

Date: _____

First Name: _____ Last Name: _____ Initial: _____

Major Complaint Information

What is your major complaint(s)? _____

When did your symptom(s) begin? _____

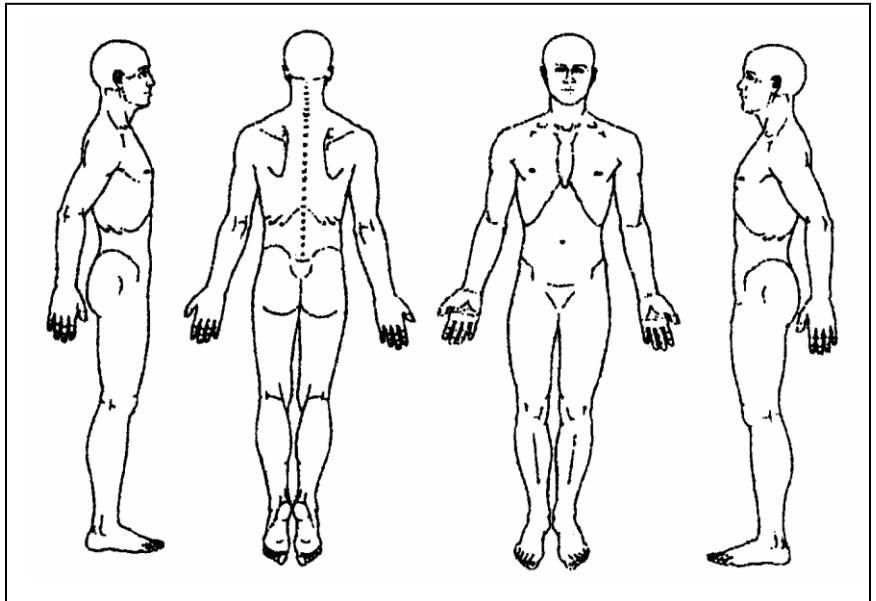
If this is an injury, describe what happened: _____

Using the symbols in the Pain Index box, mark the areas on the illustrations below where you feel pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe.)

Pain Index

S= Sharp, Stabbing Pain
 D= Dull, Nagging Ache
 B=Burning
 N= Numbness, Tingling

For example: If you are experiencing moderately severe burning pain in the back of your neck, you should note "B8" on the neck of the illustration. For any radiating pain draw an arrow from the description of your pain to where the radiation travels.



Have you experienced these symptoms before? Yes No When? _____

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Have you seen another doctor for this condition? Yes No Doctor's name: _____

Date Consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? Yes No If so, how many times do you wake up in pain per night? _____

In what position do you sleep? Back Side Stomach

Do you sleep with a pillow? Yes No How many? _____

Does heat affect the pain? Yes No If so, how? _____

Does cold affect the pain? Yes No If so, how? _____

Do you wear a heel lift? Yes No If so, which side? Right Left

Does it cause pain to cough, grunt or sneeze? Yes No If so, where? _____

Check those activities below during which you experience difficulty or pain

- Lying on back
- Lying on side
- Turning over in bed
- Lying flat on stomach
- Getting in/out of car
- Dressing self
- Sexual Activity
- Pushing
- Pulling
- Reaching
- Kneeling
- Stooping
- Sitting
- Bending forward
- Bending backward
- Walking
- Standing for long periods
- Sneezing
- Coughing
- Other _____

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Lower Back Pain

- Does pain radiate into the leg? Yes No Where: _____ Does pain radiate to the abdomen? Yes No
- Do you ever have impairment of bowel or urinary function? Yes No Explain: _____
- Do you have numbness or tingling into the legs? Yes No Explain: _____
- Do you ever experience night sweats? Yes No
- Do you have a history of corticosteroid/SAID injections? Yes No Where? _____
- Have you noticed any unexplained weight loss? Yes No

Neck Pain

- If you have a neck injury, does it affect: (check all that apply) Hearing Vision Balance Cause ringing in ears
- Do you hear grating sounds when moving head? Yes No Do you feel pressure behind your eyes? Yes No
- Does pain radiate into the arm? Yes No Where: _____
- Do you have difficulty lifting or turning your head: Yes No If so, in which direction: Right Left Up Down
- Do you experience dizziness when turning your head? Yes No

Headaches

- Do you get headaches? Yes No If yes, how often? _____
- Where is the location of your headache? _____
- Do you experience the following along with your headaches: Pain or cracking in your jaw? Yes No
- Do you have abnormal blood pressure? Yes No If yes, is it: High Low
- Do you experience nausea, vomiting, or visual disturbances? Yes No If yes, which: _____
- When was your last eye exam by a doctor? _____ Results: _____

If female, are you pregnant? Yes No Not sure If not sure, date of your last menstrual period: _____

List all medications you are taking now, including over-the-counter medication: _____

Are you allergic to any medications? Yes No Not sure Please list: _____

Have you ever had any surgeries or hospitalizations? Yes No Please list:

Type of Hospitalization/Surgery: _____ Date: _____ Type of Hospitalization/Surgery: _____ Date: _____

Have you been x-rayed in the last 12 months? Yes No When? _____

Have you ever been seen by a chiropractor before? Yes No Please list:
 Name of Chiropractor: _____ Date: _____ Name of Chiropractor _____ Date: _____

Do you have a family physician? Yes No Name of physician: _____ Phone: _____
 Address: _____
 City/State/Zip: _____

Additional Complaints

Please check all additional complaints that you have at this time:

- | | | | | |
|---|---|---|--|---|
| <input type="radio"/> Loss of concentration | <input type="radio"/> Neck stiffness | <input type="radio"/> Shortness of breath | <input type="radio"/> Cold hands | <input type="radio"/> Arthritis |
| <input type="radio"/> Eyes sensitive to light | <input type="radio"/> Neck motion restricted | <input type="radio"/> Irritable | <input type="radio"/> Cold feet | <input type="radio"/> HIV (Aids) |
| <input type="radio"/> Memory loss | <input type="radio"/> Upper-back pain/stiffness | <input type="radio"/> Anxiety | <input type="radio"/> Jaw pain | <input type="radio"/> Other (Please list) _____ |
| <input type="radio"/> Heavy feeling of head | <input type="radio"/> Mid-back pain/stiffness | <input type="radio"/> Depression | <input type="radio"/> Hypertension | _____ |
| <input type="radio"/> Dizziness | <input type="radio"/> Right/Left shoulder pain | <input type="radio"/> Insomnia | <input type="radio"/> Diabetes | _____ |
| <input type="radio"/> Ringing in ears | <input type="radio"/> Right/Left arm pain | <input type="radio"/> Fatigue | <input type="radio"/> Convulsions | |
| <input type="radio"/> Loss of balance | <input type="radio"/> Pins & needles arms/legs | <input type="radio"/> Excess perspiration | <input type="radio"/> Allergies (list) _____ | Please Specify Location |
| <input type="radio"/> Loss of smell | <input type="radio"/> Right/Left leg pain | <input type="radio"/> Digestive trouble | <input type="radio"/> Anemia | <input type="radio"/> Numbness _____ |
| <input type="radio"/> Loss of taste | <input type="radio"/> Right/Left wrist pain | <input type="radio"/> Nausea | <input type="radio"/> Heart disease | <input type="radio"/> Swelling _____ |
| <input type="radio"/> Pain behind eyes | <input type="radio"/> Right/Left ankle pain | <input type="radio"/> Vomiting | <input type="radio"/> Hepatitis | <input type="radio"/> Cuts _____ |
| <input type="radio"/> Vision problems | <input type="radio"/> Right/Left elbow pain | <input type="radio"/> Diarrhea | <input type="radio"/> Cancer (type) _____ | <input type="radio"/> Bruising _____ |
| <input type="radio"/> Fainting | <input type="radio"/> Right/Left knee pain | <input type="radio"/> Constipation | | |
| <input type="radio"/> Palpitation | <input type="radio"/> Joint swelling/stiffness | <input type="radio"/> Nervousness | <input type="radio"/> Asthma | |
| <input type="radio"/> Muscular incoordination | <input type="radio"/> Sinus trouble | <input type="radio"/> Painful urination | <input type="radio"/> Ulcer | <input type="radio"/> Smoking/tobacco use |
| <input type="radio"/> Stroke | <input type="radio"/> Chest pain | <input type="radio"/> High cholesterol | <input type="radio"/> Heart attack | <input type="radio"/> Alcohol/Drug addiction |

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If yes, please list: _____

Have you ever had: Motor Vehicle Injury Sports Injury Work Injury Slip and Fall Injury
 If yes, please explain: _____

FAMILY HISTORY: Are there any diseases/health issues in your immediate family? Yes No If yes, please describe:

Personal Information

Address: _____
 City / State / Zip: _____
 Home Phone: () _____ Work Phone: () _____
 Mobile Phone: () _____ Email: _____
 Social Security Number: _____ Birth Date: _____ Age: _____ Sex: M F
 Occupation: _____ Employers Name: _____
 Work Address: _____
 City / State/ Zip: _____
 Marital Status: Single Married Divorced Widowed Spouse's name: _____ # of Children ____
 Children's Names: _____

How were you referred to Oneka Chiropractic, P.A.? _____

In case of emergency contact: _____ Relationship: _____
 Home Phone: () _____ Work Phone: () _____

Insurance Information

Insurance Company: _____
Phone: () _____ Insured's Name: _____
Address: _____ Insured's ID #: _____
City / State/ Zip: _____ Group #: _____
Insured's Birth Date: _____ Insured's Employer: _____
Employer's Address: _____ City / State/ Zip: _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Injury: _____ Hour: _____ AM PM Location: _____

How did the accident occur? Motor Vehicle Accident On-the-job-injury Other: _____

Please describe the accident in detail: _____

If **work related**, did you report the injury to your foreman or employer? Yes No

If **work related**, name and phone number of foreman or authorized person: _____

If **auto accident**, were you: Driver Passenger Pedestrian

If **auto accident**, were you struck from: Behind Right side Left side Front Auto was parked

If **auto accident**, did your car strike the other(s) involved? Yes No

Or, did the other car strike yours? Yes No Undetermined Did the vehicles airbag's deploy? Yes No

Were you wearing a seat belt? Yes No

Did anybody strike any objects inside the car? Yes No If yes, describe what was struck: _____

_____ Lost work time: Yes No If yes, date returned to work: _____

Do you have an attorney who has advised you in this case? Yes No Attorney Name: _____

Attorney's address: _____

City / State / Zip: _____ Attorney's Phone: () _____

Authorization and Assignment

I authorize Oneka Chiropractic, P.A. to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.
I authorize the direct payment to Oneka Chiropractic, P.A. of any sum I now or hereafter owe Oneka Chiropractic, P.A. by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or Oneka Chiropractic, P.A. based in whole or in part upon the charges made for services rendered at this office. I understand whatever amounts Oneka Chiropractic, P.A. does not collect from insurance proceeds (whether it be all or part of what is due) I personally owe Oneka Chiropractic, P.A.
I, the undersigned, do hereby appoint Oneka Chiropractic, P.A. authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs Oneka Chiropractic, P.A. may incur to collect my bill.

Date: _____ Patient's Signature: _____