



CORRECTIVE CARE HEALTH SURVEY

Today's Date: _____ How Did You Health About Our Office? _____

PATIENT INFORMATION

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

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

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

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Do you have Insurance you would like us to check: Yes No

Are You Married? Yes No Do You Have Children? Yes No Are They Currently Under Care Here? Yes No

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Reason For Today's Visit: New Injury Old Injury Chronic Pain Health Condition Wellness Care

Is your problem the result of ANY type of accident? Yes No Please Describe: _____

Are You In Pain? Yes No

Primary Complaint _____ Secondary _____ Third _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Which of the above is the worst? _____

How long have your experienced this problem? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

What do you think caused this? _____

What have you done for this in the past? _____

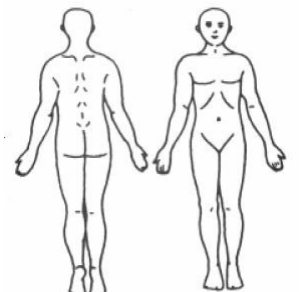
WOULD YOU LIKE TO GET RID OF THIS PROBLEM? YES NO

Are you looking for a temporary relief of the problem or long-term correction? _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

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? _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes, how many times?** _____ **When was the last episode?** _____ **How did the injury happen?** _____

Other forms of treatment tried: No Yes **If yes, please state what type of treatment:** _____, and who provided it: _____ **How long ago?** _____ **What were the results.** Favorable Unfavorable → please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

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

- | | | | | |
|--|----------------------------|----------------------|------------------------------|--------------------------|
| ___ Headache | ___ Pregnant (Now) | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/Sexual Dysfun. | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Convulsions/Epilepsy | ___ Fainting | ___ Digestive Problems | ___ Heart Problem |
| ___ Shoulder Pain | ___ Tremors | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Chest Pain | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Pain w/Cough/Sneeze | ___ Ringing in Ears | ___ Menopausal Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot or Knee Problems | ___ Hearing Loss | ___ Menstrual Problem | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage Problem | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disability | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble | |
| ___ Numb/Tingling legs, feet, toes | ___ Allergies | ___ Trouble Sleeping | ___ Hepatitis (A,B,C) | |

I hereby authorize payment to be made directly to New Life 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 New Life Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

_____-_____-_____
Date Completed

Doctor's Signature

_____-_____-_____
Date Form Reviewed

PATIENT'S NAME: _____ Date: _____

FAMILY HEALTH HISTORY

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	Father Age____	Mother Age____	Spouse Age____	Brother(s) Age____ Age____		Sister(s) Age____ Age____		Children Age____ Age____ Age____		
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										
Other:										

PATIENT'S NAME: _____ Date: _____

ACTIVITIES OF LIFE

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

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

PATIENT'S NAME: _____ Date: _____