

# PATIENT INFORMATION

## PATIENT NAME

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Gender: M F Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Apt# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## SPOUSE OR GUARDIAN

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone# \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_

## EMERGENCY

Name and address of nearest relative or friend not living with you.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone# \_\_\_\_\_

Relation to Patient \_\_\_\_\_

## PAYMENT METHOD

For all services that are not paid by a third party.

Cash  Check  Visa  Mastercard  Discover  American Express

*If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.*

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## MY CERTIFICATION

I certify that the above information is correct and I request services.

x \_\_\_\_\_  
Signature of patient or person acting on patient's behalf \_\_\_\_\_ Date \_\_\_\_\_

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## MY PRIVACY

I have received a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

x \_\_\_\_\_  
Signature of patient or person acting on patient's behalf \_\_\_\_\_ Date \_\_\_\_\_



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### Family Health History

Many Health Problems are hereditary in nature and may be handed down generation after generation. Please review the below- listed diseases and conditions, and indicate those that are current health problems of a family member or yourself. Leave blank those spaces that do not apply. If you require more space use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate. Thank you.

Condition	Self Age( )	Mother Age( )	Father Age( )	Brother(s) Age( )Age( )	Sister(s) Age( )Age( )	Children Age( ) Age( ) Age( )
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Stroke						
TIA						
Ulcer						
High Cholesterol						
Lupus						
Rheumatoid Arthritis						
Other:						

If any of the above family members are deceased, please list their age at death and cause: \_\_\_\_\_

\_\_\_\_\_

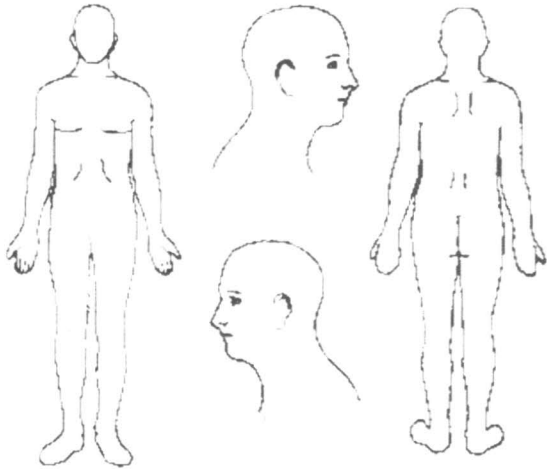
\_\_\_\_\_

Date of Visit: \_\_\_ / \_\_\_ / \_\_\_ Patient: \_\_\_\_\_ Age: \_\_\_\_\_

What brought you here today? \_\_\_\_\_

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE  
 B = BURNING  
 S = STABBING  
 N = NUMBNESS  
 P = PINS & NEEDLES



**PAIN SCALE**

Please circle the number that best describes your pain

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

Describe your past health history:

Prior Illness: \_\_\_\_\_

Past Hospitalizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Patient Signature: X \_\_\_\_\_

(DO NOT WRITE BELOW THIS LINE)

**INITIAL EVALUATION & MANAGEMENT**

**Range of Motion**

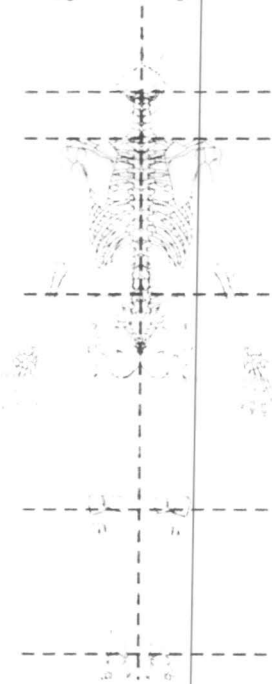
Cervical	Normal	Pain
Flexion	50	
Extension	60	
Left Lat Flex	45	
Right Lat Flex	45	
Left Rotation	80	
Right Rotation	80	
Lumbar	Normal	Pain
Flexion	60	
Extension	25	
Left Lat Flex	25	
Right Lat Flex	25	
Left Rotation	30	
Right Rotation	30	

**Health HX Notes:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Asymmetry**

- C0
- C1
- C2
- C3
- C4
- C5
- C6
- C7
- L1
- L2
- L3
- L4
- L5
- SAC
- L-IL
- R-IL



Using arrows (↕) mark postural asymmetry

Using arrows (↕) mark the misaligned vertebrae

- T1
- T2
- T3
- T4
- T5
- T6
- T7
- T8
- T9
- T10
- T11
- T12

**Tissue**



Mark tissue abnormalities  
 TP, LG, TN, SK, FS

*TP - Trigger Points, LG - Ligaments (swollen or tender), TN - Tendons, SK - Skin, FS - Fascial Restrictions.*

**HISTORY OF PRESENT COMPLAINT**

Complaint: \_\_\_\_\_  
 Qual & Chara: \_\_\_\_\_  
 On, Dur, Intens, Freq, Loc, Rad: \_\_\_\_\_  
 \_\_\_\_\_  
 Better or worse: \_\_\_\_\_  
 \_\_\_\_\_  
 Prior TX, meds, other: \_\_\_\_\_  
 \_\_\_\_\_

**EXAMINATION**

<b>Reflexes</b> (Wexler Scale)  Biceps _____ Triceps _____ Brac/rad _____ Patella _____ Achilles _____	B/P: ____/____ PULSE: _____ RESP: _____ HT: _____ WT: _____ GRIP: (R) ____ (L) ____	Notes: _____ _____ _____ _____
	Sensory: C5: _____ C6: _____ C7: _____ C8: _____ T1: _____ L3: _____ L4: _____ L5: _____ S1: _____ D= Deficit N= Normal (R) or (L)	
	General Orth/Neuro Examination: Spinous Percus: _____ Valsalva: _____ Dejerine Triad: _____ Rhomberg: _____ (+) or (-), (R) or (L)	

Test	(+)	(-)	R	L	Indication
Distraction					nerve root compression
Jackson					nerve root compression
Max Cerv Rot Comp					nerve root compression
Cerv Comp					nerve root compression
Soto Hall					(cerv) (thor) vertebral trauma
Spurlings					nerve root irritation
Shoulder Depress					nerve root compression

	(+)	(-)	R	L	Indication
Bechterew					sciatic disk compression
Bevor's					abdominal muscle weakness
Minors Sign					radicular disk pain
Ely					upper lumbar lesion
Fajersztajn					intervertebral disk syndrome
Nachlas					upper lumbar lesion
Gluteal punch					spinal lesion
Goldthwaite					lumbar differentiation
Heel walk					5th lumbar motor deficit
Kemps					intervertebral disk rupture
Lasague					(muscle) (disk) (nerve) irritation
Braggards					lumbar antalgic spasm
Supported Adam's					lumbosacral differentiation

	(+)	(-)	R	L	Indication
Libman's					(low) (normal) (high) pain threshold
Burn's Bench					(hysteria) (malingering)
Hoover's					(hysterical paralysis) (malingering)

**MUSCLE TESTS**

Level	Muscle	Muscle Grade	
C5	Deltoids	L:	R:
C6	Biceps	L:	R:
	Wrist extensors	L:	R:
C7	Triceps	L:	R:
	Wrist flexors	L:	R:
	Finger extensors	L:	R:
C8	Finger flexors	L:	R:
T1	Finger abductors	L:	R:
L2-L3	Hip flexors	L:	R:
L4-L5	Hip extensors	L:	R:
L3-L4	Knee extensors	L:	R:
L5-S1	Knee flexors	L:	R:
L4-L5	Ankle extensors	L:	R:
S1-S2	Ankle flexors	L:	R:

**TREATMENT PLAN**

Initial TX on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Level of Care: (include duration and frequency of visits)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Specific Treatment Goals: \_\_\_\_\_  
 \_\_\_\_\_

Specific Objective Eval: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Doctor Signature: X \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_