Enright Chiropractic, LLC

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Patient Health Assessment

General Information

Patient Name:_____ Date:_____
Patient Address:_____
Patient Sex: M___F___ Date of Birth:_____ Social Security #:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
E-mail address:_____
Patient Employer:_____ Patient Occupation:_____
Subscriber Name:_____ Relation to Patient:_____
Subscriber Employer:_____ Subscriber Social Security #:_____
Referred for Treatment by:_____
Primary Medical Doctor:_____
Health Insurance Plan:_____ Group #:_____ Member #:_____

Complaint History

1. Describe your current complaint in detail and how the problem began:_____

_____

How long have you had this condition?_____ Date of Onset:_____

2. How would you describe the pain?
   - ☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness
   - ☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

3. How would you rate the intensity of your pain when it is at its worst? *(Circle the appropriate number)*

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

4. How often is the pain present?

0 1 2 3 4 5 6 7 8 9 10
(never) *(frequent)* *(constant)*

5. Since your problem began is the pain?
   ☐ Getting worse ☐ Getting better ☐ Staying the same

6. How did your problem begin? Explain:_____
   ☐ Auto accident ☐ Work related accident ☐ Other type of accident
   ☐ Gradual ☐ Sudden ☐ No specific reason

7. What makes your problem better?
   ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying down ☐ Inactivity

8. What makes your problem worse?
   ☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Moving around/exercise ☐ Lying down ☐ Inactivity

9. Are you currently taking any medications? ☐ Yes ☐ No
   *If yes, please describe*_____

10. Were you previously treated for an earlier occurrence of this same condition? ☐ Yes ☐ No
    If yes, by whom? ☐ MD ☐ Chiropractor ☐ Physical therapist ☐ Other

11. What is your physical activity at work?
    ☐ Mostly sitting ☐ Light manual labor ☐ Moderate manual labor ☐ Heavy manual labor ☐ Retired

12. Do you exercise?
    ☐ No regular exercise ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5-7 times a week
    ☐ Cardiovascular ☐ Stretching ☐ Weight Machine ☐ Free Weights ☐ Sports_____ Type

13. What is your present general stress level:
    ☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?
    ☐ No effect ☐ Have some limited physical restrictions, but can function
    ☐ Need some assistance with daily activities ☐ Cannot work
    ☐ Cannot function without assistance ☐ Totally disabled

Patient Health Assessment (cont.)

Past or Present Symptoms, Conditions or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	☐	☐	High blood pressure	☐	☐
Shoulder pain	☐	☐	Heart condition	☐	☐
Arm/elbow pain	☐	☐	Respiratory condition	☐	☐
Hand pain	☐	☐	Digestive problems	☐	☐
Upper back pain	☐	☐	Kidney/bladder problem	☐	☐
Lower back pain	☐	☐	Menstrual problems	☐	☐
Pain in upper leg or hip	☐	☐	Breast soreness/lump	☐	☐
Pain in lower leg or knee	☐	☐	Sinus Conditions	☐	☐
Pain in ankle or foot	☐	☐	Allergies/asthma	☐	☐
Jaw pain	☐	☐	Cancer	☐	☐
Swelling/stiffness of joints	☐	☐	Stroke	☐	☐
Headaches	☐	☐	Excessive weight gain/loss	☐	☐
Dizziness	☐	☐	Skin condition	☐	☐
Fainting spells	☐	☐	Arthritis	☐	☐
Convulsions	☐	☐	Diabetes	☐	☐
General prolonged fatigue	☐	☐	Prostate condition	☐	☐
Condition of uterus/ovaries	☐	☐			

Tobacco Use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Alcohol use:
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

Caffeine use: *(Coffee, tea, soft drinks)*
☐ Past ☐ Present
☐ Occasional ☐ Moderate ☐ Heavy

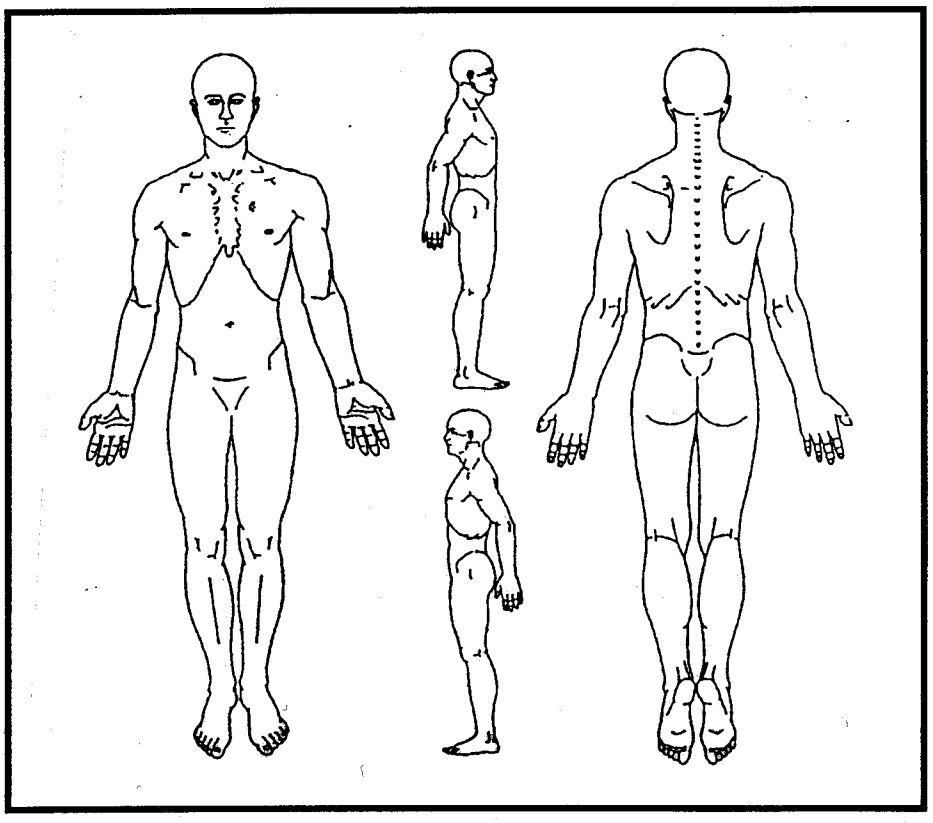
Pregnancy: ☐ Past ☐ Present

Surgical Procedure:
☐ Past ☐ Present

Please list:_____
_____

Comments:_____
_____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date