

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?** _____

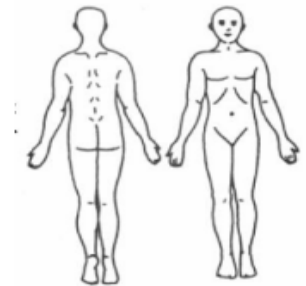
What were the results? _____ Name of Previous Chiropractor: _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

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 **injury(s)** to your **spine, minor or major, or surgeries** that the doctor should know about:

*Have you had any recent (within the past year): **X-rays** Yes No **AND/OR MRI** Yes No

If yes, When: _____ Facility/Dr.: _____

*List any prescription and non prescription medications you take:

PAST HISTORY

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

___ 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	___ Disability	___ Heart Attack	___ Diabetes	___ Cancer
___ Cerebral Vascular	___ Broken Bone	___ 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.) 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.

REGARDING: X-rays/Imaging Studies

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.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

Patient Name _____

Date _____