Patient Information

Legal First Name: _____Middle Name: _____ Last Name: _____

Street: _____Apt: _____

City: _____ State: _____ Zip: _____

Social Security #:_____ Marital Status: S M W D Spouse:_____

Language: _____English _____ Spanish _____ Indian _____Japanese _____ Chinese _____ Korean _____ French _____ German _____ Russian _____ Other_____

Race: _____ White _____American Indian or Alaska Native _____ Asian _____Native Hawaiian/Other Pacific Islander _____ Black or African American _____ Hispanic or Latino _____ Decline to Answer _____Other_____

Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

DOB: _____ Home Phone: _____ Work Phone:_____

Cell Phone: _____

Please check your contact preference: _____Hm _____ Wk _____ Cell _____Email _____ Postal Mail

Email hm: _____ Email wk: _____

Emergency Contact:_____ Phone Number: _____

Whom may we thank for referring you to our office? _____

Occupation: _____ Employer: _____

Employer Address: _____

Patient History

Are you seeing anyone else for other problems or health conditions? □ Yes □ No

Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

_____

_____

_____

Past health history

Have you...	Yes	No	If yes, include date & provider seen
...been hospitalized in the last 5 years?	□	□	_____
...been diagnosed with Diabetes? Type I____or Type II_____	□	□	_____
...been treated for hypertension?	□	□	_____

Do you smoke? □Never □Former Smoker □Current/Every Day Smoker □Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals...
List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by
Please be as specific as possible

_____

_____

_____

_____

_____

Do you have allergies? □Food □Environmental □Medication
List Type of Allergy and Reaction

_____

_____

_____

Assignment & Release

Please Sign Both Lines

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me 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 or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: _____

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

All bills are due within 10 days of statement. If payment is not received within 10 days, a $15.00 finance charge will be applied to your account unless otherwise discussed with billing department.

Patient's/Parent's/Guardian's Signature: _____

General Physical Examination

Name:

Vital Signs: ☒ Check normal, circle & describe abnormal.

Pulse: L ________ R ________ Blood Pressure: L ________/________ R ________/________ Temp. ________ VBI: L ________ R ________

Resp: ________/min. Visual acuity: L ________/________ R ________/________ Height: ________ Weight: ________

Observation: ☐ WNL

Development: ☐ good, ☐ fair, ☐ poor

☐ Posture: ____________________

☐ Gait: ____________________

☐ Skin (bruising, scars): ____________________

☐ Asymmetry: ____________________

☐ Other: ____________________

Range of motion: ☐ WNL

Flexion (45°)			Flexion (90°)		
Extension (55°)			Extension (30°)		
Lateral flexion (45°)			Lateral flexion (20°)		
Rotation (70°)			Rotation (30°)		

Neurologic exam: ☐ WNL

Light touch		
Sharp/dull		
Vibration		

Biceps (C5)(musculocut.)		
Brachioradialis (C6)(radial)		
Triceps (C7)(radial)		
Patellar (L4)(femoral)		
Medial hamstring (L5)(sciatic)		
Achilles (S1)(tibial)		
Babinski		
Other:		

Resisted neck ROM (C1-C4)		
Shoulder elevation (CN XI, C3-C4)		
Shoulder abduction (C4-C6)		
Elbow flexion (C5-C6)		
Elbow extension (C6-C8)		
Wrist/finger flexion (C7-T1)		
Wrist/finger extension (C6-C8)		
Hip flexion (L1-L3)		
Knee extension (L2-L4)		
Knee flexion (L4-S1)		
Plantar flexion (L5-S2)		
Dorsiflexion (L4-L5)		
Other:		

I (smell)	VII (facial express)
II (light, vision)	VIII (Weber, Rinne)
III, IV, VI (gaze)	IX, X (ahhh)
V (face sensation)	XI (trap/SCM)
V, VII (corneal refl.)	XII (tongue)

Palpation: ☐ WNL

☐ Skin, temperature, moisture: ____________________

☐ Parotids, thyroid, lymph nodes: ____________________

Mark on drawing

☐ pain (circle)

☐ spasm (s)

☐ edema (e)

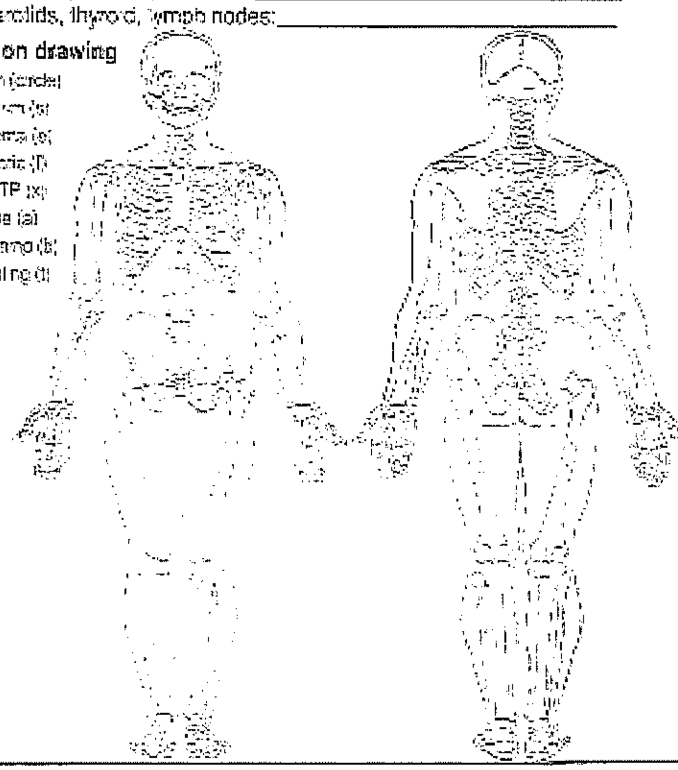
☐ fibrotic (f)

☐ MFTP (x)

☐ ache (a)

☐ burning (b)

☐ tingling (t)



Spinal Palpation

	C0	
	C1	
	C2	
	C3	
	C4	
	C5	
	C6	
	C7	
	T1	
	T2	
	T3	
	T4	
	T5	
	T6	
	T7	
	T8	
	T9	
	T10	
	T11	
	T12	
	L1	
	L2	
	L3	
	L4	
	L5	
	S1	
	Co	
	SI	

Orthopedic exam: ☐ WNL, ☐ other: ____________________

Heel walk (L5, L4, L5)			Resisted muscle test			Kemp's test	
Toe walk (S1)			Compression			SLR passive, active	
Squat & rise			Maximal compression			Braggard's	
Tandem Romberg			Distraction			Patrick's (FABERE)	
Romberg			PROM			Thomas/Gaenslen's	
Adam's Sign			Jull's (active flexion)			Hip contradiction	
Other:			Soto Hall/Srudinski			SI distraction/compression	

Additional exam procedures: ☐ WNL

☐ Auscultation (heart, lungs):

☐ Other:

Signature: Date:

GENERAL

1) ____ Fever
2) ____ Chills
3) ____ Night Sweats
4) ____ Loss of Sleep
5) ____ Fatigue
6) ____ Nervousness
7) ____ Weight Loss or Gain
8) ____ Allergies
9) ____ Bleeding Problem
10) ____ Anemia
11) ____ Diabetes
12) ____ Cancer
13) ____ Thyroid Disease/Goiter
14) ____ Alcoholism
15) ____ Drug Abuse

EYE EAR NOSE THROAT

16) ____ Poor Vision
17) ____ Pain in Eye(s)
18) ____ Deafness/Difficulty Hearing
19) ____ Nosebleeds
20) ____ Nose Problems
21) ____ Sinus Trouble
22) ____ Dental Problems
23) ____ Hoarseness
24) ____ Tonsillectomy

GASTROINTESTINAL

25) ____ Poor Appetite
26) ____ Poor Digestion
27) ____ Difficulty Swallowing
28) ____ Belching or Gas
29) ____ Frequent Nausea
30) ____ Vomiting
31) ____ Vomiting Blood
32) ____ Pain over Abdomen
33) ____ Ulcer
34) ____ Black or Bloody Stools
35) ____ Liver Problems
36) ____ Gall Bladder Problems
37) ____ Jaundice
38) ____ Hernia
39) ____ Diarrhea
40) ____ Constipation
41) ____ Hemorrhoids
42) ____ Appendicitis

RESPIRATORY

45) ____ Difficulty Breathing
46) ____ Chronic Cough
47) ____ Spitting Phlegm
48) ____ Spitting Blood
49) ____ Wheezing/Asthma
50) ____ Pneumonia
51) ____ Tuberculosis

CARDIOVASCULAR

52) ____ Irregular Heartbeat
53) ____ High Blood Pressure
54) ____ Pain over Heart
55) ____ Previous Heart Trouble
56) ____ Ankle Swelling
57) ____ Varicose Veins
58) ____ Rheumatic Fever
59) ____ Stroke

GENITOURINARY

60) ____ Frequent Urination
61) ____ Painful Urination
62) ____ Blood in Urine
63) ____ Kidney Disease
64) ____ Urinary Infection
65) ____ Inability to Control Urination
66) ____ Difficulty Starting Urine Flow
67) ____ Get Up ____ Times per Night to Urinate
68) ____ Breast Lump or Pain
69) ____ Venereal Infection
70) ____ Sexual Difficulties

SKIN

71) ____ Itching
72) ____ Bruising Easily
73) ____ Change in Mole(s)
74) ____ Skin Cancer

MEN ONLY

43) ____ Testicular Swelling/Pain
44) ____ Prostate Problems

NEUROLOGIC

82) ____ Weakness
83) ____ Twitching
84) ____ Tremors
85) ____ Headache
86) ____ Fainting
87) ____ Dizziness
88) ____ Convulsions
89) ____ Epilepsy
90) ____ Numbness/Tingling
91) ____ Arm/Leg Pain (125)
92) ____ Mental Disorder

MUSCULOSKELETAL

93) ____ Neck Stiffness/Pain
94) ____ Pain Between Shoulders
95) ____ Low Back Pain
96) ____ Swollen Joints
97) ____ Painful Joints (CC)
98) ____ Muscle Aches/Soreness
99) ____ Spinal Curvature
100) ____ Arthritis

HABITS

101) ____ Smoking ____ Packs/Day
102) ____ Drinking
103) ____ Recreational Drug Use

EXERCISE

104) ____ None
105) ____ 1-2 Times/Week
106) ____ 3-5 Times/Week
107) ____ 6-7 Times/Week

WOMEN ONLY

75) ____ Painful Periods
76) ____ Excessive Flow
77) ____ Irregular Cycles
78) ____ Vaginal Burning/Itching
79) ____ Hot Flashes

80) _____
Date Last Period Began

81) _____
Date of Last PAP Test

FAMILY HISTORY

Include information on brothers, sisters, parents and grandparents. DO NOT INCLUDE YOURSELF.

108) ____ Diabetes
109) ____ Thyroid Disease/Goiter
110) ____ Tuberculosis
111) ____ Kidney Disease
112) ____ High Blood Pressure
113) ____ Heart Disease
114) ____ Cancer
115) ____ Muscle, Bone or Nerve Disease

NAME:	Date:	**SOAP NOTES**
Subjective Notes	**Side: Left Right Bilateral**	

Patients feelings:

Pain

Description: *Improving - Worse - None*
Rate of Change: *Gradual – Slightly - Slowly*
Changed since: *Last, visit - month - week*
Quality: *achy – burning – dull – sharp – stiff – throbbing*
Rate level: *mild -- moderate -- serve*
Level: 1 2 3 4 5 6 7 8 9 10
Worse: *M - A - E - N - As Day Progresses*
How often: constant - frequent - intermittent - occasional

Pain radiating to: _____

What exacerbates pain: _____

Headaches

Location: *frontal – temporal –occipital*
Worse: *M A E N ADP sleep constant*
Level: 1 2 3 4 5 6 7 8 9 10
Duration: _____ **times per week**

Objective

Adjusted diversified on

C rotation 2 3 4 5 6 7
AP T 1 2 3 4 5 6 7 8 11
L Flexion 1 2 3 4 5
R or L SI

Decreased motion:

R or L Rotation
R or L Bending
Flexion
Extension

Increased tone of

Pain with palpation at:

ICD Diagnosis:

Graston / Cupping

Adjustment: 98940 98941 98943 KIDS
Manual Therapy: 97140 ROM: 97110 / 97150
E-stim: 97014 Infrared Therapy: 97026
Acupuncture: 97810 – Location: _____
Kinesio Taping: 99070 Heat/Cold: 97010
99070: In-Season Athlete
99201-New Patient
Other: _____

Patient is to ***ice heat stretch*** at home

Plan to re-evaluate: _____

Assessment

Post Treatment Assessment

Unchanged - Stable - Improved - Worse
Percentage of change: _____%
Changed since: *Last, visit - month - week*

Goals

Within _____ weeks be able to

_____

by _____% in the _____

SIGNATURE	DATE OF SERVICE

SIGNATURE	DATE OF SERVICE