The Family Chiropractic Center
Patient Office Policy

To Our Patients:

Welcome to The Family Chiropractic Center. We are pleased that you have chosen what we believe is one of the best non-drug approaches to patient care available today. Our practice is committed to providing you with the finest personalized health care through comprehensive evaluation of your condition, concise explanation of our findings and recommendations, and the most effective treatment – expertly performed. We focus on alternative approaches for the treatment of degenerative and chronic conditions of the musculoskeletal system and believe that the body has superior recuperative capabilities when it is restored to proper balance and given the environment necessary to function optimally. The goal of The Family Chiropractic Center is to restore our patients to the most functional and distress-free state possible – without the use of pharmaceuticals or surgery. We understand the special needs of our patients and want your visit to our facility to be as comfortable and pleasant as possible.

The following information is provided to familiarize you with the policies and procedures of The Family Chiropractic Center, to allow us to serve you more completely, and to get the best results in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results.

New Patients
Initial visits are comprehensive information gathering sessions. Complete evaluation and review of your medical history are essential. In order to provide you with the most effective treatment, it is important that you complete the new patient documentation forms in as much detail and as accurately as possible.

Insurance
In an effort to keep costs down and still provide the best service for our patients, we have set up procedures and payment options. In this era of rising health costs, etc., we are doing our utmost to provide the best service for a fair cost. The two options available for insurance patients are:

- If you want to utilize your health insurance and have our office file, we will itemize services by procedures and code accordingly. We are in-network providers for BlueCross BlueShield and PHCS. We will file on out-of-network insurance if the deductible is $1000 or less.
- If you are self pay but file on your own with insurance or payflex, then for paperwork purposes, you are like an insurance patient and will have an additional $5.00 processing fee per visit.

Please provide the front office with your specific insurance information and our office manager will be happy to assist you with any questions or concerns about your individual needs.

Self Pay
If you are self pay, we will code by time and give you a receipt.

Also, please note that while we do accept personal injury coverage for auto accidents, these fees vary. We do not accept cases only utilizing a 3rd party liability for auto accidents.

Signing In
When you arrive, please take a clipboard, fill out the front side, in detail, and return it to the front desk. You will be called and assigned a treatment room as soon as the doctor is ready for you. Other patients may be called before you because of the particular services being received that day, or their doctor may be available before yours.

New Injuries
In the event you sustain a new injury, please let the front desk know when you schedule your appointment. There may be additional paperwork to be filed, or the doctors may need to refer you for x-rays of an injured area and perform an exam of the injured area before being able to treat.

Appointments
After your visit, please stop at the front desk to make or confirm your next appointment.

Missed Appointments
If you find it necessary to change your scheduled appointment, we will not charge you if you provide a minimum of 24 hour notice. The first missed appointment will be charged $25.00. Every missed appointment after that will be charged $50.00.

Payment of Bills
Payment is due at the time services are rendered. We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our office immediately so that arrangements can be made. Our policy is that patients maintain a zero balance. Any and all unpaid balances are subject to a 10% or minimum of $10.00 monthly late fee. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible. Please also bring in the attached explanation of benefits.

Rescheduling Appointments
We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day. If the same day is not possible, be sure to make up the missed appointment within one week.

Progress Evaluations & Re-examinations
Progress evaluations & re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments. If you haven't been treated for more than 3 months or after 12 visits, whichever comes first, you will need to be scheduled for a re-examination.

Upsets
We are here to serve you. Please speak with the staff or doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion). We see your comments as helping us to help you and others.

Technique
We are trained in a wide variety of adjusting techniques – AK, NET, ATM, DTS, activator, S.O.T. and diversified to name a few. Each patient's treatment protocol will be designed to meet their particular needs, whatever they may be. Our light force adjusting is specifically designed to meet the needs of young children and senior patients.

Nutrition plays a vital role in the recovery and maintenance of health. We use the most effective vitamins, minerals, herbs and natural health products available to facilitate your body's healing.

Please discuss any concerns or questions about your nutrition before purchasing any item. **There are absolutely NO refunds on opened nutritional products.**

BioAllergenix

To assist the body in its healing process, it is often necessary to rid the body of allergies or sensitivities. We utilize a non-invasive allergy evaluation and desensitization technique to achieve clearing of any allergies. Ask us for more information.

STAGES OF CHIROPRACTIC CARE

1. INTENSIVE CARE / RELIEF
   The purpose of this stage is in correcting and/or stabilizing the subluxation complex so that the body can begin its natural healing process. This is the time visits will be most frequent. This stage includes **any** new patient or established patient with an injury, exacerbation, accident or new condition. The completion of intensive care is determined by re-examination through chiropractic and physical examinations.

2. RE-CONSTRUCTIVE CARE (CORRECTIVE)
   This stage begins after the completion of the intensive care stage. The purpose is stabilizing and normalizing your body's capacity to function normally and express its natural healing process completely.

3. WELLNESS CARE
   This stage begins after the completion of the previous stage (re-constructive care). This stage is based on maintaining optimal health. The frequency of visits are less than during the previous stages because the body is functioning more effectively and without the hindrances that are seen in the intensive care stage; however, this is the most important stage for your long term health.

ARRANGEMENTS FOR YOU

It is our sincerest desire to provide care for you and your entire family.

This office is here to serve you to the best of our ability and at a reasonable fee. Thank you for choosing this office for your health care. No patient has ever been refused chiropractic care in this office due to finances. If at any time during your care at this office finances become a problem, please do not hesitate to discuss it with any of the staff. We are here to serve you and provide the services YOU need.

THANK YOU FOR TAKING PERSONAL RESPONSIBILITY FOR YOUR HEALTH AND FOR ALLOWING US TO SHARE IN YOUR WELL BEING.

YOURS IN HEALTH,

DRS. CHUCK AND JAN

I have read and understand the procedure policies of the TFCC and agree to abide by the above policies.

_____ _____
Signature Date

The Family Chiropractic Center
1124 N. Locust
Denton, TX 76201

I have read and understand my rights under the HIPAA regulations but have refused a copy.

I have read and understand my rights under the HIPAA regulations and have taken a copy with me for my records.

_____Printed Name

_____Signature

_____Date

The Family Chiropractic Center
1124 N. Locust
Denton, TX 76201

Please complete the following information to be added to our special events mailing and email update list:

Name and Mailing Address:

_____

_____

_____

Email:

_____

01-27-16

The Family Chiropractic Center

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____ Date_____

Home Address_____City _____State_____ Zip Code _____

Home Phone_____Cell Phone_____

Best # to Call_____ E-Mail_____

Date of Birth _____ Sex: Male Female

Driver License # with State:_____

Guardian Social Security # (if patient is under 18 years of age):_____

Occupation _____Employer Name _____

Employer Address _____

Office Phone _____ May we contact you at this number? Yes No

Do you have insurance? Yes No ***If you would like for us to file your claim, please give your insurance card to the front office staff to be copied, and we will call to verify your benefits.***

Marital Status: S M D W Spouse's name _____

Date of last physical exam _____ Doctor's name _____

Reported findings _____

List all surgeries / serious illnesses / hospitalizations (include years in brackets) _____

_____

List all broken bones / dislocations / major dental work (include years in brackets) _____

_____

Person to contact in case of emergency _____

Address _____ Phone _____

Name of closest relative not living with you _____

Address _____ Phone _____

Person responsible for account _____ Relationship to patient_____

I hereby give my consent to The Family Chiropractic Center to provide services to me and/or my family. I understand that there is a fee for services and that fees are payable at the time services are rendered. **I hereby agree to such fees and understand that I am liable for any and all legal fees and/or reasonable interest if collection services become necessary**.

Responsible
Party/Patient_____Date_____

01-27-16

The Family Chiropractic Center

CONFIDENTIAL DETAILED HISTORY FORM – PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____

PERSONAL INFORMATION:

Height: _____ **Weight:** Current_____ One year ago_____ Change in the past two years _____

Vision: Corrected? Yes____ No____ What is your vision? RT_____ LT_____

Vision recently changed? Yes___ No___ How?_____

Chiropractic: Have you previously received chiropractic care? Yes____ No____ If "yes," date of last care:_____

Auto accidents: Past year_____ Past five years_____ Over five years_____ Describe:_____

_____

X-Ray history: (Include all X-rays, CAT scans / MRIs / dye studies / dental x-rays)

TYPE	AREA OF THE BODY	TYPE	AREA OF THE BODY
_____		_____	
_____		_____	
_____		_____	

Transfusions: Have you ever had a blood transfusion? _____ Blood type? _____

Dental visits: Every 6 months_____ Annual_____ Toothache/emergency only_____ Complete dentures_____

Psychological: Ever diagnosed as having a mental/emotional disorder? Yes_____ No_____ When? _____

Any family member diagnosed as having such disorders? Yes_____ No_____ When? _____

Drugs: Currently taking…nerve pills, pain killers, muscle relaxers, tranquilizers, birth control pills, "pep" pills, others.
Please list all the medications you are currently taking.

Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____
Name _____ Function/Purpose_____

Elimination: Approximately how many times during the day do you urinate? _____ night?_____

How often do you have a bowel movement? _____ any problem?_____

Women: Currently… Periods began at what age?_____ pain during cycle_____ regular menstrual periods_____
irregular menstrual periods_____ pre-menopausal_____ post-menopausal_____ hysterectomy_____

Allergies? Yes___ No___ List_____

Do you smoke? Yes___ No___ What? _____ # per day? _____ How many years? _____

Do you diet? Yes___ No___ Explain? _____

Take vitamins? Yes___ No___

What?_____Function?/Purpose_____
What?_____Function?/Purpose_____
What?_____Function?/Purpose_____
What?_____Function?/Purpose_____
What?_____Function?/Purpose_____
What?_____Function?/Purpose_____

Vegetarian? Yes___ No____ Eat red meat? Yes___ No___

Eat fast foods? Yes___ No___ # times/week _____

Drink coffee? Yes___ No___ # cups/day _____ Drink cola? Yes___ No___ # per day _____

Drink tea? Yes___ No___ # cups/day _____ Drink water? Yes___ No___ # glasses/day ____

Drink alcohol? Yes___ No___What?_____ # per day?_____ # per week? _____

Play sports? Yes___ No___ What? _____ Currently in training? Yes___ No____

Describe your exercise program: _____

_____

Have hobbies? Yes___ No___ What? _____

Energy level: Sufficient for normal activities? Yes___ No___ Comment: _____

Work schedule: # business work hours/week _____ # home work hours/week _____

Sleep: # hours/night _____ quality? _____

age of mattress _____ comfortable? Yes___ No___ use a bed board? Yes_____ No_____

PLEASE INDICATE BY CHECKING IN THE APROPRIATE SPACE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST

THIS IS A CONFIDENTIAL HEALTH REPORT

__Alcoholism	__Cold sores	__Goiter	__Miscarriage	__Scarlet fever
__Anemia	__Diabetes	__Gout	__Multiple sclerosis	__Stroke
__Appendicitis	__Diptheria	__Heart disease	__Mumps	__Tuberculosis
__Arteriosclerosis	__Eczema	__Influenza	__Pleurisy	__Typhoid fever
__Arthritis	__Emphysema	__Lumbago	__Pneumonia	__Ulcers
__Cancer	__Epilepsy	__Malaria	__Polio	__Venereal disease
__Whooping cough	__Fever blisters	__Measles	__Rheumatic fever	__Chorea

Family history of:

__arteriosclerosis
__cardiovascular disease
__oral contraceptives
__TIAs
__diabetes
__hypertension
__antihypertensive meds
__other
__stroke
__other _____

O=OCCASIONAL F=FREQUENT C=CONSTANT

O	F	C	GENERAL
Y	Y	Y	Allergy
Y	Y	Y	Chills
Y	Y	Y	Convulsions
Y	Y	Y	Dizziness-on standing
Y	Y	Y	Dizziness-bending over
Y	Y	Y	Dizziness-other
Y	Y	Y	Fainting
Y	Y	Y	Fatigue
Y	Y	Y	Fever
Y	Y	Y	Headache
Y	Y	Y	Loss of sleep
Y	Y	Y	Loss of weight
Y	Y	Y	Nervousness/depression
Y	Y	Y	Neuralgia
Y	Y	Y	Numbness
Y	Y	Y	Sweats
Y	Y	Y	Tremors

O	F	C	MUSCLE & JOINT
Y	Y	Y	Arthritis
Y	Y	Y	Bursitis
Y	Y	Y	Foot trouble
Y	Y	Y	Hernia
Y	Y	Y	Low Back pain
Y	Y	Y	Lumbago
Y	Y	Y	Neck pain or stiffness
Y	Y	Y	Pain between shoulders
			Pain or numbness in:
Y	Y	Y	Arms
Y	Y	Y	Elbows
Y	Y	Y	Hands
Y	Y	Y	Hips
Y	Y	Y	Legs
Y	Y	Y	Knees
Y	Y	Y	Feet
Y	Y	Y	Painful tail bone
Y	Y	Y	Short leg
Y	Y	Y	Sciatica
Y	Y	Y	Spinal curvature
Y	Y	Y	Swollen joints

LIST JOINTS:_____

_____

_____

_____

_____

WHAT ADDITIONAL INFORMATION FO YOU BELIEVE WE SHOULD KNOW?

O	F	C	GASTRO-INTESTINAL
Y	Y	Y	Belching or gas
Y	Y	Y	Colitis
Y	Y	Y	Colon trouble
Y	Y	Y	Constipation
Y	Y	Y	Diarrhea
Y	Y	Y	Difficult digestion
Y	Y	Y	Distension of abdomen
Y	Y	Y	Excessive hunger
Y	Y	Y	Gall bladder trouble
Y	Y	Y	Hemorrhoids
Y	Y	Y	Intestinal worms
Y	Y	Y	Jaundice
Y	Y	Y	Liver trouble
Y	Y	Y	Nausea
Y	Y	Y	Pain over stomach
Y	Y	Y	Poor appetite
Y	Y	Y	Vomiting
Y	Y	Y	Vomiting of blood
Y	Y	Y	Heartburn/indigestion

O	F	C	EYES, EARS, NOSE & THROAT
Y	Y	Y	Asthma
Y	Y	Y	Colds
Y	Y	Y	Crossed Eyes
Y	Y	Y	Deafness
Y	Y	Y	Dental Decay
Y	Y	Y	Earache
Y	Y	Y	Ear discharge
Y	Y	Y	Ear noises
Y	Y	Y	Enlarged glands
Y	Y	Y	Enlarged thyroid
Y	Y	Y	Eye pain
Y	Y	Y	Failing vision
Y	Y	Y	Far sightedness
Y	Y	Y	Gum trouble
Y	Y	Y	Hay fever
Y	Y	Y	Hoarseness
Y	Y	Y	Nasal obstruction
Y	Y	Y	Near sightedness
Y	Y	Y	Nosebleeds
Y	Y	Y	Sinus infection
Y	Y	Y	Sore throat
Y	Y	Y	Tonsillitis

O	F	C	CARDIO-VASCULAR
Y	Y	Y	Hardening of arteries
Y	Y	Y	High blood pressure
Y	Y	Y	Low blood pressure
Y	Y	Y	Pain over heart
Y	Y	Y	Poor circulation
Y	Y	Y	Rapid heart beat
Y	Y	Y	Slow heart beat
Y	Y	Y	Swelling of ankles

O	F	C	RESPIRATORY
Y	Y	Y	Chest pain
Y	Y	Y	Chronic cough
Y	Y	Y	Difficult breathing
Y	Y	Y	Spitting up blood
Y	Y	Y	Spitting up phlegm
Y	Y	Y	Wheezing

O	F	C	SKIN
Y	Y	Y	Boils
Y	Y	Y	Bruise easily
Y	Y	Y	Dryness
Y	Y	Y	Hives of allergy
Y	Y	Y	Itching
Y	Y	Y	Skin eruptions (rash)
Y	Y	Y	Varicose/spider veins

O	F	C	GENITO-URINARY
Y	Y	Y	Bed-wetting
Y	Y	Y	Blood in urine
Y	Y	Y	Frequent urination
Y	Y	Y	Inability to control kidneys
Y	Y	Y	Get up at night to urinate
Y	Y	Y	Kidney infection or stones
Y	Y	Y	Painful urination
Y	Y	Y	Prostate trouble
Y	Y	Y	Pus in urine

O	F	C	FOR WOMEN ONLY
Y	Y	Y	Cramps or backache
Y	Y	Y	Excessive menstrual flow
Y	Y	Y	Hot flashes
Y	Y	Y	Irregular cycle
Y	Y	Y	Lumps in breast
Y	Y	Y	Menopausal symptoms
Y	Y	Y	Painful menstruation
Y	Y	Y	Vaginal discharge

ARE YOU NOW PREGNANT? YES NO

SIGNATURE **DATE**

01-27-16

THE FAMILY CHIROPRACTIC CENTER

DOCTOR/PATIENT RELATIONSHIP IN CHIROPRACTIC

* INFORMED CONSENT FORM *

Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical, and spinal conditions. It is important to understand what to expect from chiropractic health care services.

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body, and gives the body an opportunity to use its inherent recuperative powers.

A patient, in coming to the chiropractor, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnoses, and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial, and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor. The chiropractor provides a specialized, non-duplicating health service. The chiropractor is licensed in a special practice and is available to work with other types of providers in your health care regime.

At The Family Chiropractic Center, we use a combination of different treatment procedures. We will use our hands, our adjusting table, and/or our activator device to deliver safe and gently adjustments. This may cause an audible "pop" or "click," much as you experience when you crack your knuckles. You may or may not experience or feel a sense of movement in the joint being adjusted.

Conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under the control, or be helped through, medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both make great strides in alleviating pain and controlling disease.

With any health care procedure there are certain complications that may arise, and we strive to inform you of such risks. High force, extreme rotation adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Massage and trigger point therapies have an associated risk of bruising and/or release of emboli. Heat therapies may cause first and second-degree burns and/or hemorrhage. Risks associated with over-the-counter medications and prescription drugs are undesirable side effects such as liver damage and patient dependence. The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, and an extended convalescent period. The risks associated with remaining untreated are the formation of adhesions and reduction of mobility depending on the severity.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to The Family Chiropractic Center to perform the treatment and acknowledge that no guarantee as to the results that may be obtained from this treatment has been given to me.

I understand that full payment is due at time of service and that all nutritional products once taken off premises are ineligible for return/refund. Our office endeavors to treat people with all needs, so if special circumstances exist, please discuss these with the doctors or office manager. I also understand and agree to pay for scheduled appointments that I am unable to keep and was not able to give at least 24 hours notice of wishing to cancel. I understand that your time and my time are valuable. If for any reason there is a balance in any account (insurance or nutrition), and payment is not made within 30 days of request for payment, TFCC is entitled to charge me up to 2% interest per month.

Patient Name (please print):_____ Patient Signature:_____

Parent/Guardian (print):_____ Parent/Guardian Signature:_____

Date:_____

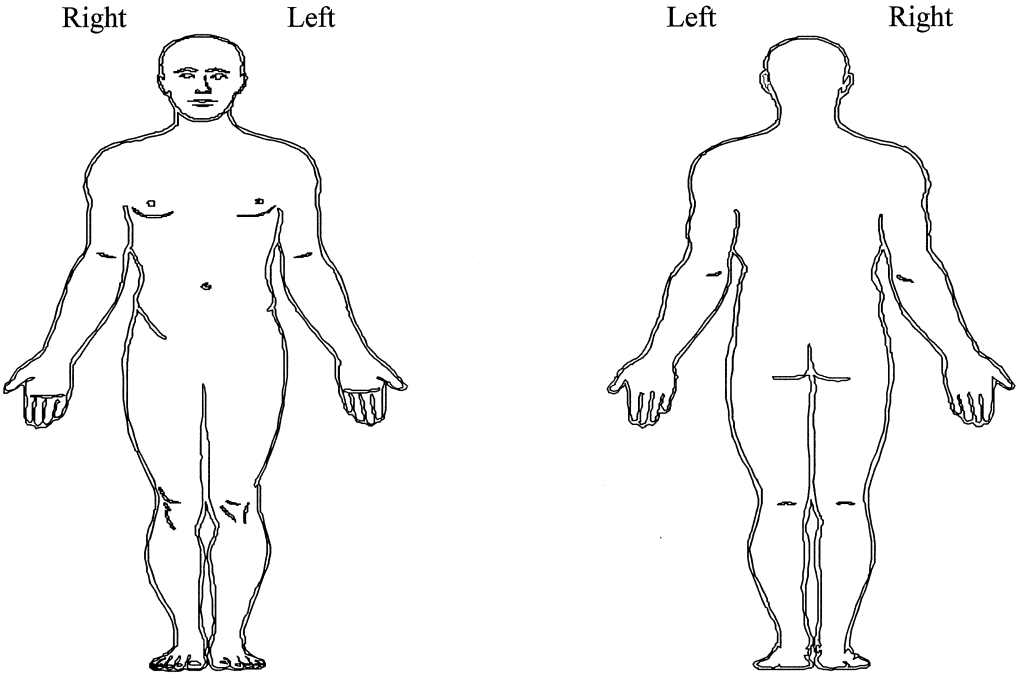
01-27-16

For Exams & Re-exams Insurance / Cash

COMPLAINTS & TREATMENT AUTHORIZATION

I, _____, certify that the complaints listed below are true as related by me. I wish to be treated for these complaints and any additional complaints or problems, which may arise during the course of my consultant, exam and treatment(s).

Please circle ALL the areas of your complaints that use the appropriate symbol below that best depicts your complaint(s).



Dull & Achy:	**D**	**Cramping:**	**C**	**Throbbing:**	**TH**
Burning:	**B**	**Numbness:**	**N**		
Tingling:	**T**	**Sharp:**	**S**		

As well if you have any scars or bruises, please circle area and label accordingly.

Use the pain scale below to describe the complaint(s) that you have circled in the diagram above.

No Pain = 0	**Uncomfortable = 4**	**Unable to Work = 8**
Mildly Uncomfortable = 2	**Very Uncomfortable = 6**	**Terrible Pain = 10**

CHIEF COMPLAINTS OR SYMPTOMS:

WHEN COMPLETING THE FOLLOWING COMPLAINT SECTION PLEASE BE THOROUGH. ANY AREA(S) OF PAIN THAT YOU LIST, SUCH AS NECK PAIN, MUST HAVE CORRESPONDING ACTIVITIES THAT AGGRAVATE THIS PAIN. FOR EXAMPLE, ACTIVITIES SUCH AS TURNIG YOUR HEAD WHILE DRIVING OR READING OR WORKING ON THE COMPUTER MAY ALL INCREASE NECK PAIN.

Neck Pain: **Left** **Right** **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.
Circle all areas of radiation, if any:

left shoulder	left arm	left forearm	left hand	base of skull
right shoulder	right arm	right forearm	right hand	none

The neck pain also seems to be related to: headaches upper back pain

List any particular activity that aggravates this condition:

1._____2._____3._____

Upper Back Pain: **Left** **Right** **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

Select or list the areas of radiation, if any or circle none.

left neck	left shoulder	left arm	none
right neck	right shoulder	right arm	Other _____

List any particular activity that aggravates this condition:

1._____2._____3._____

Middle Back Pain: **Left** **Right** **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Low Back Pain: **Left** **Right** **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

Select the areas of radiation, if any: left hip left thigh left knee left foot

no radiation of pain right hip right thigh right knee right foot

List any particular activity that aggravates this condition:

1._____2._____3._____

Shoulder Pain: **Left** **Right** **Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Elbow Pain: **Left** **Right** **Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Wrist Pain: **Left** **Right** **Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Hip Pain: **Left** **Right** **Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Knee Pain: **Left Right Bilateral**
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the intensity (severity) of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Foot Pain: Left Right Bilateral
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

Other Complaints:
Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.
Describe the intensity (severity) of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 _____.
This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

List any particular activity that aggravates this condition:

1._____2._____3._____

The following are complicating factors that have a tendency to slow down healing and response to care; please circle all apply:

- ☐age greater than 45
- ☐Metabolic disorders such as diabetes, fibromyalgia, chronic fatigue, celiac disease, lupus
- ☐History of numerous injuries or auto accidents, > 4 minor or greater than 1 major
- ☐Congenital anomalies of the spine such as spina bifida
- ☐Developmental anomalies of the spine
- ☐Rheumatoid arthritis or other arthritides affecting the spine
- ☐Ankylosing spondylitis or other spondylarthropathy
- ☐Degenerative disc disease
- ☐Disc protrusions (HNP)
- ☐Scoliosis
- ☐Prior cervical spinal surgery
- ☐Prior lumbar spinal surgery
- ☐Prior vertebral fracture
- ☐Osteoporosis
- ☐Spinal stenosis or foraminal stenosis
- ☐Prior spinal injury
- ☐Smoker
- ☐Prior drug or alcohol abuse
- ☐ Poor diet
- ☐ Poor fitness habits
- ☐ Overweight greater than 25 lbs.

Date: _____ Patient Signature: _____