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Tobacco

☐ Smoker ☐ Non-Smoker ☐ Ex-Smoker

Heart Disease/Family History

Did your parents die of a heart attack before age 60?

☐ Yes, one of them. ☐ Yes, both of them.

☐ No. ☐ Not sure.

Do you have diagnosed heart disease? ☐ Yes ☐ No.

If yes, specify _____

Physical Activity

How would you rate the amount of physical activity you perform while at work?

☐ Very Little ☐ Little ☐ Moderate ☐ Active

How much of your day must you stand up?_____ %.

sit down?_____ %.

How would you rate the amount of physical activity you perform during your leisure time?

☐ Very Little ☐ Little ☐ Moderate ☐ Active

Please list the activities you participate in on the average of 2 times per week. _____

_____

Alcohol

☐ Does Drink ☐ Ex-Drinker ☐ Never Drank

If you drink alcohol, enter the average number of drinks per week: _____

Diabetes

Does anyone in your family have diabetes? ☐ Yes ☐ No. If yes, specify _____

Do you have diagnosed diabetes? ☐ Yes ☐ No. If yes, specify _____

Stress

How often do you use drugs or medication which affect your mood or help you to relax?

☐ Almost every day ☐ Every day ☐ Sometimes

☐ Rarely ☐ Never

Are these medications prescribed by a physician? ☐ Yes ☐ No

How would you rate your level of stress (on a scale of 1-10, 1 being no stress 10 high stress) *More...*

at Home_____ at Work_____

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Diet

What was your weight at age 21? _____

Beverages

How many cups of coffee or tea do you drink each day?

_____

How many ounces of cola and other soft drinks do you drink each day? _____

How many ounces of the soft drinks are a diet brand?

_____

Do you eat the following foods daily?

	Yes	No	Amount
Whole Grain Breads	☐	☐	_____
Whole Grain Cereals	☐	☐	_____
Fresh Raw Vegetables	☐	☐	_____
Fresh Cooked Vegetables	☐	☐	_____
Canned Vegetables	☐	☐	_____
Fresh Fruit	☐	☐	_____
Canned Fruit	☐	☐	_____

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize Bigelow Chiropractic to inspect and copy any requested reports, relating to my treatment. Photocopies of this medical authorization shall have the same force and effect as the original.
I hereby authorize anyone in receipt of a photochopy of this document to release my medical records.

Date:_____ Signature:_____ Witness:_____

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Injury/Pain

Please describe your injury or symptoms _____

_____

How long has this been present? _____

Have you ever had a previous back injury or back pain? ☐ Yes ☐ No. If yes, please specify

_____

_____

Have you ever had back surgery? ☐ Yes ☐ No. If Yes, What Type? ☐ Laminectomy ☐ Fusion ☐ Chymopapain ☐ Other ☐ Unknown

Previous Medical Help: ☐ General DC ☐ General MD ☐ Chiropractic Orthopaedist ☐ Ortho. Surgeon ☐ Chiropractic Neurologist ☐ Medical Neurologist ☐ Neurosurgeon ☐ Psychologist ☐ Physical Therapist ☐ Exercise Physiologist ☐ Nutritionist ☐ Osteopath ☐ Back School ☐ Other (please list)

Please circle the description of your present pain.

AT BEST	AT WORST	THERE WAS...
0	0	...no pain
1	1	...mild pain which you are aware of but not bothered by
2	2	...moderate pain that you can tolerate without medication
3	3	...moderate pain that is intolerable, requires medication
4	4	...more severe pain
5	5	...intensely severe pain

How many work days have you missed this year because of back pain? _____ Was your injury work related? ☐ Yes ☐ No

What was the mechanism of injury? ☐ lifting ☐ falling ☐ sudden movement ☐ twisting ☐ repetitive activity ☐ unusual activity ☐ motor vehicle accident ☐ other (please describe) _____

Were you carrying any weight? ☐ Yes ☐ No. If yes, approximately how many pounds? _____

Was the onset of symptoms? ☐ sudden ☐ gradual
Have the symptoms changed since the onset? ☐ better ☐ worse ☐ no change

Were there any predisposing activities or conditions? ☐ frequent heavy lifting ☐ sustained posture ☐ prolonged activity ☐ sickness/infection ☐ overtired ☐ pregnancy ☐ other (please describe)

Have you had to change jobs due to your injury? ☐ Yes ☐ No. If yes, please state old job and present job. _____

_____

General

☐ Right Handed? ☐ Left Handed? Wear Glasses? ☐ Yes ☐ No. If yes, when _____

Have you had any major surgery in the last two years? ☐ Yes ☐ No. If yes, please specify _____

Do you presently take any medications or other drugs? ☐ Yes ☐ No. If yes, please specify _____

Any allergies (please list) _____

Other conditions or factors pertinent to your treatment (please list) _____

Family illnesses _____

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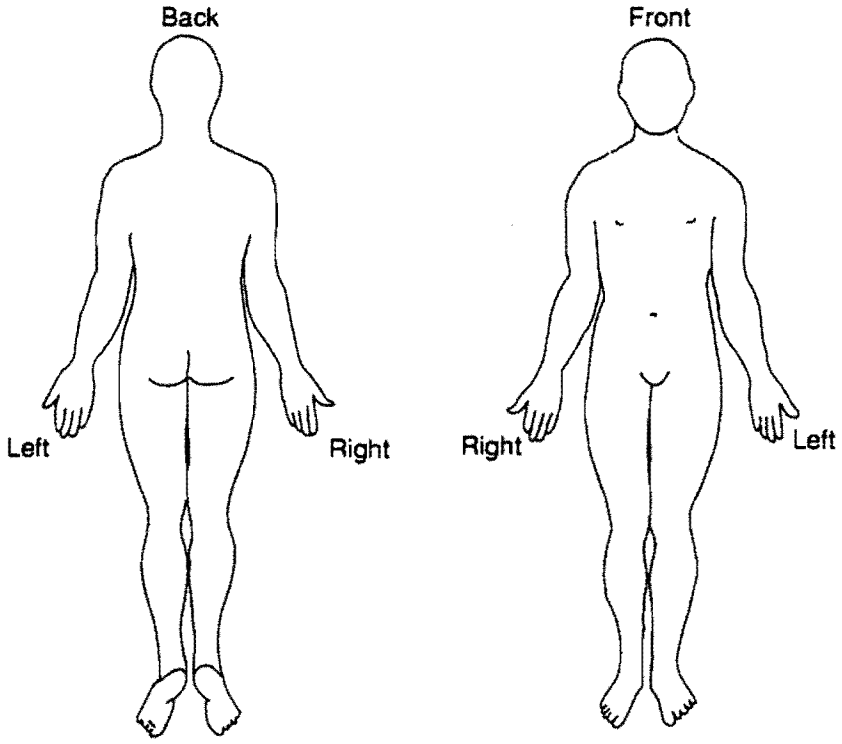
Date: _____ Name: _____

Pain Drawing

Draw location of your pain on body outlines and mark how bad it is on pain line at bottom of page.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
MMM	= = = =	0000	•••••••••	///////	XXXXX
M	= = = = =	00	••••	////	XXX



No Pain ——— **Worst Possible Pain**

1) Have you ever had cancer?
2) Does your pain ever wake you from a sound sleep?
3) Are you losing weight now without trying?
4) Are you coughing up blood or noticing it in your stool or urine?
5) Have you had any loss of bladder or bowel control?
6) Have you lost consciousness or had double vision recently?
7) Are you seeing any other doctor now for any reason?
8) Do you have any other symptoms or health problems?
9) Is there any chance that you are pregnant now?
10) Do you take any nutritional supplements. If so list them here:

_____ _____ _____ _____

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Patient Information and Health Appraisal

Date_____

Name_____

Address_____

City, State, Zip_____

Phone H_____

W_____

Cell_____

E-Mail_____

DOB_____

Last xray taken_____

Work Related_____

DOI_____

Reported to Employer_____

Employer Name_____

Workers Comp Carrier_____

_____

Auto Accident_____

DOA_____

Reported to your car insurance co?_____

Billable insurance company name_____

_____

Phone # _____

Referred by_____

Ins. Company_____

_____

Phone #_____

Policy #_____

Group #_____

Policy Holder_____

Place of Employment_____

_____

Coverage:

Chiro____Xray____NMR____Combi____

Deductible_____ Ded met_____

Co-pay amount $_____

Limitation/Maximums_____

Effective date_____

Mail Claims

_____

_____

_____

Info given by_____

Claim #_____