Whom may we thank for referring you to this office? _____ E_____ RM#_____ Code:_____

Cornerstone Chiropractic Health Profile

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone:_____

Social Security #: _____ Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Emergency Contact: Name: _____ Phone: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

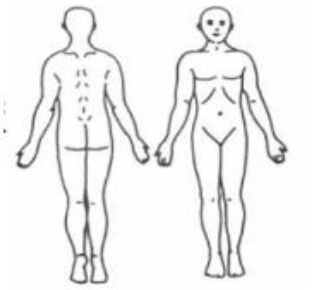
Pain Scale for Primary Complaint (Please rate your pain on a scale of 1-10 with 1 being almost no pain and 10 being the worst pain): Pain Now____ Pain at Best ____ Pain at Worst ____ Average Pain ____

When did the problem(s) begin? _____ How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? □No □ Yes **If yes,** when: _____ by whom? _____

What were the results? _____ Name of Previous Chiropractor: _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Is your problem the result of ANY type of accident? □ Yes, □ No

*Identify any other i**njury(s)** to your **spine**, <u>minor or major, or surgeries</u> that the doctor should know about:

_____

_____

*Have you had any recent (within the past year): <u>X-rays</u> □ Yes □ No **AND/OR** <u>MRI</u> □ Yes □ No
If yes, When: _____ Facility/Dr.: _____

*List any prescription and non prescription medications you take:

_____

PAST HISTORY

<u>Please mark **P** for in the **Past, C** for **Currently** have, or **N** for **Never**</u>

___ Headache ___ Dizziness/Loss of balance ___Neck Pain ___ Jaw Pain, TMJ ___ Shoulder Pain ___Upper Back Pain

___ Mid Back Pain ___Low Back Pain ___ Foot/Knee Problems ___ Hip Pain ___ Scoliosis ___ Pain w/Cough/Sneeze

___ Allergies/Sinus Problems ___ Blurred Vision ___Numb/Tingling arms, hands, fingers ____ Numb/Tingling legs, feet, toes

___ Asthma ____Double Vision ___ Digestive Problems ___ High Blood Pressure ___ Prostate Problems

___Hormone/Menstrual Problems ___Dislocations ___ Tumors ___Arthritis ___ Fracture ___ Broken Bone ___Disability

___ Heart Attack ___ Diabetes ___Cancer ___Cerebral Vascular ___ Other serious conditions: _____

FAMILY HISTORY:

Has any member of your family experienced cancer, heart disease, stroke, high blood pressure, or any other serious medical conditions? ☐ No ☐ Yes: _____

ACTIVITIES OF DAILY LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Carry/Lift	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sit to Stand	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Static Standing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Climb Stairs	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Read/Concentrate	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Getting Dressed	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Washing/Bathing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sleep	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Walking	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Driving	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Other: _____	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform

PRIMARY RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL:	USUAL ACTIVITY LEVEL:
_____	_____	_____

QUALITY OF LIFE SURVEY

How have you taken care of your health in the past? Circle those that apply:

Medications Emergency Room Routine Medical Exercise Nutrition/Diet Holistic Care

Vitamins Chiropractic Other (Please Specify):_____

How have others been affected by your health condition?

No one is affected Haven't noticed any problem They tell me to do something People avoid me

Are there health conditions you are afraid this might turn into?

Family Health Problems Heart Disease Cancer Diabetes Arthritis Fibromyalgia

Depression Chronic Fatigue Need Surgery

How has your health condition affected your job, relationships, finances, family, or other activities?

Please give examples:_____

_____

Patient Name: _____ Date:_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Please give 3 examples:_____

What are you most concerned with regarding your problem?_____

_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific._____

What would be different/better without this problem? Please be specific.

_____

What do you desire most to get from working with us?_____

_____

What would that mean to you?_____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, X Rays and Therapeutic Procedures: I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. I have conveyed my understanding of the risks associated with exposure to x-rays.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Cornerstone Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

I hereby authorize payment to be made directly to Cornerstone Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Cornerstone Chiropractic for any and all services I receive at this office.

FEMALES ONLY THIS PORTION: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

The first day of my last menstrual cycle was on ____-____-____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

REGARDING: X-rays/Imaging Studies

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**