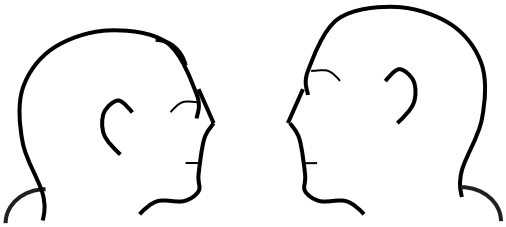
DATE OF VISIT ___/___/20___ Patient_____ Age_____

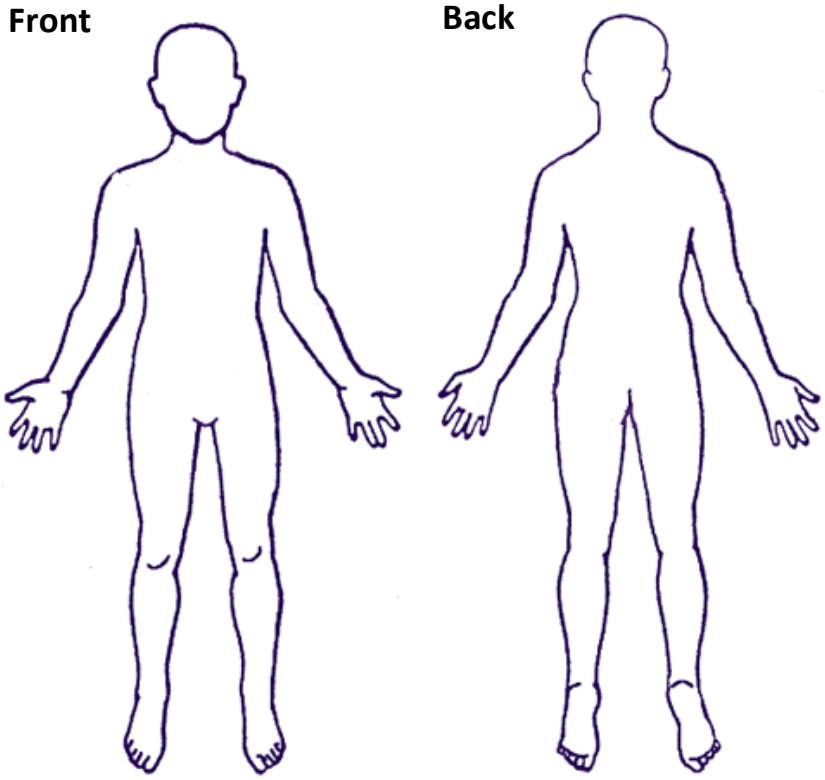
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE			EXCRUCIATING

PATIENT NAME: _____ DATE: _____ DR Karim

FAMILY & SPORT CHIROPRACTIC

FIRST NAME _____ **MIDDLE NAME** _____

LAST NAME _____ **NICK NAME** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE _____ **CELL PHONE** _____ **CELL CARRIER**_____

E-MAIL _____ **PREFERRED METHOD OF CONTACT** _____

SOCIAL SECURITY _____

How were you referred to this office?_____

DATE OF BIRTH _____/_____/_____ **AGE** _____ **GENDER** (CHECK ONE) ◯ MALE ◯ FEMALE

MARITAL STATUS (CHECK ONE) ◯ SINGLE ◯ MARRIED ◯ OTHER

OCCUPATION _____ **EMPLOYER** _____

OFFICE PHONE _____

SPOUSE'S NAME _____

CHILDREN _____ **AGES OF CHILDREN** _____

EMERGENCY CONTACT _____ **PHONE** _____

RACE (CHECK ONE)

□ WHITE □ BLACK/AFRICAN AMERICAN □ HISPANIC □ AMERICAN INDIAN/ALASKA NATIVE

□ ASIAN □ OTHER □ DOES NOT SPECIFY

ETHNICITY (CHECK ONE)

□ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO □ DOES NOT SPECIFY

PREFERRED LANGUAGE (CHECK ONE)

Chief Complaint

CHIEF COMPLAINT (PURPOSE FOR THIS APPT)

_____

DATE SYMPTOMS APPEARED _____ **WAS THIS ACCIDENT RELATED?** □ YES □ NO

IS THIS CONDITION GETTING WORSE? □ YES □ NO **IS IT CONSISTENT OR DOES IT COME AND GO?**

SOCIAL HISTORY

WORK ACTIVITY:

WHAT IS YOUR JOB DESCRIPTION?

_____

WHAT DO YOU DO MOST OF THE DAY AT WORK? □ SIT □ STAND □ LIGHT LABOR □ HEAVY LABOR

□ OTHER: _____

HOW WOULD YOU DESCRIBE THE PHYSICAL STRESS LEVEL AT WORK? □ LOW □ MEDIUM □ HIGH

ALCOHOL

□ **Do not drink alcohol** □ **Social consumption** □ **Drink the following regularly:** □beer □liquor □wine

Quantity of _____ OZ./glasses per □Day □Week □Month

Do you currently use illegal drugs? □Yes □No

SMOKING

Do you currently smoke tobacco of any kind? □ YES □ Former smoker □ Never been a smoker

IF YES, how often do you smoke? □ Current every day smoke □ Current sometimes smoker

□ **Smoke: #_____ Per** □Day □Week □Month

□ **Chew: #_____ Can Per** □Day □Week □Month

PERSONAL HEALTH HISTORY

ARE YOU CURRENTLY UNDER THE CARE OF A HEALTHCARE PROVIDER OR ANY OTHER DOCTOR? □ YES □ NO

HAS ANY DOCTOR DIAGNOSED YOU WITH HYPERTENSION RECENTLY? □ YES □ NO

HAS ANY DOCTOR DIAGNOSED YOU WITH DIABETES RECENTLY? □ YES □ NO

DO YOU WEAR ANY OF THE FOLLOWING? □ HEEL LIFTS □ INNERSOLES □ ARCH SUPPORTS □ ORTHOTICS

HAVE YOU SEEN A CHIROPRACTOR IN THE PAST? □ YES □ NO **DATE OF LAST VISIT:** _____

IF YES, NAME AND LOCATION OF PREVIOUS CHIROPRACTOR:

_____ **PHONE:** _____

WERE YOU SATISFIED WITH THE CARE? □ YES □NO

ALLERGIES

DO YOU HAVE ANY ALLERGIES INCLUDING ALLERGIES TO ANY MEDICATIONS? □ YES □ NO

REACTION: _____

PATIENT NAME: _____ DATE: _____ DR Karim

MEDICATIONS

CURRENT MEDICATIONS, INCLUDING FREQUENCY AND DOSAGE IF KNOWN. IF NO MEDICATIONS, CHECK HERE: □

	MEDICATION NAME	QUANTITY/DOSE (i.e. 1 tablet/ 5 mg)	FREQUENCY (i.e. 2 times/ day)	DATE STARTED
1				
2				
3				
4				
5				
6				

DO YOU CURRENTLY USE RECREATIONAL DRUGS? □ YES □ NO

INJURIES:

□ BACK INJURY □ FRACTURE □ LACERTATION (SEVERE) □ BROKEN BONES □ HEAD INJURY □ MOTOR VEHICLE ACCIDENT

□ DISABILITY(IES) □ INDUSTRIAL ACCIDENT □ SOFT TISSUE INJURY □ FALL (SEVERE) □ JOINT INJURY

□ OTHER: _____

SURGERIES:

	DATE	PROCEDURE	DESCRIPTION	
1				IN PATIENT/OUT PATIENT
2				IN PATIENT/OUT PATIENT
3				IN PATIENT/OUT PATIENT
4				IN PATIENT/OUT PATIENT
5				IN PATIENT/OUT PATIENT

FAMILY HISTORY

RELATION	AGE (NOW OR AT DEATH)		LIST ANY SIGNIFICANT DISEASE(S)	SERIOUS ILLNESS/ CAUSE OF DEATH
FATHER		□ ALIVE □ DECEASED		
PATERNAL GRANDFATHER		□ ALIVE □ DECEASED		
PATERNAL GRANDMOTHER		□ ALIVE □ DECEASED		
MOTHER		□ ALIVE □ DECEASED		
MATERNAL GRANDFATHER		□ ALIVE □ DECEASED		
MATERNAL GRANDMOTHER		□ ALIVE □ DECEASED		
BROTHER(S)		□ ALIVE □ DECEASED		
SISTER(S)		□ ALIVE □ DECEASED		

REVIEW OF SYSTEMS

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING BY CHECKING THE BOX:

CONSTITUTIONAL	□ NONE □ DAYTIME DROWSINESS □ FEVER □NIGHT SWEATS □ CHILLS □ FATIGUE □ LOSS OF APPETITE □ WEIGHT GAIN/LOSS
EYES/VISION	□ NONE □ CATARACTS □ ITCHING □ WEARS CONTACTS/GLASSES □ BLINDNESS □ DOUBLE VISION □ PHOTOPHOBIA □ BLIND SPOTS □ EYE PROBLEMS □ TEARING
EARS, NOSE & THROAT	□ NONE □ FAINTING □ HISTORY OF HEAD INJURY □ RUNNY NOSE □ DIZZINESS □ FREQUENT SORE THROATS □ LOSS OF SENSE OF SMELL □ SINUS INFECTION □ EAR DISCHARGE □ HEADACHES □ NOSEBLEEDS □ EAR PAIN □ HEARING LOSS □ NASAL CONGESTION
RESPIRATION	□ NONE □ COUGH □ SHORTNESS OF BREATH □ WHEEZING □ ASTHMA □ COUGHING UP BLOOD □ SPUTUM PRODUCTION
CARDIOVASCULAR	□ NONE □ HIGH BLOOD PRESSURE □ PAROXYSMAL NOCTURNAL DYSPNEA □ VERICOSE VEINS □ CLAUDICATION □ LOW BLOOD PRESSURE □ ULCERS □ SHORTNESS OF BREATH WITH EXERTION □ ORTHOPNEA HEART PROBLEM □ HEART MURMUR □ PALPITATIONS
GASTROINTESTINAL	□ NONE □ BELCHING □ DIFFICULTY SWALLOWING □ JAUNDICE □ ABDOMINAL PAIN □ BLACK/TARRY STOOL □ HEARTBURN □ ULCERS □ ABNORMAL STOOL □ CONSTIPATION □ HEMMERHOIDS □ RECTAL BLEEDING □ DIARRHEA □ INDIGESTION
FEMALE	□ NONE □ BIRTH CONTROL □ FREQUENT URINATION □ VAGINAL DISCHARGE □ BREAST LUMP/PAIN □ HORMONE THERAPY □ ABNORMAL VAGINAL BLEEDING □ BURNING URINATION □ IRREGULAR MENSTRUATION □ CRAMPS □ URINE RETENTION **DO YOU HAVE ANY CONCERNS ABOUT YOUR SEXUAL HEALTH?** □ YES □ NO **ARE YOU/HAVE YOU BEEN A VICTIM OF DOMESTIC OR SEXUAL ABUSE?** □ YES □ NO
MALE	□ NONE □ BURNING URINATION □ FREQUENT URINATION □PROSTATE PROBLEMS □ ERECTILE DYSFUNCTION □ HESITANCY/DRIBBLING □ URINE RETENTION DO YOU HAVE ANY CONCERNS ABOUT YOUR SEXUAL HEALTH? □ YES □ NO ARE YOU/HAVE YOU BEEN A VICTIM OF DOMESTIC OR SEXUAL ABUSE? □ YES □ NO
ENDOCRINE	□ NONE □ EXCSESSIVE APPETITE □ GOITER □ UNUSUAL HAIR GROWTH □ COLD INTOLERANCE □ EXCESSIVE HUNGER □ HAIR LOSS □ VOICE CHANGES □ DIABETES □ EXCESSIVE THIRST □ HEAT INTOLERANCE
SKIN	□ NONE □ CHANGE IN SKIN COLOR □ HISTORY OF SKIN DISORDERS □ RASH □ CHANGE IN NAIL TEXTURE □ HAIR LOSS □ ITCHING □ SKIN LESIONS/ULCERS □ HIVES □ NUMBNESS □ VARICOSITIES
NERVOUS SYSTEM	□ NONE □ DIZZINESS □ LIMB WEAKNESS □ SEIZURES □ STROKE □ LOSS OF CONSCIOUSNESS □ SLEEP DISTURBANCE □ UNSTEADINESS OF GAIT/LOSS □ FACIAL WEAKNESS □ LOSS OF MEMORY □ SLURRED SPEECH □ HEADACHE □ NUMBNESS □ STRESS
PSYCHOLOGICAL	□ NONE □ BI-POLAR DISORDER □ DEPRESSION □ MEMORY LOSS □ ANXIETY □ CONFUSION □ INSOMNIA □ MOOD CHANGE □ BEHAVIORAL CHANGE □ CONVULSIONS □ LOSS OR CHANGE OF APPETITE
HEMATOLOGIC	□ NONE □ BLEEDING □ BLOOD TRANSFUSION □ FATIGUE □ ANEMIA □ BLOOD CLOTTING □ BRUISING EASILY □ LYMPH NODES SWELLING

PATIENT NAME: _____ DATE: _____ DR Karim

HEALTH REVIEW:

HOW MANY HOURS OF SLEEP ARE YOU GETTING PER NIGHT? □ LESS THAN 5 □ 6-8 □ 8-10 □ 10 OR MORE

HOW MANY DAYS/ WEEK DO YOU EXERCISE FOR 30 MINUTES OR MORE? □ 0 □ 1-2 □ 3-4 □ 5-6 □ 7

LIST MAJOR STRESSORS: _____

***IN ADDITION, TALK WITH YOUR DOCTOR ABOUT OTHER AREAS WHICH MAY BE AFFECTING YOUR HEALTH, SUCH AS WORRIES ABOUT FINANCES, SOCIAL SUPPORT, ALCHOHOL, TOBACCO AND DRUG USE.**

INSURANCE:

PLEASE CHECK ANY AND ALL INSURANCES THAT MAY BE APPLICABLE:

□ MAJOR MEDICAL □ WORKER'S COMPENSATION □ MEDICAID □ MEDICARE □ AUTO ACCIDENT □ MEDICAL SAVINGS
□ OTHER: _____

NAME OF PRIMARY INSURANCE COMPANY: _____

NAME OF SECONDARY INSURANCE COMPANY (IF ANY): _____

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

WHILE WE WORK CLOSELY WITH YOU TO RESOLVE YOUR CHIEF COMPLAINT, AS HEALTH PROFESSIONALS, WE ARE ALSO CONCERNED ANOUT YOUR OVERALL WELLNESS. ON FUTURE VISITS WE WILL DISCUSS ISSUES WITH YOU THAT MAY IMPACT YOUR OVERALL HEALTH.

ALL ANSWERS I HAVE GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE, AND I AGREE TO CONTINUE WITH MY CHIROPRACTIC EVALUATION AT FAMILY & SPORT CHIROPRACTIC AT THIS TIME.

PATIENT'S SIGNATURE_____ **DATE:**_____

GUARDIAN'S SIGNATURE AUTHORIZING CARE:_____ **DATE:**_____

PATIENT NAME: _____ DATE: _____ DR Karim