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. _____

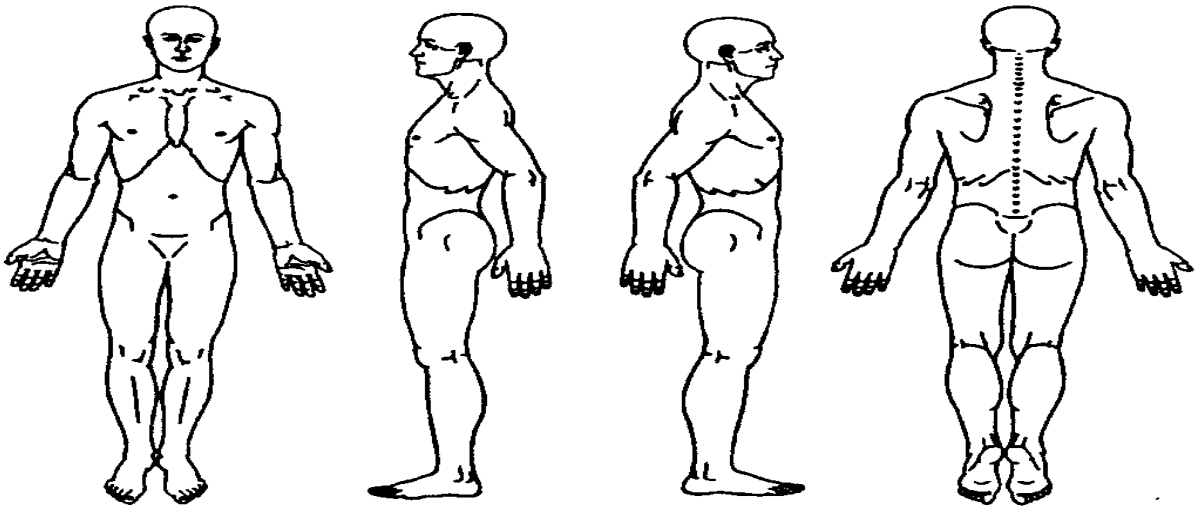
List any known allergies you have had to any medications. _____
If no allergies are known, check here: ☐

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:_____

Does any of the following make the pain worse:

- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ 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:_____

Does any of the following make it better:

- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ 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 it interfere with your daily activities:

- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

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

Check if you have ever had any of the following:

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

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_____