GREATER ROCHESTER
CHIROPRACTIC
Collaborative Spine Care

30 ALLENS CREEK RD, ROCHESTER, NY 14618
WWW.GRCHEALTH.COM
(585) 442-3220

Patient Information

Name:			Date	
Address/City/State/ZIP:				
Date of Birth:	Age:	Gender: M F	Social Security #:	
Cell Phone:	Home:		Work:	
Email (for appointment reminders):				
Emergency Contact:	Phone:		Relationship:	
Marital Status: ___Single	___Living with partner	___Married	___Widowed	___Separated ___Divorced
Spouse/Partner Name:			# of Children:	
Primary Care Physician:			Phone:	
Whom may we thank for referring you to our practice?:				

Health History

Main condition/symptom: _____

Other condition/symptoms: _____

How long have you had these symptoms? _____

Height: ____ ft ____ in 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: _____

Allergies: ___Cortisone ___ Latex Other: _____

Food Allergies: _____

Medication Allergies: _____

Medication List (include regularly used over-the-counter medications.)

Medication Name	Dosage and Frequency

Family Medical History

Family Member	Diagnoses/Details

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Social History

Smoking	Caffeine	Recreational Drug Use	Alcohol
__ never	__ never	__ never	__ never
__ former	__ fewer 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 ___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

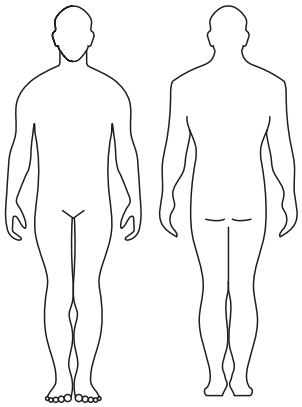
Using the symbols below, please indicate the location of your discomfort on the body diagram.

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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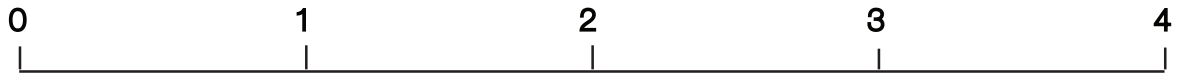
Functional Rating Index

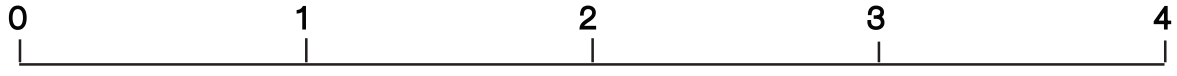
Patient's Name:	Today's Date:
Please indicate area of discomfort: Neck Low Back Mid Back Other:	

1. Pain Intensity



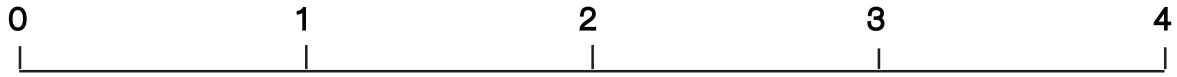
0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping



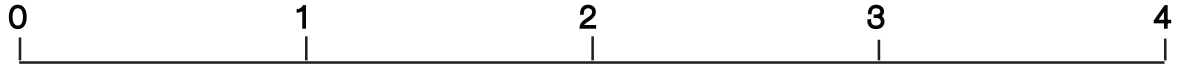
0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

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



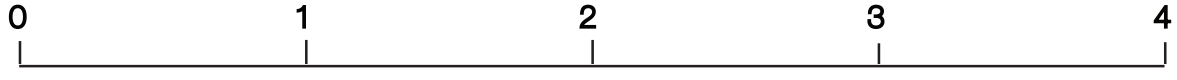
0	1	2	3	4
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% assistance

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

Functional Rating Index continued

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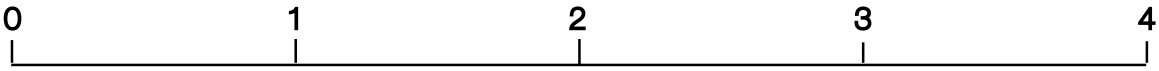
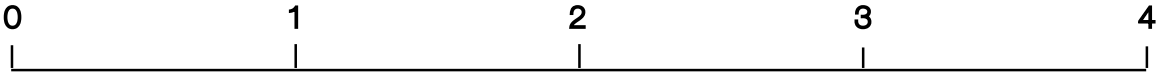
6. Recreation



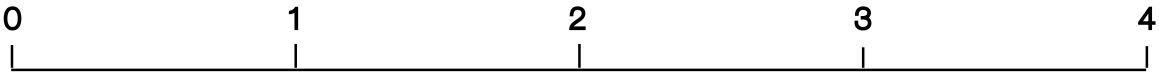
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Can not do any activities

7. Frequency of Pain



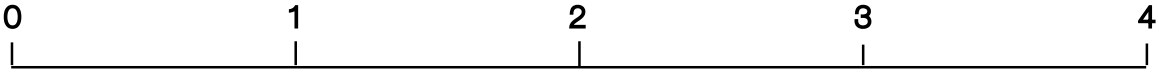
0	1	2	3	4
No Pain	Occasional pain; 25% of the day	Intermittent pain 50% of the day	Frequent pain; 75% of the day	Constant pain 100% of the day

8. Lifting



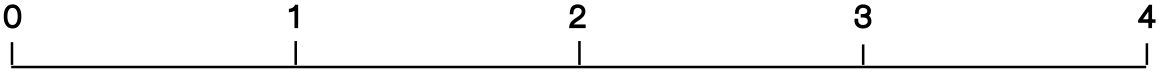
0	1	2	3	4
No Pain w/ heavy weight	Increased Pain w/ heavy weight	Increased Pain w/ moderate weight	Increased Pain w/ light weight	Increased Pain w/ any weight

9. Walking



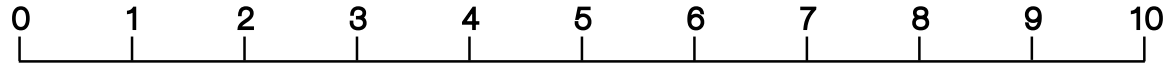
0	1	2	3	4
No Pain any distance	Increased Pain after 1 mile	Increased Pain after 1/2 mile	Increased Pain after 1/4 mile	Increased Pain with all walking

10. Standing



0	1	2	3	4
No Pain after several hours	Increased Pain after several hours	Increased Pain after one hour	Increased Pain after 1/2 hour	Increaed Pain with any standing

VAS: Rate your pain for today



0	10
No Pain	Worst Pain in my life

Patient Signature _____ Date _____