Pittsburgh Chiropractic & Manual Therapy Center

Patrick Jones, D.C.
Jaclyn Andrews, D.C.

Name_____ Date_____ Referral_____
Address _____ City_____ State_____ Zip Code_____
Home Phone_____ Work Phone _____ Cell Phone _____
E-mail_____ Age_____ Birth Date___/___/_____ Sex M/F Marital Status M S W D
Occupation_____ Employer_____ Years Employed_____

REASON FOR THIS VISIT

Nature of Injury: ☐ Automobile ☐ Work ☐ Other
Please describe the reason for your visit. If exact date is not known, a rough date is acceptable.
Date Condition Began ____/____/____. _____
_____
Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, when? _____
List other practitioners you have seen for this injury/condition. _____

What treatment have you had for this condition in the past?

☐ Physical therapy ☐ Chiropractic ☐ Injections ☐ Surgery
☐ Medications ☐ Massage ☐ Other:_____

Mark any of the following tests/exams you have had and indicate the date:

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound
☐ NCV/EMG ☐ Blood work ☐ Other:_____

How often are your symptoms present?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What time of day or week is your pain worse? _____

Since it began, is your condition: ☐ Improving ☐ Getting worse ☐ Staying the same

What makes the condition better?

☐ Sitting ☐ Standing ☐ Walking
☐ Movement ☐ Exercise ☐ Inactivity/Rest
☐ Lying down ☐ Medication ☐ Stretching
☐ Ice ☐ Heat ☐ Other:_____

What makes the condition worse?

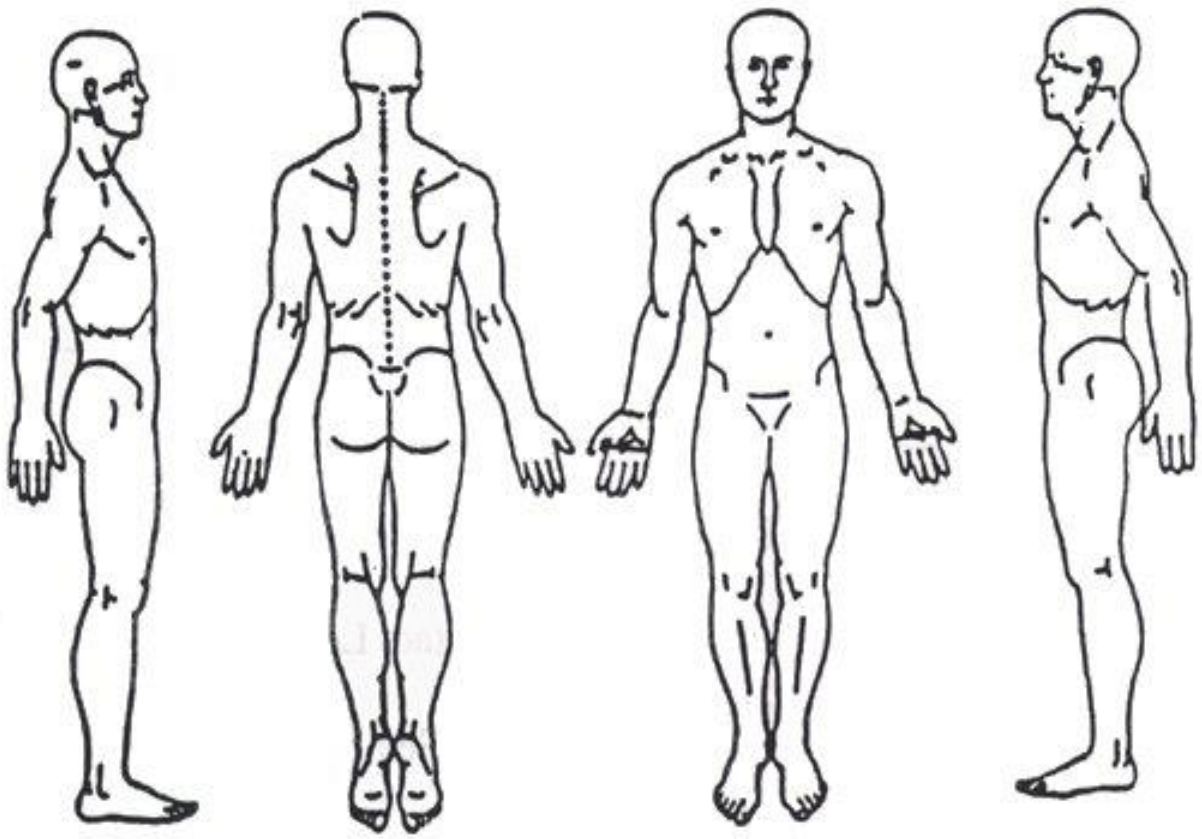
☐ Sitting ☐ Standing ☐ Walking
☐ Movement ☐ Exercise ☐ Inactivity/Rest
☐ Driving ☐ Reaching ☐ Stress
☐ Coughing ☐ Sneezing ☐ Lying Down
☐ Lifting (heavy) ☐ Lifting (light) ☐ Bending
☐ Stair stepping ☐ Twisting ☐ Looking up
☐ Looking Down ☐ Other:_____

Describe your current symptoms:

☐ Dull	☐ Aching	☐ Sore	☐ Tight
☐ Stiff	☐ Throbbing	☐ Shooting	☐ Sharp/Stabbing
☐ Radiating	☐ Tingling	☐ Numbness	☐ Burning
☐ Weakness	☐ Other:_____		

Attempt to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ////////////////// **Tingling** XXXXXXXX **Burning** BBBBBBBB **Stabbing** SSSSSSSS **Aching** AAAAAAAAA
Dull DDDDDDDD **Tight** TTTTTTTT **Weakness** WWWW **Shooting** ZZZZZZZZZ



VAS: Mark the number(s) that accurately represents the intensity of your pain for your complaint(s):

Neck Low back
Example: (NO PAIN: 0 1 2 (3) 4 5 6 7 X 9 10 UNBEARABLE PAIN)

Pain TODAY: **0 1 2 3 4 5 6 7 8 9 10**

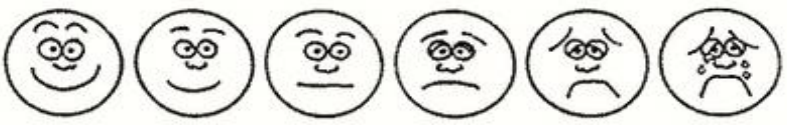
AVERAGE Pain: **0 1 2 3 4 5 6 7 8 9 10**

Pain at BEST: **0 1 2 3 4 5 6 7 8 9 10**

Pain at WORST: **0 1 2 3 4 5 6 7 8 9 10**

Do you engage in physical activity? YES NO
Indicate the average duration of activity in minutes and days per week. <15 20-30 30-60 60+ 1 2 3 4 5/week

How would you rate your current level of health?



Medical History

Have you been treated for any conditions in the past year? ☐ Yes ☐ No

If yes, please describe: _____

Is there a chance you are pregnant? ☐ Yes ☐ No

What medications are you taking and for what conditions? (Please list dosage and frequency):

_____

_____

What vitamins, minerals, or herbs do you currently take and for what conditions? (Please list dosage and frequency)

_____

Have you ever:	Yes	No	Briefly explain:
Broken bones?	☐	☐	
Been hospitalized?	☐	☐	
Been in an auto accident?	☐	☐	
Had sprains/strains?	☐	☐	
Been struck unconscious?	☐	☐	
Had surgery?	☐	☐	
Prolonged use of corticosteroids?	☐	☐	

Family History

List present and past health conditions of family members. (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	Yes	No
Do your symptoms interfere with daily life?	Yes	No
Do changes in weather affect your symptoms?	Yes	No
Do you wear orthotics?	Yes	No

Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Water	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods/Sweeteners	☐	☐	☐	☐

Have you suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chest pain/conditions
- ☐ Cold extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion problems
- ☐ Dizziness
- ☐ Ears ring
- ☐ Excessive menstruation
- ☐ Eye pain/difficulties
- ☐ Fatigue
- ☐ Frequent urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High blood pressure
- ☐ Hot flashes
- ☐ Irregular heart beat
- ☐ Irregular cycle
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Loss of balance
- ☐ Loss of memory
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Pacemaker
- ☐ Prostate trouble
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shortness of breath
- ☐ Sinus infection
- ☐ Sleep problems/insomnia
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen joints
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose veins
- ☐ Other: _____

Other – details to be covered during consultation:

YES NO Do you have a history of cancer?
YES NO Have you had any unexplained weight loss?
YES NO Failure to respond to a course of conservative care (4-6 weeks)?
YES NO Have you had spinal pain for more than 6 weeks?

YES NO Prolonged use of corticosteroids (such as organ transplant Rx)?
YES NO Intravenous drug use?
YES NO Current or recent urinary tract, respiratory tract, or other infection?
YES NO Immunosuppression medication &/or condition?

YES NO History of significant trauma?
YES NO Minor trauma in person >50 years old?
YES NO Do you have osteoporosis? (weak bones)

YES NO Acute onset urinary retention or overflow incontinence (wet underwear)?
YES NO Loss of anal sphincter tone or fecal incontinence (bowel accidents)?
YES NO Saddle anesthesia (numbness in groin region)?
YES NO Global or progressive muscle weakness in the legs (legs give out)?

YES NO Do you feel your problem can be helped?
YES NO Do you avoid activities because of pain?
YES NO Are you dissatisfied with your job or current status in your life?
YES NO If your condition did not fully resolve, would you be ok with that?

Do you have any fears, worries, and/or concerns?

_____
_____
_____
_____