

• GOSHORN CHIROPRACTIC •

725 Ridge Road, Webster NY 14580
 Phone: 585-671-0934 Fax 585-671- 9082

| | | | | | | | | | |
|---|------------------------|---|--|------------|---|--|---|--|--|
| Patient Last Name | | Patient First Name | | M.I. | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Age | Date of Birth (MM/DD/YYYY) | | |
| Insurance ID | | Insured Last Name | | First Name | | Home Phone Number | | | |
| Patient Address | | | | City | | State | Zip | | |
| Employer Name/ Occupation | | | Emergency Contact: Name/Number | | | Work Phone Number/Cell Phone Number / | | | |
| Is illness or injury related to <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other | | Do you have other insurance that might Cover this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Referred by: | | | |
| Marital Status | Primary Care Physician | | Social Security # | | E-mail Address | | | | |
| Please list your reasons for this visit or your condition(s) in order of importance: 1. _____ 2. _____ | | Date you first noticed: 1. _____ 2. _____ | Using a scale in which "0" is none (no pain of symptoms) and "10" is severe pain or symptoms(s) circle the number that best reflects your condition: ↓ nonetosevere ↓ 0 2 3 4 5 6 7 8 9 10 | | | | Please check the box below that best represents how much of the time you feel pain or your symptom(s) <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% | | |

For each of the reasons or conditions listed above, please mark how it happened:

1. Developed over time Illness Injury Auto accident Other _____ I don't know
2. Developed over time Illness Injury Auto accident Other _____ I don't know

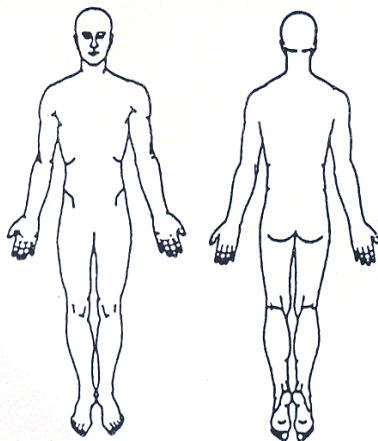
For each reason listed above, please check if it is better or worse with any of the following:

| | HEAT | | COLD | | REST | | ACTIVITY | | OTHER | | ----- |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------|
| | <u>better</u> | <u>worse</u> | <u>better</u> | <u>worse</u> | <u>better</u> | <u>worse</u> | <u>better</u> | <u>worse</u> | <u>better</u> | <u>worse</u> | |
| Reason 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ----- |
| Reason 2 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ----- |

Please check the box that best describes whether your pain
or symptom(s) limit normal activities:

Please mark the areas of discomfort
or pain on the figures
to the right using
the **symbol** that
best describes
the feeling:

- +++ Sharp or stabbing
 ooo Pins and needles
 vvv Dull or aching
 /// Numbness



| Activity | Normal | Somewhat Limited | Severely Limited |
|-------------------------|--------------------------|--------------------------|--------------------------|
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Climbing Stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Running | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Resting in bed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Computer work/typing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Normal work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Household activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Recreational activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other list below: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please continue on next page.

Please continue.....

- a. During what time of the day do you feel worse? _____
- b. Do you sleep well? Yes No What are your normal sleeping hours ? _____ **To** _____
- c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
 No Yes → For what condition? _____
 Name of doctor / provider _____ phone # _____
- d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
 No Yes If yes please describe each event below.
 Event: _____ Year _____
 Event: _____ Year _____
 Do you exercise? Yes No If yes please describe activity _____
 How many days a week? _____ How many minutes per session? _____

Personal History : Please read the following list and check the box next to each condition that applies to you.

Pain in Body

- Neck pain with difficulty swallowing
- Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- Leg pain that worsens with exercise but is relieved by resting.
- Loss of feeling in inner thighs
- Back pain with urinary problems

Types of Pain

- Severe pain interrupts sleep
- Constant pain that doesn't improve by changing positions or lying down

Current Conditions

- Unable to balance when walking
- Recent unexplained weight loss
- Recent progressive muscle weakness or shaking

- Recent or current fever over 104° F
- Loss of bowel or bladder control
- Blurred or double vision, dizziness nausea or faintness when neck is in certain positions
- Recent major accident such as a fall from height, whiplash or blow to the head
- Memory loss after injury

Previously diagnosed condition / Medical history

- Congenital bone or joint disorder
- Rheumatoid arthritis
- Allergies _____

- Severe degenerative arthritis
- History of compression fracture
- History of heart attack
- History of stroke or aneurysm
- Past history of cancer or currently diagnosed with cancer
- Diabetes with cold, burning numb feet
- Gout
- Lupus
- Ankylosing spondylitis
- Immune suppression such as from Chemotherapy, organ transplant, etc
- 3 or more months use of steroid medications or intravenous drugs (past or recent)

Please list all medications and supplements:

Family History

- Autoimmune disorders
- Arthritis
- Cancer
- Diabetes
- Heart Disease
- Kidney disease
- Mental Illness
- Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the Release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for the Payment, utilization and /or quality review for all or a portion of my care.

Signature: _____ **Today's date** ____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ **Relationship** _____ **Today's date** ____/____/____