Lovett Chiropractic Pain Relief Clinic

REQUIRED FOR YOUR CASE HISTORY FILE

(Form CH2017)

Name: _____Date of Birth: _____ Age: ____ Gender: Male Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Occupation: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
Insurance Carrier: _____
Marital Status (circle): Married Single Widowed Divorced Separated Number of Children: _____
Name of Spouse/Guardian: _____
Smoking Status: Current Daily ____ Current Some Days ____ Former ____ Never ____
Please list current medications with dosages (mg): _____
_____
Please list medication allergies: _____
Race: White Black Native American Asian Other Unknown Ethnicity: Hispanic Non-Hispanic
MAIN COMPLAINT TODAY: _____

Any other current symptoms? (*check all answers*)

( ) Headaches	( ) Dizziness	( ) Sleeping Problems	( ) Buzzing in Ears	( ) Fainting
( ) Neck Pain	( ) Feet Cold	( ) Nervousness	( ) Loss of Smell	( ) Face Flushed
( ) Neck Stiff	( ) Hands Cold	( ) Head Feels Heavy	( ) Loss of Taste	( ) Cold Sweats
( ) Back Pain	( ) Depression	( ) Loss of Memory	( ) Lights Bother Eyes	( ) Ears Ring
( ) Tension	( ) Fatigue	( ) Shortness of Breath	( ) Head Feels Heavy	( ) Diarrhea
( ) Irritability	( ) Fever	( ) Numb in Fingers	( ) Pins/Needles in Arms	( ) Loss of Balance
( ) Chest Pain	( ) Constipation	( ) Stomach Upset	( ) Pins/Needles in Legs/Toes	

Please list any health conditions/surgeries you have been treated for in the last year: _____
_____
Please explain any previous serious illness: _____
_____
Anyone in your family history with the following? If yes, please list relationship to you:
Heart Disease _____ Back Problems _____
Cancer _____ Disc Problems _____
Diabetes _____ Arthritis _____
Other _____

Have you ever suffered from: (*circle your answer*)

Dizziness	Yes	No	Arthritis	Yes	No	Neuritis	Yes	No
Backaches	Yes	No	Headaches	Yes	No	Digestive Disorders	Yes	No
Heart Trouble	Yes	No	Numbness	Yes	No	Nervousness	Yes	No
Diabetes	Yes	No	Lung Problems	Yes	No	Sinus Trouble	Yes	No
Tuberculosis	Yes	No	Anemia	Yes	No	Rheumatic Fever	Yes	No
Cancer	Yes	No	Kidney Trouble	Yes	No			

If yes, explain:_____

FEMALES ONLY (For X-ray Purposes): Are you possibly pregnant? Yes_____ No_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date