CNSREHAB

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 concerns.
Step Three	Diagnostic chiropractic, orthopedic and neurological examination procedures to determine if chiropractic care is appropriate for your condition.
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	Treatment options will be discussed and initiated if appropriate. If you are not a chiropractic case, referrals to another provider may be necessary.

Confidential Patient Information

Name		Date
Street Address	City/State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )
Email Address	Date of Birth	Current Age
	Referred by: ☐ Website ☐ Other:	

Insurance Information: (*Please bring a copy of your current card so we may check benefits for you*)
Name of Insurance Company: _____
Spouse's name and birthdate if they are the primary insured: _____

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Full-time Student ☐ Part-time Student
Employer: _____
Job Responsibilities: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/er Spouse's Name_____
Children: ☐ None ☐ Yes Children's Names & ages _____ _____
_____ _____

Family Physician: _____
Medical Specialist(s): _____ _____

DRUG or NUTRIENT/ FOOD ALLERGIES/SENSITIVITIES: _____
_____ _____

PREGNANT: ☐YES ☐NO ☐NA **HORMONE REPLACEMENT:** ☐YES ☐NO
CURRENTLY TAKING PHARMACUETICAL BIRTH CONTROL: ☐YES ☐NO
PAST PHARMACEUTICAL BIRTH CONTROL: ☐YES ☐NO How long? _____

IN CASE OF EMERGENCY

Please Contact:	Best Number to Contact:

Chiropractic Neurology & Sports Rehab, LLC

Phone 402-420-2677 Fax 402-420-3030 www.CNSrehab.com

Orthopedic / Pain Complaints

Please describe any of your pain complaints /condition:

Did it begin: ☐ Immediate or ☐ Gradually? Briefly describe when this first started:

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% or less)

Is this condition: ☐ Improving ☐ Unchanged ☐ Worsening

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 ☐

Are your symptoms: ☐ Deep or ☐ Superficial

The character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Other:

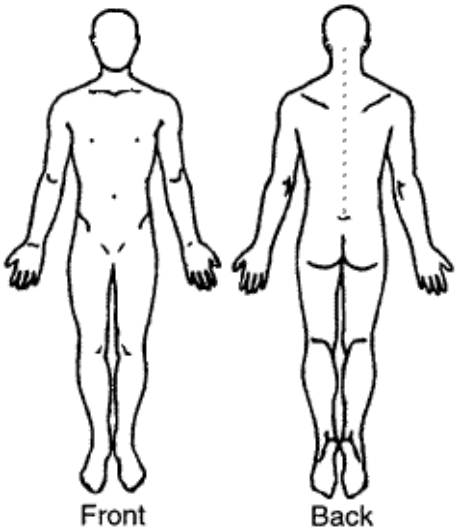
Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching
If Yes, Please describe where, when, etc.:

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.

CNS Rehab, LLC 6200 S 58th st, suite A Lincoln, NE 68516
Phone 402-420-2677 Fax 402-420-3030 info@CNSrehab.com

Emotional State	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Concentration	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Exercise Level	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ 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 Please explain with specifics including procedure, site and date of the surgery (*at least the year*):
_____
_____
_____
_____

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

Vitamins, Minerals, and Supplements Please list your current supplements
_____
_____
_____
_____
_____
_____
_____

Family History

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)_____
☐ _____ ☐ _____ ☐ _____

REVIEW OF SYSTEMS

Check the box of any of the following conditions you **HAVE HAD or CURRENTLY HAVE**.

☐ Eating Disorder	☐ Diabetes	☐ Pneumonia	☐ Multiple Sclerosis
☐ Epilepsy	☐ Anemia	☐ Tuberculosis	☐ Celiac Disease
☐ Chronic Pain	☐ Glaucoma	☐ Hepatitis Type____	☐ Rheumatoid Arthritis
☐ Alcoholism	☐ Heart Disease	☐ Thyroid Disease	☐ Hashimoto's Thyroid
☐ Drug Addiction	☐ Rheumatic Fever	☐ Shingles	☐ Other Autoimmune Dz
☐ Cancer	☐ Scarlet Fever	☐ Herpes	☐ AIDS / HIV

Check the **first** box of any of the following conditions you have **HAD**, and check the **second** box of anything you **HAVE**.

Had Have **NERVOUS SYSTEM**	**EENT**	**GI**	**MUSCULOSKELETAL**
☐ ☐ Depression	☐ ☐ Vision Correction	☐ ☐ Poor Appetite	☐ ☐ Jaw Pain
☐ ☐ Memory Difficulties	☐ ☐ Flashing Lights	☐ ☐ Excessive Thirst	☐ ☐ Difficulty Chewing
☐ ☐ Anxiety	☐ ☐ Black Spots	☐ ☐ Frequent Nausea	☐ ☐ Tooth Pain
☐ ☐ Dizziness	☐ ☐ Blurriness	☐ ☐ Black/Bloody Stools	☐ ☐ Neck Pain
☐ ☐ Fainting	☐ ☐ Hearing Loss	☐ ☐ Off & On Constipation	☐ ☐ Shoulder Pain
☐ ☐ Convulsions	☐ ☐ Ringing in Ears	☐ ☐ Off & On Diarrhea	☐ ☐ Arm/Elbow Pain
☐ ☐ Weakness / Fatigue	☐ ☐ Swallowing Difficulty	☐ ☐ Abdominal Cramping	☐ ☐ Wrist/Hand Pain
☐ ☐ Poor Balance	☐ ☐ Thyroid nodule/goiter	☐ ☐ Gas/Bloating after meals	☐ ☐ Mid Back Pain
☐ ☐ Twitches / Tremors	☐ ☐ Sinus Pain / Allergies	☐ ☐ Heartburn	☐ ☐ Lower Back Pain
☐ ☐ Sensory Loss / Numb	☐ ☐ Loss of Taste or Smell	☐ ☐ BMs less than Daily	☐ ☐ Thigh/Knee Pain
☐ ☐ Tingling / Burning	☐ ☐ Bleeding Gums	☐ ☐ Gall Bladder Problems	☐ ☐ Ankle/Foot Pain
☐ ☐ Cold Hands		☐ ☐ Liver Problems	☐ ☐ Difficulty Walking
☐ ☐ Cold Feet	**C-V**	☐ ☐ Hemorrhoids	☐ ☐ Leg or Arm Weakness
	☐ ☐ Chest Pain		
	☐ ☐ Irregular Heartbeat	**GU**	
☐ ☐ Migraines	☐ ☐ High Blood Pressure	☐ ☐ Bladder Trouble	**REPRODUCTIVE**
☐ ☐ Tension Headaches	☐ ☐ Shortness of Breath	☐ ☐ Painful Urination	☐ ☐ Erectile Difficulties
☐ ☐ Face / Eye Pain	☐ ☐ Lung/Congestion Prob	☐ ☐ Incontinence	☐ ☐ Vaginal Dryness
	☐ ☐ Varicose Veins	☐ ☐ Discolored Urine	☐ ☐ Menstrual Irregularity
	☐ ☐ Ankle Swelling	☐ ☐ Urgency w/ ⇩ volume	☐ ☐ Menstrual Cramping

Any Additional Comments:

_____

_____

Personal Habits

Tobacco	☐ None ☐ Yes Packs / Cans per week?
Cigars	☐ None ☐ Yes How many per week?
Alcohol	☐ None ☐ Yes How many drinks per week? What type?
Coffee	☐ None ☐ Yes How many cups per week?
Recreational Drugs	☐ None ☐ Yes Types? Frequency? Years of Usage?
Exercise	☐ None ☐ Yes Hours/Days per week? Types?
Water	☐ None ☐ Yes Glasses per day?
Soft Drinks	☐ None ☐ Yes Amount per week? Types?
Sleep	☐ None ☐ Yes Average hours per night?___ Do you have difficulty falling asleep or staying asleep? ☐ No ☐ Yes #times up at night_____ Why do you think this happens?
Eating	Meals per day? What types of food do you eat primarily? Do you consider your diet healthy? ☐ Yes ☐ No Explain:

YOUR GOALS: [other than reducing pain**]** What abilities or activities have you had difficulty performing because of these problems you are experiencing and would like to return to performing (playing golf, picking up kids, cleaning the house, dancing, etc.): _____

_____

_____