Active Health KC: Chiropractic & Rehab

Confidential Patient Information

3700 W. 83rd St. Ste. 217 Prairie Village, KS 66208 Phone: 913-341-1200 Fax: 913-341-1209 Website: www.activehealthKC.com

Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Date:_____/_____/_____

Patient's Full Name ______________________________

How Would You Like To Be Verbally Addressed?______________________________

Cell Phone: ____________________ Other Phone: ____________________ E-Mail: ______________________________

Sex:_________ Age:____________ Date of Birth:_____/____/______

Mailing Address:______________________________ City:______________ State:_______ Zip:____________

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children ____________________

Occupation:__________________ Hours/Week_______ Employer:________________ Business Phone________________

Education level: ☐ Highschool ☐ Some college ☐ College Graduate ☐ Post Graduate ☐ Other: ____________________

Spouse's Name:____________________________ Spouse's Daytime Phone: ______________________________

Emergency Contact:____________________________ Relationship:____________________ Phone: ________________

Family Physician: ___________________________ Clinic/Hospital: ______________________________

Date of your last physical examination:________________

Have you been treated for any other health condition by a physician in the last year: ☐ Yes ☐ No
If Yes, for what Problem: ______________________________

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: ______________________________

Doctor's Name ______________________________ City: ________________________ State: ______________

Current medications: If no current medications check here: ☐
1. ______________________ 2. ______________________ 3. ______________________ 4.______________________
5. ______________________ 6. ______________________ 7. ______________________ 8. ______________________

Current vitamins/herbs: If no current vitamins/herbs check here: ☐
1. ______________________ 2. ______________________ 3. ______________________ 4.______________________
5. ______________________ 6. ______________________ 7. ______________________ 8. ______________________

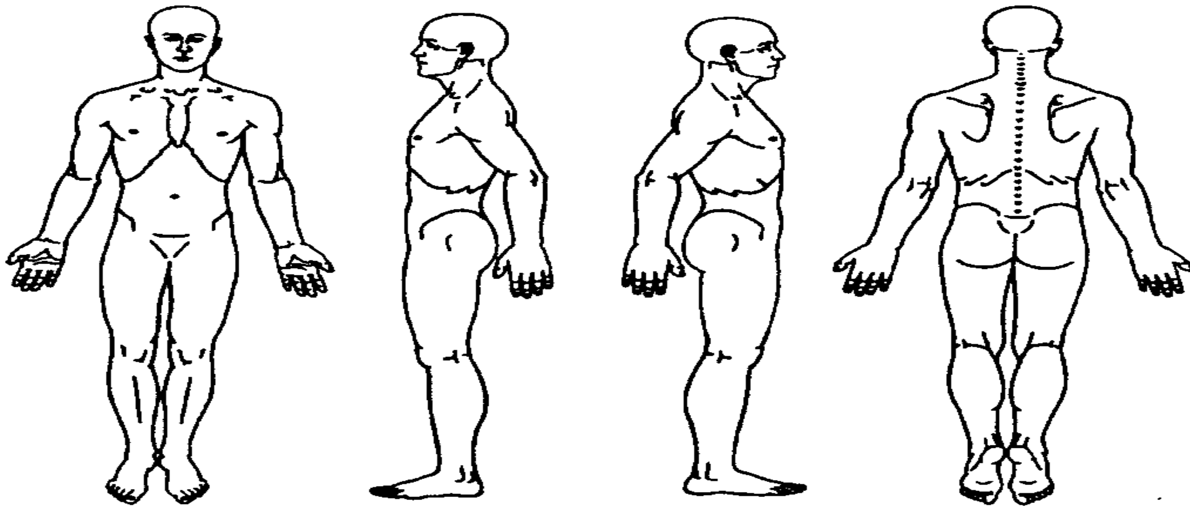
List any known allergies you have had to any medications. ____________________________
If no allergies are known, check here: ☐

Whom may we thank for referring you? :______________________________

Are you currently working with any personal trainers or coaches that we might need to coordinate with? ☐ Yes ☐ No

Please list:______________________________

Please Mark Area Of Pain For Chief Complaint On The Drawing



PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT**:

Primary symptom/problem for this visit:____

Describe what caused the pain:____

Date of Onset: ___________ Was the Onset ☐ Gradual ☐ Sudden | Is your condition getting: ☐ Worse ☐ Better ☐ Same ☐ Varies

Is your condition worse during certain times of the day: ☐ Yes ☐ No If yes, what part(s) of the day: ________________

How would you rate your pain/symptoms? On the scale below circle your rating.

	No pain/symptoms									Worst possible pain/symptoms
Right now:	0	1	2	3	4	5	6	7	8	9	10
On average:	0	1	2	3	4	5	6	7	8	9	10
At its worst:	0	1	2	3	4	5	6	7	8	9	10

Describe the quality of your complaint/pain:
- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ stabbing
- ☐ burning
- ☐ shooting
- ☐ weakness
- ☐ other:________________________________

Describe if pain is in a single spot or does it radiate:
- ☐ single location / does not radiate
- ☐ radiating dull, deep ache
- ☐ burning, sharp stabbing, tingling, numb
- ☐ other:________________________________

How often are you aware of the pain:
- ☐ 0-4%
- ☐ 5-9%
- ☐ 10-14%
- ☐ 15-19%
- ☐ 20-24%
- ☐ 25-29%
- ☐ 30-34%
- ☐ 35-39%
- ☐ 40-44%
- ☐ 45-49%
- ☐ 50-54%
- ☐ 55-59%
- ☐ 60-64%
- ☐ 65-69%
- ☐ 70-74%
- ☐ 75-79%
- ☐ 80-84%
- ☐ 85-89%
- ☐ 90-94%
- ☐ 95-100%

Does any of the following make the pain worse:
- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ other:___________________________

Does any of the following make it better:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ other:____________________________

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

On a scale of 0-10, how ready are you to make the changes necessary to control your symptoms?

0 1 2 3 4 5 6 7 8 9 10

CHIEF COMPLAINT HISTORY (Cont'd):

Have you ever experienced your present problem before? ☐ Yes ☐ No If yes, When: ________

Was treatment provided?: ☐ Yes ☐ No If yes, By whom:________________________ Outcome:_________________

Have you been seen by another health care provider for your current complaint? ☐ Yes ☐ No

If yes, by whom:___________________________ Specialty (MD, PT, DC, etc): ________ Outcome: _________________

Have you tried any self-treatment or medications (over-the-counter or prescription)? ☐ Yes ☐ No

If yes, explain;____ Outcome:________________________

Have you had any imaging for your current complaint (X-ray, MRI, CT, etc)? ☐ Yes ☐ No
If yes, please state type, result, date and place:____

Does your complaint affect your sleep? ☐ Yes ☐ No Your work? ☐ Yes ☐ No Your daily activities? ☐ Yes ☐ No

Please note anything else you would like the doctor to know about your chief complaint:
____
____

Please describe any secondary complaint(s) if present:____
____
____

TREATMENT GOALS:
On a scale of 0-10 with 0 being no pain, what is a reasonable level of pain you hope to achieve with our care? ___________________

What activity can you not perform currently that you would like to be able to do once treatment plan is finished?
(examples: play round of golf w/ no low back pain, run 3 miles without knee pain, sit for 30 minutes without pain)
____
____

PAST HEALTH HISTORY:
Have you had any of the following symptoms in the last 30 days:

☐ Pain worse at night
☐ Bacterial infection
☐ Fever or chills
☐ Constant pain unrelated to motion
☐ Bowel/bladder control issues
☐ Dizziness/vision Problems
☐ Digestion Issues
☐ Surgery
☐ Muscle weakness / loss of fine movement control
☐ Unexplained weight loss
☐ Cardiac/respiratory Issues

Check if you have ever had any of the following:

☐ History of Cancer
☐ Use of IV Drugs
☐ Surgery
☐ Falls
☐ History of HIV
☐ Blood Transfusions
☐ Fractures
☐ On the Job Injury
☐ Use of Steroids
☐ History of Hepatitis C
☐ Car Accidents

Please explain above conditions checked **or** any other serious illnesses/ hospitalizations: (Please date & describe)
____
____
____

Females: Date of last gynecological and breast exam:_______________ Date of last menstrual cycle: ________________________

Males: Date of last prostate exam:______________________

SOCIAL HISTORY:

	Yes	No		
Do you exercise?	☐	☐	_____ times per week	Type(s):___________________________
Do you smoke?	☐	☐	_____ packs per day	
If you have quit smoking, when did you quit?___________________				
Do you use other forms of tobacco?	☐	☐	What/How much per day? ________________________________	
Do you consume alcohol?	☐	☐	How many drinks per week? ______________________________	
Do you eat a balanced diet?	☐	☐	If no, explain: ____	
Do you get adequate sleep?	☐	☐	If no, explain: ____	
Is work stressful to you?	☐	☐	If yes, explain: ____	
Is family/social life stressful to you?	☐	☐	If yes, explain: ____	
Do you use recreational drugs?	☐	☐	If yes, explain: ____	

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, major illness.
If deceased, please indicate reason of death.

Mother: ____

Maternal Grandparents: ____

Father: ____

Paternal Grandparents: ____

Sisters: ____

Brothers: ____

Other: ____

Do you have any of the following?

Constitutional
___Unexplained Weight Loss
___Fatigue or Weakness
___Fever

Skin
___Rashes
___Hives
___Itching

Eyes
___Glaucoma
___Cataracts
___Double Vision

Gastrointestinal
___Nausea or Vomiting
___Constipation
___Diarrhea
___Digestive Problems

Respiratory
___Cold/Flu/Cough
___Coughing Blood
___Wheezing

Genitourinary
___Blood in Urine
___Bladder Leakage
___Burning/Frequent Urination

Mental Status
___Anxiety/Depression
___Mood Swings
___Difficult Sleeping
___Stress

Ears, Nose, Throat
___Difficulty Hearing
___Buzzing or Ringing in Ears
___Dizziness
___Loss of Smell
___Sinus Trouble
___Difficulty Swallowing
___Loss of Taste

Allergic/Immunologic
___Hives/Hay Fever

Hematologic/Lymphatic
___Ease of bruising
___Gums Bleed Easily
___Enlarged Glands

Musculoskeletal
___Spinal Pain
___Joint Swelling
___Joint Stiffness

Cardiovascular
___Chest Pain
___Shortness of Breath
___Racing Heartbeat
___Fainting Spells

Endocrine
___Loss of Hair
___Heat/Cold Intolerance
___Diabetes
___Excessive Sweating
___Change in Appetite

Neurological
___Headaches
___Memory Loss
___Tremors
___Numbness
___Loss of Strength
___Seizures

Please read and sign:
I hereby state that all information that I have provided Active Health KC: Chiropractic & Rehab is complete and truthful and that I fully disclosed my health history.

SIGNED: ____ Date______________________________