ABOUT THE PATIENT Full Circle Chiropractic 55 Mouse Creek Rd NW Cleveland, TN 37312

Name _____ Today's Date_____ Birth date_____ Age_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell phone _____ Work phone _____ Gender ❑ M ❑ F

Would you like text message and/or email reminders of your appointments?_____

Significant Other's Name _____ Kids Names and Ages_____

Your Employer_____ Type of work _____

E-mail Address_____ Have you ever been to a Chiropractor? No Yes

Emergency Contact _____ Phone Number _____

Do you have insurance?_____Would you like us to bill your insurance for you? _____

How were you referred?_____

Purpose of this appointment_____

Have you ever had same/similar condition? Describe:_____

Days lost from work?_____

Reason For Seeking Care

Present Complaints

1) **What is your major injury/complaint?**_____ How long have you had it? _____
   Is the complaint (circle one or more): Dull Sharp Ache Numb/Tingling Stabbing
   What is your complaint at its worst on a scale of 0 to 10 (10 being emergency room pain)?_____
   What percentage of the day is it there? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
   Is the pain worse at a certain time of day (circle)? Morning / Night / During the day / Worse with activities
   Does the complaint travel or radiate anywhere? _____
   Does it affect your (circle) : Sleep / Work / Daily Routine / Sitting / Driving
   What makes it better/worse?_____

2) **Second injury/complaint?** _____ How long have you had it? _____
   Is the complaint (circle one or more): Dull Sharp Ache Numb/Tingling Stabbing
   What is your complaint at its worst on a scale of 0 to 10 (10 being severe)? _____
   What percentage of the day is it there? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
   Is the pain worse at a certain time of day (circle)? Morning / Night / During the day / Worse with activities
   Does the complaint travel or radiate anywhere? _____
   Does it affect your (circle) : Sleep / Work / Daily Routine / Sitting / Driving
   What makes it better/worse?_____

3) **Third injury/complaint?** _____ How long have you had it? _____
   Is the complaint (circle one or more): Dull Sharp Ache Numb/Tingling Stabbing
   What is your complaint at its worst on a scale of 0 to 10 (10 being severe)? _____
   What percentage of the day is it there (circle)? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
   Is the pain worse at a certain time of day (circle)? Morning / Night / During the day / Worse with activities
   Does the complaint travel or radiate anywhere? _____
   Does it affect your (circle) : Sleep / Work / Daily Routine / Sitting / Driving
   What makes it better/worse?_____

Family History

Father's side: Heart Disease Cancer Diabetes Heavy Medication Use Arthritis Other_____

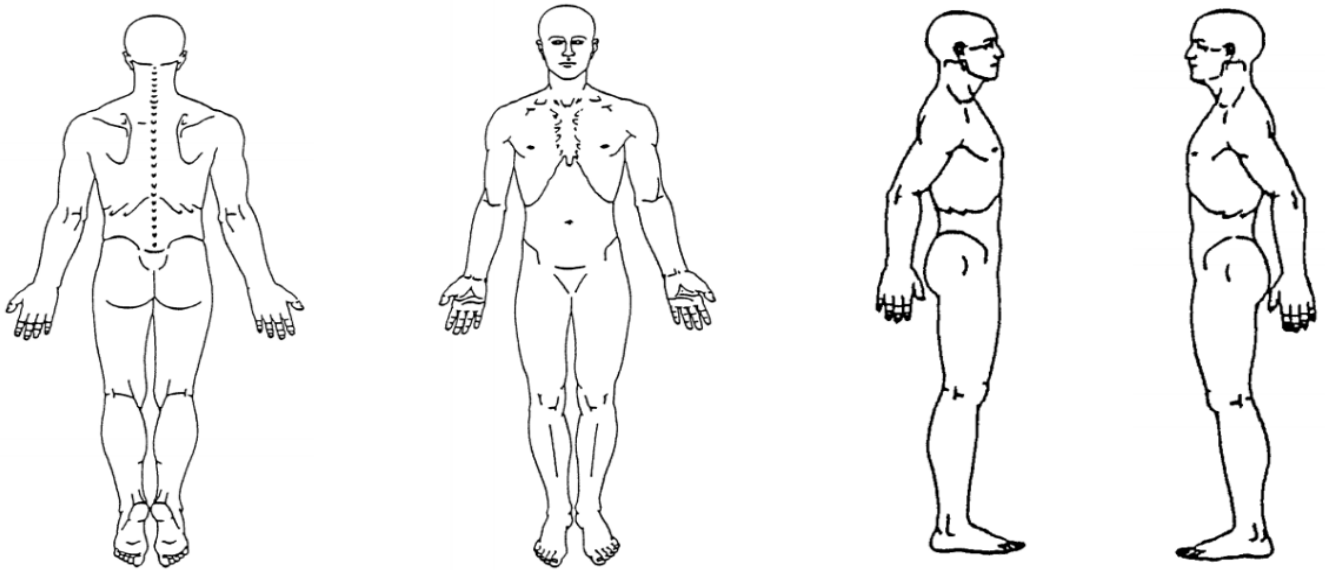
Mother's side: Heart Disease Cancer Diabetes Heavy Medication Use Arthritis Other_____

Is there any other family history you want us to know? _____

Please draw the specific areas of pain AND what type on pain it is.

A = Ache B = Burning N = Numbness

P = Pins and Needles S = Stabbing O = Other (stiffness/other dysfunction)



Have you received care for this? What type/results of treatment? _____

Is there anything else you would like help with concerning your overall health?

_____

_____

_____

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

This rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do, or from doing it/enjoying life as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worse.

Please circle the number which best describes your situation

1) **home and family RESPONSIBILITIES**. (Yard Work/Errands/Taking care of kids/chores)
(No limitation) 0 1 2 3 4 5 6 7 8 9 10 (Unable to perform)

2) **Recreation**. This category includes hobbies, sports, and other leisure time activities.
(No limitation) 0 1 2 3 4 5 6 7 8 9 10 (Unable to perform)

3) **Social Activities.** Activities that occur with friends such as parties, theater, dining out, etc.
(No limitation) 0 1 2 3 4 5 6 7 8 9 10 (Unable to perform)

4) **Occupation**. Activities that are related to jobs such as a homemaker or construction worker.
(No limitation) 0 1 2 3 4 5 6 7 8 9 10 (Unable to perform)

5) **Self Care**. This includes personal maintenance such as driving, showering, getting dressed, etc.
(No limitation) 0 1 2 3 4 5 6 7 8 9 10 (Unable to perform)

6) **Life-Supporting Activity**. This refers to eating, sleeping, breathing.
(No limitation) 0 1 2 3 4 5 6 7 8 9 10 (Unable to perform)

Patient Signature: _____ Score _____ Date _____

GENERAL HEALTH HISTORY

Patient Name _____ ***Mark the conditions that apply to you.***

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies/Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner Use
❑	❑	Hands or Feet Cold	❑	❑	HIV Positive
❑	❑	Muscle Aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg/Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain All Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems

Other _____

1) Any medications that you are taking? _____
   _____
2) Other doctors you are seeing? _____
   _____

Past History

1) List any auto collisions: _____ Was any care received? _____
2) Work injuries: _____ Was any care received? _____
3) Sport, recreational, home injuries: _____ Was any care received? _____
4) Please describe any past conditions and treatment received: _____
   _____
5) Hospitalizations_____
6) Surgeries? _____