

WELCOME TO CHIROPRACTIC NEUROLOGY & SPORTS REHAB, L.L.C.

Outline Procedures for New Patients

Step One	All new patients are requested to fill out a personal health questionnaire prior to their appointment.
Step Two	Your consultation with a doctor to discuss your health problems.
Step Three	Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if chiropractic care is appropriate for your condition. If not appropriate referrals will be made.
Step Four	You will be advised if there is the need of any additional procedures such as X-rays, MRI, Cat Scan or EMG.
Step Five	If your case requires immediate attention, treatment will be administered.
Step Six	You will be advised as to a time you can return for your "report of findings" so that the Doctor will inform you as to your examination results and whether or not your case has been accepted. You will be informed of specific recommendations or referrals in regards to your condition.

Confidential Patient Information

Name		Date	
Street Address		City/State	Zip Code
Home Phone ()	Work Phone ()	Cell Phone ()	
Email Address	Date of Birth	Current Age	
Social Security #		Method of Payment	

Insurance Information:

Name of Insurance Company	
Are you the Primary Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, Primary's name:	Date of Birth:
Policy Number:	Group Number:

Referred by: Previous/Current Patient Physician Attorney Insurance Network Online Yellow Pages

Name / Company	
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Work Status: Employed Retired Disabled Full-time Student Part-time Student

Employer	Occupation & Job Responsibilities	
Employer Address (if a Workman's Compensation Claim)	City/State	Zip Code

Marital Status: Married Single Divorced Widow/er Spouse's Name _____

Children: No Yes Children's Names _____ Age: _____
 _____ Age: _____
 _____ Age: _____
 _____ Age: _____

Chief Complaint

When did you first notice this condition:

Did it begin: Immediate or Gradually? Briefly describe

What is the exact location of your symptoms:

Do your symptoms Spread? No Yes Where?

How often do you experience these symptoms? Constant Frequent (75% of the time) Intermittent (50%)
 Occasional (25%) Rarely (less than 25%)

Is this condition: Worsening Improving or Unchanged

What is the intensity of your symptoms? Severe Moderately Severe Moderate Mild to Moderate Mild

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain)
 1 2 3 4 5 6 7 8 9 10

Is your pain: Deep or Superficial

Please indicate the character of your pain: Dull Sharp Burning Aching Knife-like Throbbing

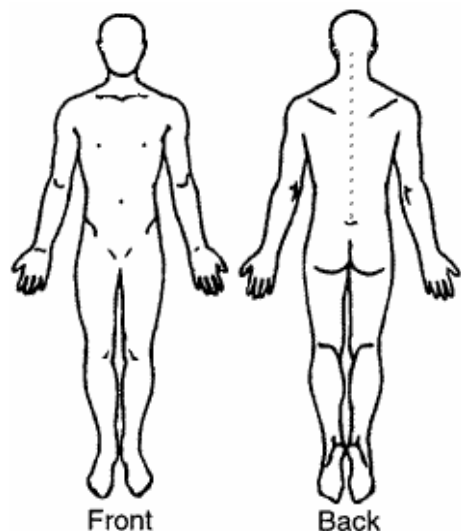
Are you experiencing any of the following associated symptoms? Pins/Needles Tingling Numbness Twitching
 If Yes, Please describe:

Please indicate what activities Provoke or Aggravate your condition:
 Sitting ___min. Standing Walking Lying Pushing Pulling Lifting Gripping Heat Cold
 Coughing/sneezing Bending/Stooping Mental Activities Bright lights Other _____
 Other _____ Other _____ Other _____

Please indicate what helps to alleviate the pain.
 Lying Down Sitting Walking Standing Rest Heat Cold Stretching Massage Darkness/Quiet
 Medications (what kind?) _____ _____ _____

Please list what doctors you have seen for this condition. (Please include diagnoses & treatment received.)

On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviation/s that most accurately reflects the type of discomfort that you have been experiencing.



- Numbness = **N** *Entumecimiento* Tingling = **T** *Hormigueo*
 Dull Ache = **A** *Dolor* Sharp Pain = **P** *Dolor Agudo*
 Burning = **B** *Ardor* Stiffness = **S** *Rigidez*

Please Estimate and Mark Your Pain Level

No Pain _____ **Intolerable**

Please include any other relevant history in regards to this complaint.

Medical History

Medications Please list your current medications (prescribed & over-the-counter) and for what reason.

Emotional State	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Mental Abilities	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Exercise Level	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Dietary Habits	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor
Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Poor

Motor Vehicle Accidents No Yes Please Explain: (head-on, rear-ended, from the side, injuries, etc.)
 Mo./Yr: ___/___ Type: _____
 Mo./Yr: ___/___ Type: _____

Work Injuries No Yes Explain: _____

Illnesses/Hospitalizations: No Yes Explain: _____

Injuries, Accidents, Falls, or Traumas No Yes Explain: _____

Surgeries: No Yes Explain: _____

Females Only: What age did you start your menses? _____ Regular Irregular Menopause? No Yes
 Birth Control Medications? (currently or previously) No Yes - please estimate total time taking: _____

Have any of your family members ever suffered from any of the following conditions?
 Diabetes Heart Disease Stroke Neurological Disorders (type) _____
 Autoimmune Disorders (type) _____ Cancer (type) _____
 _____ _____ _____

Vitamins, Minerals, and Supplements Please list all of your current supplements

Family History

Mother Alive & Well, age ___ Deceased age ___ Cause _____
 Any Health Conditions? _____

Father Alive & Well, age ___ Deceased age ___ Cause _____
 Any Health Conditions? _____

Brother Alive & Well, age ___ Deceased age ___ Cause _____
 Any Health Conditions? _____

Brother Alive & Well, age ___ Deceased age ___ Cause _____
 Any Health Conditions? _____

Sister Alive & Well, age ___ Deceased age ___ Cause _____
 Any Health Conditions? _____

Sister Alive & Well, age ___ Deceased age ___ Cause _____
 Any Health Conditions? _____

Children: Names, Ages and any health conditions? _____

