
☐ Asthma ☐ Arthritis ☐ Cancer ☐ Stroke ☐ Autoimmune
☐ Other: _____

☐ Explain: _____

☐ None; I certify that to the best of my knowledge, I have not been treated for or diagnosed with any of the above conditions.

Family Health History (Check all that apply):

- ☐ None ☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Thyroid Issues ☐ Other:

Medications, Vitamins, & Supplements (Please list name, dosage, and frequency)

(If taking more than 3 medications, please attach a separate list.)

PATIENT ACKNOWLEDGMENT

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I understand that failure to provide accurate and complete information may result in a delay or cancellation of my appointment.

Patient Signature: _____

Date: _____

Office Use Only

Reviewed by: _____ Date: _____