GREATER ROCHESTER CHIROPRACTIC

BRIGHTON
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Joshua T. Keeler, DC
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WEBSTER
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CONFIDENTIAL PATIENT INFORMATION

Patient's Name:_____ Today's Date:_____

Gender: ☐M ☐F Date of Birth:____ / ____ / ____ Age:____ Social Security #:_____

Address:_____ City:_____ State:_____ ZIP:_____

Phone: (H):_____ (W):_____ (C):_____

E-mail Address:_____ (For appointment reminders)

Emergency Contact:_____ Phone:_____ Relationship:_____

Marital Status: ☐single ☐living with partner ☐married ☐widowed ☐separated ☐divorced

Spouse's / Partner's Name:_____ # of Children:_____

Primary Care Physician:_____

Whom May We Thank For Referring You To Our Practice?:_____

HEALTH HISTORY

Main condition/symptom:_____

Other conditions/symptoms:_____

How long have you had these conditions/symptoms?:_____

Height: ____feet ____inches Weight: _____lbs. Last known Blood Pressure: ____ /____

Hypertension: ☐Yes ☐No Diabetes: ☐Yes* ☐No *If yes: ☐Type I ☐Type II

Surgeries:_____ Approx. dates:_____

Hospitalizations:_____ Approx. dates:_____

Major Illnesses:_____ Approx. dates:_____

Are you currently taking any medications? ***(Include regularly used over-the-counter medications)*** ☐**No**

Medication Name	Dosage and Frequency (i.e. 5 mg once per day, etc.)

Family Medical History

Family Member	Diagnosis / Details

Please complete and sign the back ⟶

SOCIAL HISTORY

Smoking	Caffeine	Recreational Drug Use	Alcohol
☐ never	☐ never	☐ none	☐ never
☐ former	☐ less than 3 per day	☐ recreational	☐ 1-3 per week
☐ every day	☐ 3-6 per day	☐ addiction	☐ 4-6 per week
☐ occasionally	☐ more than 3-6 per day	☐ in recovery	☐ more than 6 per week

Occupation:_____ or ☐unemployed ☐in school ☐retired

Employer:_____

Have you been bothered by any of the following problems?

1) During the past month, have you felt down, depressed or hopeless? ☐Yes ☐No

2) During the past month, have you felt little interest or pleasure in doing things? ☐Yes ☐No

CURRENT COMPLAINTS

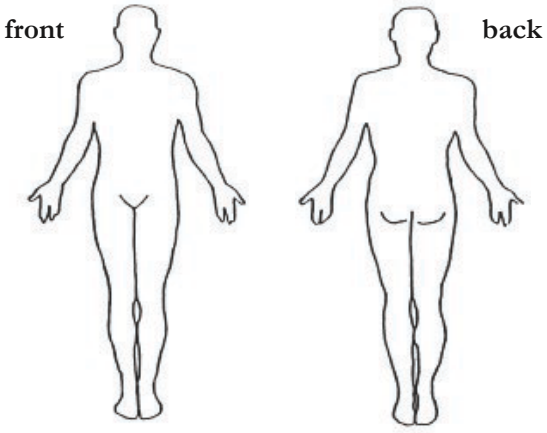
Using the symbols below, please indicate the location of your discomfort on the body diagram.

SHARP/STABBING † † † †

DULL/ACHEY V V V V

PINS/NEEDLES 0 0 0 0

NUMBNESS \ \ \ \



Please circle your pain level.

(no pain) **0 1 2 3 4 5 6 7 8 9 10** (severe pain)

Do you have pain every day? ☐Yes ☐No Does your pain wake you at night? ☐Yes ☐No

What increases your pain?:_____

What decreases your pain?:_____

Are your symptoms: ☐Worsening ☐Unchanged ☐Improving

Have you had previous chiropractic care?: ☐Yes ☐No

Have you seen other doctors for this condition? If so, who?:_____

Do you perform neck/back exercises?: ☐Yes ☐No Date of last physical exam:_____

Date of last spinal X-RAYs/MRIs:_____ Date of last bloodwork:_____

Patient Signature:_____ **Date:**_____

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FUNCTIONAL RATING INDEX

Name _____ Date _____

Please indicate area of discomfort:

❑ Neck ❑ Low back ❑ Mid-back ❑ Other _____

1. Pain Intensity

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% assistance

4. Travel (driving, etc.)

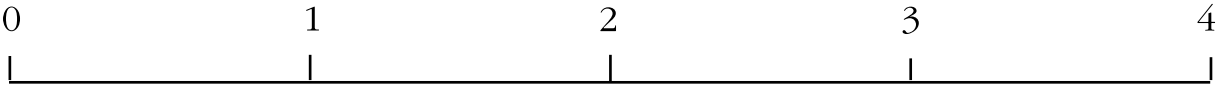
0	1	2	3	4
No Pain on long trips	Mild Pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work

0	1	2	3	4
Can do usual work + unlimited extra work	Can do usual work + no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

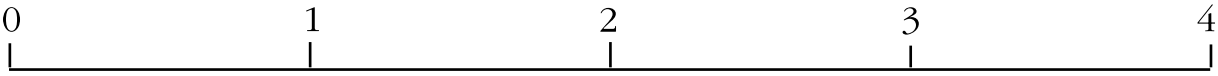
Please complete and sign the back ⟶

6. Recreation



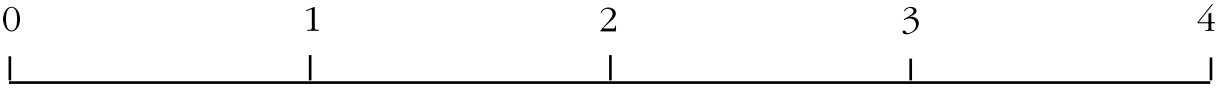
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Can not do any activities

7. Frequency of Pain



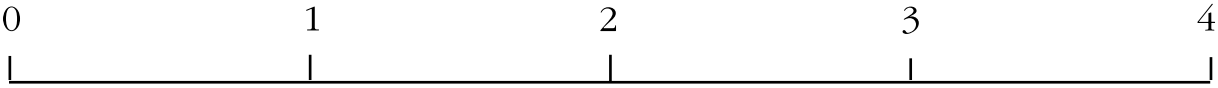
No Pain	Occasional pain; 25% of the day	Intermittent pain 50% of the day	Frequent pain; 75% of the day	Constant pain 100% of the day

8. Lifting



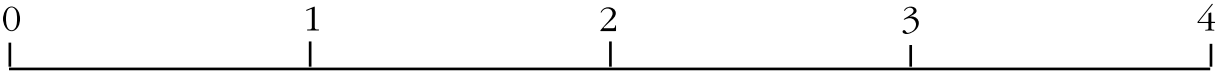
No Pain w/ heavy weight	Increased Pain w/ heavy weight	Increased Pain w/ moderate weight	Increased Pain w/ light weight	Increased Pain w/ any weight

9. Walking



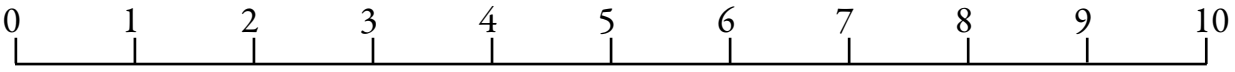
No Pain any distance	Increased Pain after 1 mile	Increased Pain after 1/2 mile	Increased Pain after 1/4 mile	Increased Pain with all walking

10. Standing



No Pain after several hours	Increased Pain after several hours	Increased Pain after one hour	Increased Pain after 1/2 hour	Increased Pain with any standing

VAS: Rate your pain for today



No Pain	Worst Pain in my life

Patient Signature _____ **Date** _____

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CONSENT TO TREAT A MINOR

(Required for patients under 18 years of age)

Name of Minor: _____ Date of Birth: _____ / _____ / _____

As the parent/legal guardian of the minor mentioned below I hereby give _____ DC, permission to administer examinations and chiropractic care as deemed necessary within the scope of practice of Chiropractic in the state of New York.

Name of Parent/ Legal Guardian:_____

Signature of Parent/Legal Guardian:_____

Date:_____

Witness (*office staff*):_____