

2) How long have you had this problem?

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

Symptom/Condition History

Other Health Insurance _____

Health Insurance Plan _____ Group# _____ Member ID# _____

Referred for Treatment by _____

Insured's Employer _____

Relation to Patient _____ Insured Soc. Security# _____

Name of Insured (if other than you) _____

Patient Employer _____

Patient Occupation _____ Social Security# _____

E-mail address _____ Date of Birth _____

Home Phone # _____ Work Phone# _____ Cell# _____

City _____ State _____ Zip Code _____

Patient Address _____

Patient Name _____ Date _____

General Information

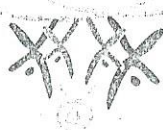
Patient Health Assessment

Dr. William Wallace

Dr. Glenn Eigenmann

Dr. Brian Wallace

Somerset Hills
CHIROPRACTIC



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 (minimal) 1 2 3 4 5 6 7 8 9 10 (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?

- 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

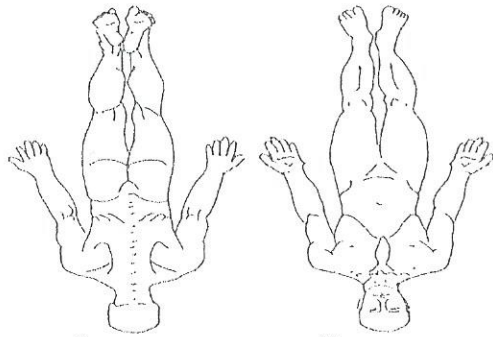
Past or Present Symptoms, Conditions or Habits

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

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

Signature _____

Date _____



Please shade in the figures below where you have pain.

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