PRO REHAB
Chiropractic & Rehabilitation Services

Initial Health Status — *Chiropractic*

Patient Name:_____ Birthdate:_____ Sex: **M / F**

Address: _____

City: _____ State: _____ Zip: _____ E-Mail Address: _____

Occupation: _____ Employer: _____ SS# _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Emergency Contact:_____ Phone:_____ Relation: _____

Describe your current problem and how it began.

❑ Headache ❑ Neck Pain ❑ Mid-Back Pain ❑ Low Back Pain

Other:_____

Is this? ❑ Work Related ❑ Auto Related ❑ N/A

Date Problem Began: _____/_____/_____

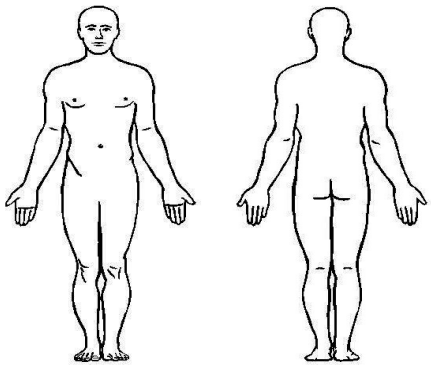
How Problem Began: _____

Current Complaint (How you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain *Unbearable Pain*

Please mark an **X** on the picture where you have pain or other symptoms.



How often are your symptoms present?

❑ 0-25%(Occasional) ❑ 26-50% ❑ 51-75% ❑ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities?

0 1 2 3 4 5 6 7 8 9 10

No interference *Unable to carry on activities*

Have you had any imaging studies (X-Ray, MRI, etc.) for the area(s) of your complaint? **Y / N**

In general, how would you say your overall health is right now? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Please check any of the following that apply to you:

❑ Alcohol/Drug Dependence
❑ Menstrual Problems
❑ High Blood Pressure
❑ Abnormal Weight ❑ Gain ❑ Loss
❑ Taking Birth Control Pills
❑ Pain at night
❑ Cancer/Tumor
❑ Epilepsey/Seizures
❑ Prostate Problems
❑ Diabetes
❑ Currently Pregnant, # weeks _____
❑ Corticosteriod use (Cortisone/Prednisone etc.)
❑ Pain Unrelieved by position or rest
❑ Numbness in Groin/Buttocks
❑ Tobacco Use
❑ Surgeries _____
_____
❑ Recent Fever
❑ Urinary Problems
❑ Stroke
❑ Marked Morning Pain/Stiffness
❑ Dizziness/Fainting
❑ Visual Disturbances
❑ Osteoporosis
❑ Other: _____
_____

I certify to the best of my knowledge, that the above information is complete and accurate. I agree to notify this practitioner immediately whenever I have changes in my health condition, or health plan coverage in the future. I request that payment of authorized benefits be made to the above named practitioner, on my behalf, for any services rendered to me. I agree to pay all of these charges not covered by a third party payer. I am financially responsible for all fees incurred, regardless of medical insurance. If the debt must be sent to a collection agency, I understand I will assume responsibility to pay any and all charges set forth by the collection agency. I understand that my practitioner or his affiliates may need to contact my physician, insurance company, or lawyer to coordinate my care. Therefore I give authorization to do so if necessary. I authorize a copy of this to be used in place of the original.

Patient Signature: _____ Date: _____