Somerset Hills
CHIROPRACTIC

Patient Health Assessment

General Information

Patient Name_____ Date_____

Patient Address_____

City_____ State_____ Zip Code_____

Home Phone #_____ Work Phone#_____ Cell#_____

E-mail address_____ Date of Birth_____

Patient Occupation_____ Social Security#_____

Patient Employer_____

Name of Insured (if other than you)_____

Relation to Patient_____ Insured Soc.Security#_____

Insured's Employer_____

Referred for Treatment by_____

Health Insurance Plan_____ Group#_____ Member ID#_____

Other Health Insurance_____

Symptom/Condition History

1) Please describe your current condition and how the problem began_____

_____

2) How long have you had this problem? _____

3) How would you describe your pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness

☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

4) How would you rate the intensity of your pain right now? (Circle a number)

0 1 2 3 4 5 6 7 8 9 10
(minimal) (mild) (moderate) (severe) (unbearable)

5) How often is the pain present during your waking day? (Check appropriate box)

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

6) Since your problem began, is your pain

☐ Getting better ☐ Getting worse ☐ Staying the same

7) How did your problem begin? _____

☐ Auto accident ☐ Work related accident ☐ Other type of accident

☐ Gradual ☐ Sudden ☐ No specific reason

8) What makes your problem better?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Lying down ☐ Moving ☐ Rest

9) What makes your problem worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Lying down ☐ Moving ☐ Rest

10) Are you currently taking any medications for this condition or any other conditions?_____

11) Were you previously treated for this condition? ☐Yes ☐ No
If yes, please describe by whom ☐ MD/DO ☐Chiropractor ☐ Physical therapist
☐ Acupuncturist ☐other_____

12) What were the approximate dates of treatment, the type of treatment and how did you respond to treatment?_____
_____

13) What is your physical activity at work?
☐ Mostly sitting ☐ Light manual ☐ Moderate manual ☐ Heavy manual

14) Do you exercise?
☐ No regular exercise ☐ 1-2 times/week ☐ 3-4 times/week ☐5-7 times/week
☐ Cardiovascular ☐ Stretching ☐ Weight Machine ☐ Free Weights
☐ Sports _____

15) What is your general stress level?
☐ No stress ☐ Minimal stress ☐ Moderate Stress ☐ Greatly stressed

16) Do you take vitamins, herbs or nutritional supplements?
☐ No ☐ Yes If yes, what do you take? _____

17) Is your problem affecting your ability to work or do other routine daily activities?
☐ No effect ☐ Have some restrictions but can function
☐ Need some assistance with activities ☐ cannot work
☐ cannot function without assistance ☐ totally disabled

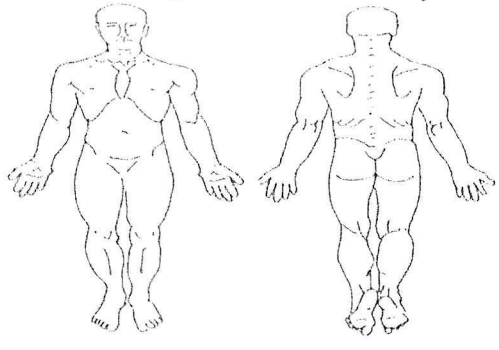
Past or Present Symptoms, Conditions or Habits

Please check the box indicating whether this applies to past or present.

Symptoms/Conditions	Past	Present
Rheumatoid arthritis	☐	☐
Ankylosing spondylitis	☐	☐
Bone fractures	☐	☐
Malignancy of the spine	☐	☐
Infection of the bones or joints	☐	☐
Myelopathy	☐	☐
Cauda Equina syndrome	☐	☐
Carotid artery problems	☐	☐
Aneurysm	☐	☐
Instability of joints	☐	☐
Benign tumors of the spine	☐	☐
Osteoporosis	☐	☐
Bleeding disorders	☐	☐
Nerve problems	☐	☐
Anticoagulants/blood thinning therapy	☐	☐
Dizziness	☐	☐
Drop Attacks	☐	☐
Double vision	☐	☐
Difficulty speaking	☐	☐
Difficulty swallowing	☐	☐
Nausea	☐	☐
Numbness	☐	☐
Nystagmus	☐	☐
Neck pain	☐	☐

Jaw pain	☐	☐
Headaches	☐	☐
Fainting spells	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐
Transient ischemic attacks	☐	☐
Shoulder pain	☐	☐
Arm/hand pain	☐	☐
Upper back pain	☐	☐
Lower back pain	☐	☐
Hip pain	☐	☐
Knee pain	☐	☐
Ankle/foot pain	☐	☐
Arthritis	☐	☐
Fatigue	☐	☐
Respiratory condition	☐	☐
Digestive problems	☐	☐
Kidney problems	☐	☐
Menstrual problems	☐	☐
Sinus/ allergy/ asthma conditions	☐	☐
Weight gain/loss	☐	☐
Cancer	☐	☐
Skin condition	☐	☐
Diabetes	☐	☐
Prostate problems	☐	☐
Tobacco use	☐	☐
Alcohol use	☐	☐
Caffeine use	☐	☐
Pregnancy	☐	☐
Surgery	☐	☐

Please shade in the figures below where you have pain.



Signature_____ Date_____