

# GREATER ROCHESTER CHIROPRACTIC

**BRIGHTON**  
Leslie W. Lange, DC  
Joshua T. Keeler, DC  
E. Daniel Quatro, DC  
Jason T. Swinton, DC  
Megan A. Tuzzo, DC

30 Allens Creek Rd.  
Rochester, NY 14618  
(585) 442-3220 TEL  
(585) 442-1017 FAX

**WEBSTER**  
Amy E. Kochersberger, DC

488 Plank Rd.  
Webster, NY 14580  
(585) 787-1310 TEL  
(585) 787-1957 FAX

## 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

- never  
 former  
 every day  
 occasionally

### Caffeine

- never  
 less than 3 per day  
 3-6 per day  
 more than 3-6 per day

### Recreational Drug Use

- none  
 recreational  
 addiction  
 in recovery

### Alcohol

- never  
 1-3 per week  
 4-6 per week  
 more than 6 per week

Occupation: \_\_\_\_\_ or  full-time parent  unemployed  in school  retired

Employer: \_\_\_\_\_

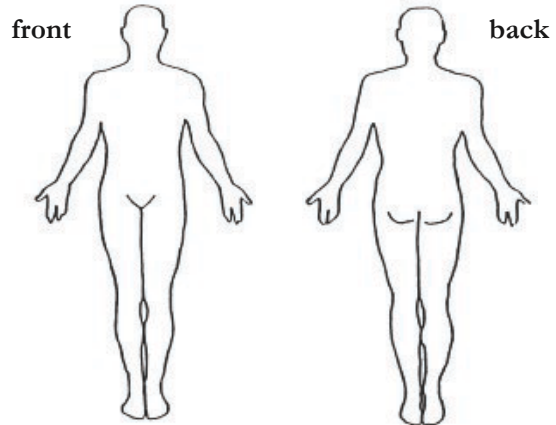
Have you been bothered by any of the following problems?

- 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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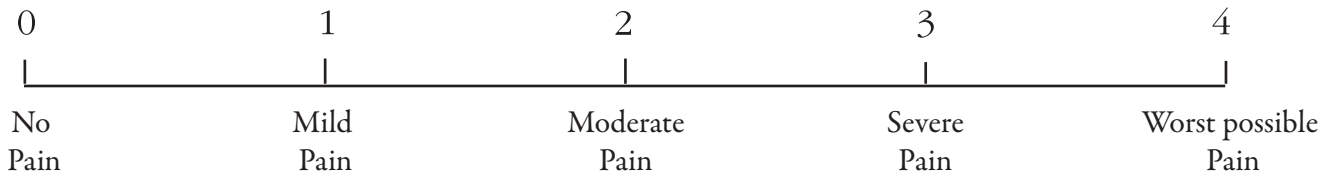
## FUNCTIONAL RATING INDEX

Name \_\_\_\_\_ Date \_\_\_\_\_

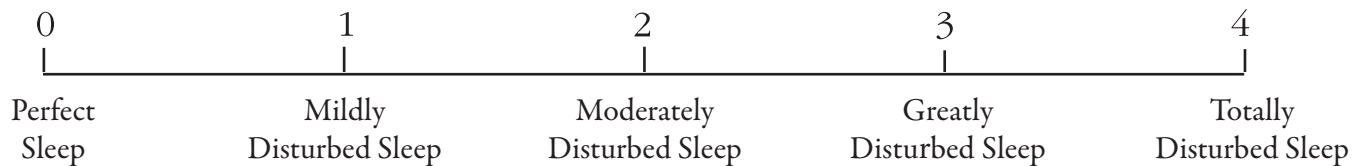
**Please indicate area of discomfort:**

Neck       Low back       Mid-back       Other \_\_\_\_\_

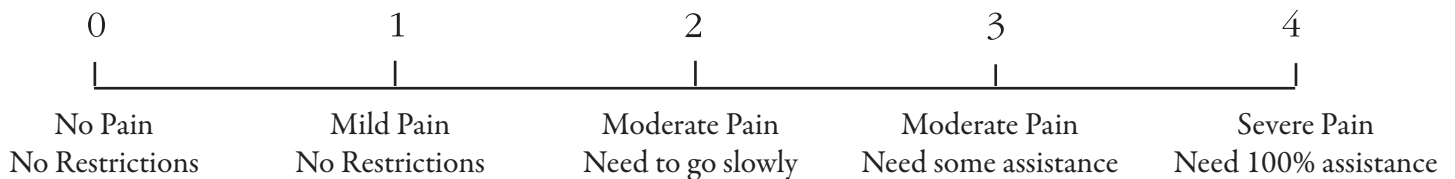
### 1. Pain Intensity



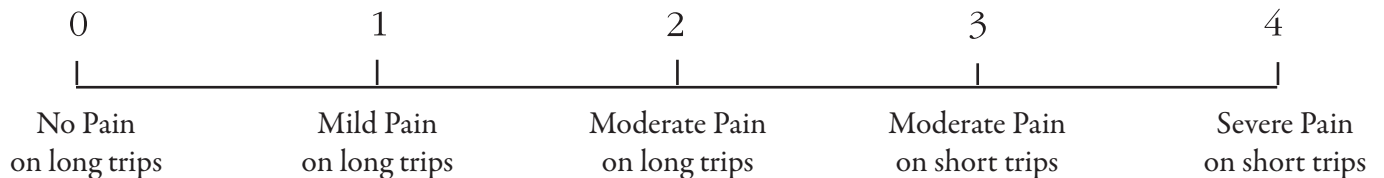
### 2. Sleeping



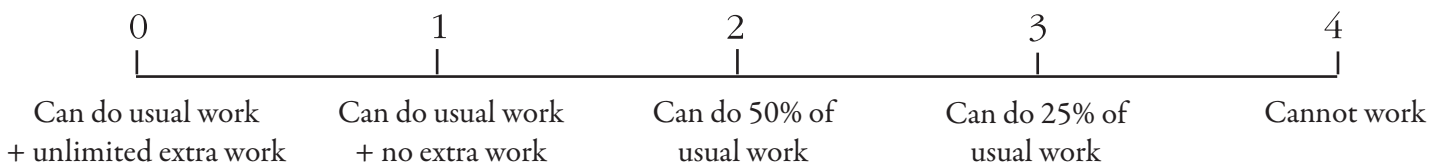
### 3. Personal Care (washing, dressing, etc.)



### 4. Travel (driving, etc.)

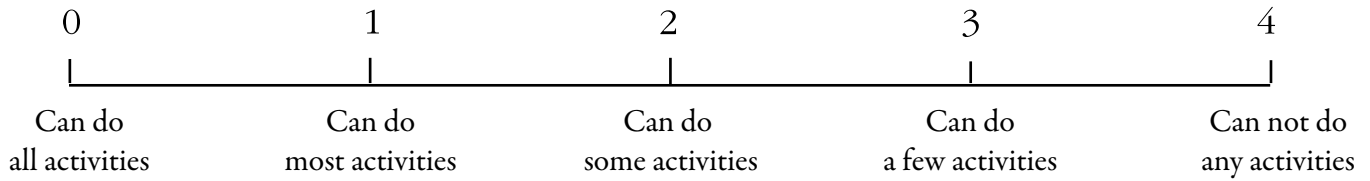


### 5. Work

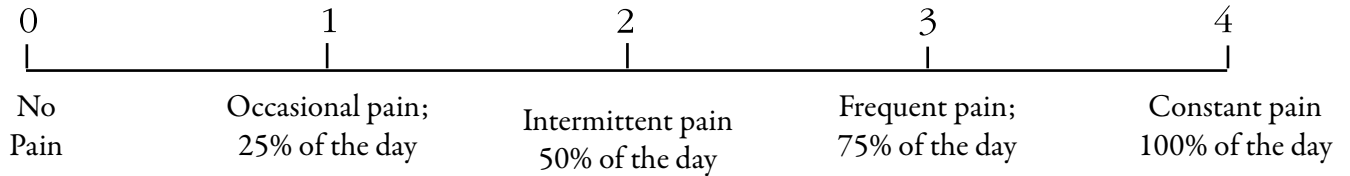


**Please complete and sign the back** →

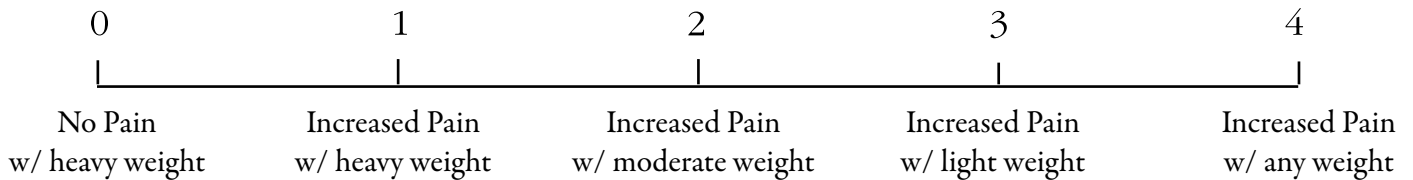
6. Recreation



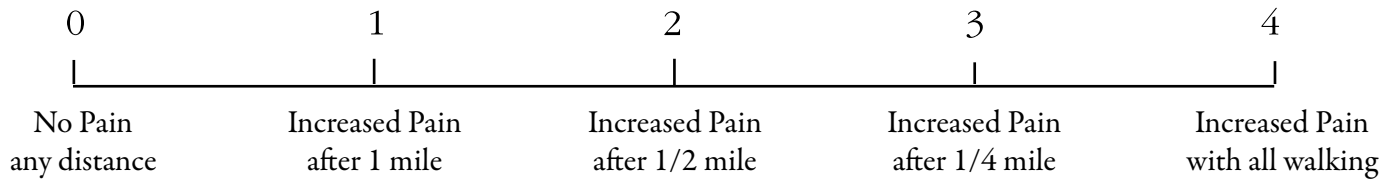
7. Frequency of Pain



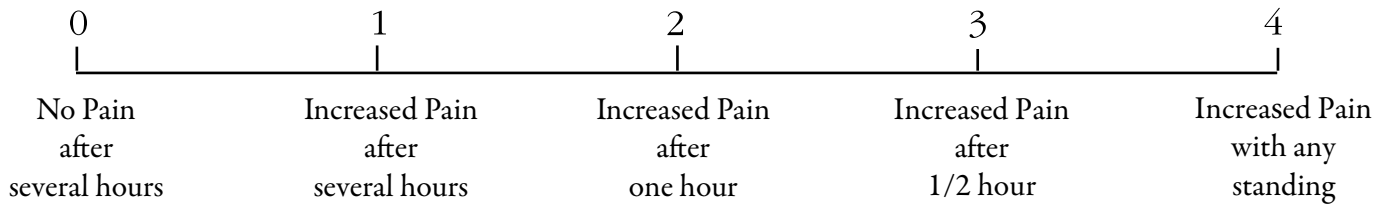
8. Lifting



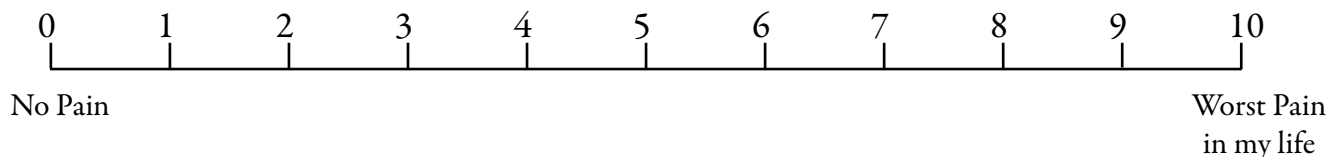
9. Walking



10. Standing



VAS: Rate your pain for today



Patient Signature \_\_\_\_\_ Date \_\_\_\_\_