Augustine Chiropractic Offices

PATIENT INFORMATION

First Name _____ Last Name _____

Gender ☐ M ☐ F Date of Birth ____/____/____ Age _____ Marital Status: M S W D

Home Address _____

City _____ State _____ Zip Code _____

Phone _____ ☐ W ☐ H ☐ C 2nd Phone _____ ☐ W ☐ H ☐ C

Email _____

What is your preferred method of communication? ☐ Phone ☐ Text ☐ Email

Employer _____

Work Address _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Phone _____ ☐ W ☐ H ☐ C

Are you Medicare Eligible? ☐ Yes ☐ No

Will you use this location from your:	☐ Home	☐ Office	☐ or Both?	
Approximately, how far did you travel to get here today?	☐ 0-3 miles	☐ 3-5 miles	☐ 5-10 miles	☐ 10+ miles
Approximately, how long did it take you to get here today?	☐ 0-5 mins.	☐ 6-10 mins.	☐ 11-15 mins.	☐ 15+ mins.

How did you first hear about Augustine Chiropractic?

_____

If you were referred by someone please tell us who so we may thank them.

_____

_____ _____

(Patient or Legal Guardian Signature) (Date)

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PATIENT HISTORY

Name_____ Age_____ Date of Birth____/____/____ Gender ☐ M ☐ F

Height_____ft._____in. Weight_____lbs. Occupation_____For how long?_yrs.___mos.

1. Have you had chiropractic care before? ☐ Yes ☐ No If yes, how recently? _____

2. Reason for today's visit:

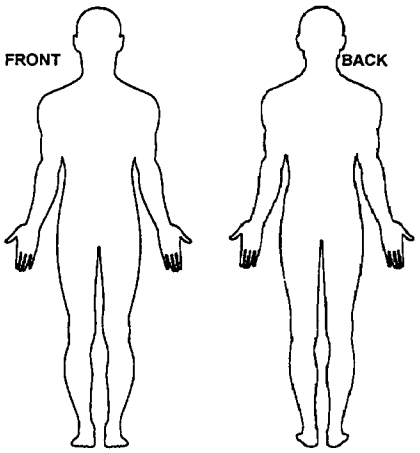
☐ Pain ☐ Discomfort ☐ Stiffness ☐ Maintenance Care ☐ Recent Injury ☐ Previous Injury ☐ Other _____

3a. When did your complaint(s) first begin?_____ 3b. Today, is the condition: ☐ Same ☐ Better ☐ Worse Explain

what helps and/or worsens the condition: _____

4. Where is/are your area(s) of complaint today? Check all that apply	Rate pain and discomfort between 1-10 (1 = minimal, 10 = severe)	Check off the type of Complaint: Radiating	Sharp	Dull	Tingling	Numbnes	Burning	Inflamed/ swollen	Frequency: Constant	Intermittent
☐ Headache/Migraine										
☐ Neck										
☐ Shoulder(s)										
☐ Arm(s)										
☐ Elbow(s)										
☐ Wrist(s)										
☐ Upper Back										
☐ Middle Back										
☐ Lower Back										
☐ Hip(s)										
☐ Sciatica										
☐ Knee(s)										
☐ Ankle(s)										

5. Use the figures below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



6. Have you experienced this/these complaint(s) before? ☐ Yes ☐ No

if yes, when? _____

7. Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, how many weeks? _____

8. Are you currently experiencing any of the following:

☐ Nausea or vomiting ☐ Rapid eye movement ☐ Numbness on one side of the face or body ☐ Fainting or lightheadedness ☐ Dizziness

☐ Difficulty walking ☐ Difficulty speaking ☐ Headache or neck pain ☐ Difficulty swallowing ☐ Double vision

(If yes to any, please describe) _____

9. Current prescriptions or over-the-counter medications: _____

PAST HISTORY: MUSCULOSKELETAL CONDITIONS (please check all that apply)

☐ Headaches/Migraines ☐ Hip Pain/Discomfort ☐ Arthritis
☐ Neck Pain/Discomfort ☐ Sciatica ☐ Fused/Fixated Joints
☐ Shoulder Pain/Discomfort ☐ Elbow Pain/Discomfort ☐ Herniated Disc
☐ Upper Back Pain/Discomfort ☐ Wrist Pain/Discomfort ☐ Joint Replacement
☐ Middle Back Pain/Discomfort ☐ Knee Pain/Discomfort ☐ Osteoporosis
☐ Low Back Pain/Discomfort ☐ Ankle Pain/Discomfort ☐ Osteopenia
☐ Inflammation/Swelling; where_____

OTHER CONDITIONS

☐ Cancer ☐ Heart Disease
☐ Tumors ☐ AIDS/HIV
☐ Stroke ☐ Diabetes
☐ Seizure Disorders ☐ Hepatitis
☐ High Blood Pressure ☐ Tuberculosis
☐ Pacemaker ☐ Hernia
☐ Allergies
☐ Other _____

10. Indicate if you have experienced any of the following and mark how recently.

Surgeries?	☐ Yes ☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months_____yrs.
Accidents/Broken Bones?	☐ Yes ☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months_____yrs.
Hospitalizations?	☐ Yes ☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months_____yrs.

If yes to any, list and describe _____

11. Family Health History: (check all that apply) ☐ Cancer ☐ Tumors ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease

_____ _____

(Patient or Legal Guardian Signature) (Date)

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PATIENT ACTIVITY ASSESSMENT FORM

Name_____ Today's Date_____/_____/_____

Occupation_____ Age _____

The purpose of this form is to assist the doctor in better understanding your daily activities, your ability to perform them, and how they relate to the function of your body. Your answers will provide important information in establishing a customized plan of care designed to place you on the path toward attaining and maintaining your health care goals.

STANDING OR SITTING

Do you primarily stand or sit at work: ☐ Stand ☐ Sit

Approximately how many hours per week:

☐ 0-20 hours ☐ 20-40 hours ☐ 40+ hours

Are those hours primarily spent:

On the phone:

☐ Cell ☐ Desktop Phone ☐ Headset ☐ No headset

Typing at a keyboard:

☐ Laptop ☐ Desktop computer

☐ Other: _____

What is your most common posture:

☐ Sitting upright ☐ Slouched ☐ Crossed legs ☐ Stand

Does your work require you to:

☐ Bend ☐ Twist ☐ Lift ☐ Carry ☐ N/A

What type of shoes do you wear on a regular basis:

☐ Dress ☐ Heels ☐ Running ☐ Boots ☐ Athletic ☐ Sandals

☐ Other: _____

Do you wear orthotics: ☐ Yes ☐ No

SLEEPING

What type of bed do you sleep in:

☐ Memory foam ☐ Adjustable firmness ☐ Inner spring

☐ Other: _____

How many hours of sleep do you get per night: ☐ 8 hrs or less ☐ More than 8 hrs

What position do you sleep in: ☐ Back ☐ Stomach ☐ Side ☐ All

Do you regularly wake up with any back stiffness: ☐ Yes ☐ No

Do you regularly wake up with any neck stiffness: ☐ Yes ☐ No

BODY STRESSORS

Do your daily activities require you to lift and/or carry objects: ☐ Yes ☐ No

If yes, how often:

☐ Occasionally ☐ Frequently ☐ Constant

If yes, approximately, how heavy:

☐ 10 lbs or less ☐ 10-30 lbs ☐ More than 30 lbs.

Do you exercise: ☐ Yes ☐ No

If yes, approximately how many days per week:

☐ 0-1 day(s) ☐ 1-3 days ☐ 3+ days

Type(s) of exercise:

Weight training:

☐ Free weights ☐ Machines ☐ Other: _____

Cardio training:

☐ Elliptical ☐ Treadmill/Running ☐ Other: _____

Do you participate in sports: ☐ Yes ☐ No

If yes, please indicate all that apply:

☐ Football ☐ Basketball ☐ Skiing ☐ Body building ☐ Soccer

☐ Tennis ☐ Walking/Hiking ☐ Volleyball ☐ Racquetball ☐ Yoga

☐ Dancing ☐ Cycling/biking ☐ Golf

☐ Other _____

Do you have children at home? ☐ Yes ☐ No

If yes, how many? ☐ 1 ☐ 2-3 ☐ More than 3 _____

Do any of your children require you to carry them? ☐ Yes ☐ No

CHIROPRACTIC ACTIVITY ASSESSMENT

Did You Know: the absence of pain is not an indication of health? ☐ Yes ☐ No

Did You Know: pain has a cause and many times that cause begins in the spine? ☐ Yes ☐ No

Did You Know: over-the-counter pain medications and / or prescriptions may only mask the pain? ☐ Yes ☐ No

Did You Know: your daily activities can cause joint pain and dysfunctions in the spine and extremities? ☐ Yes ☐ No

Did You Know: these joint dysfunctions can cause decreased joint motion and function in the body? ☐ Yes ☐ No

Did You Know: decreased joint motion can also affect your ability to enjoy a healthy and active lifestyle? ☐ Yes ☐ No

Did You Know: the health benefits of routine chiropractic care may include any of the following: ☐ Yes ☐ No

1) Improved nerve communication
2) Improved joint motion
3) Improved joint coordination
4) Improved physical function
5) Improved physical performance
6) Improved posture
7) Increased daily activity
8) Provide pain and stress relief