Welcome to Our Office
Just a few reminders

ANSWER ALL QUESTION
NONE ARE OPTIONAL

MARK ON THE DIAGRAM OF THE BODY
WHERE THE PROBLEM IS

MEDICARE AND MAJOR MEDIACL DO NOT COVER
OLD INJURIES THAT HAVE NOT CHANGED
OR MAINTAINACNE CARE

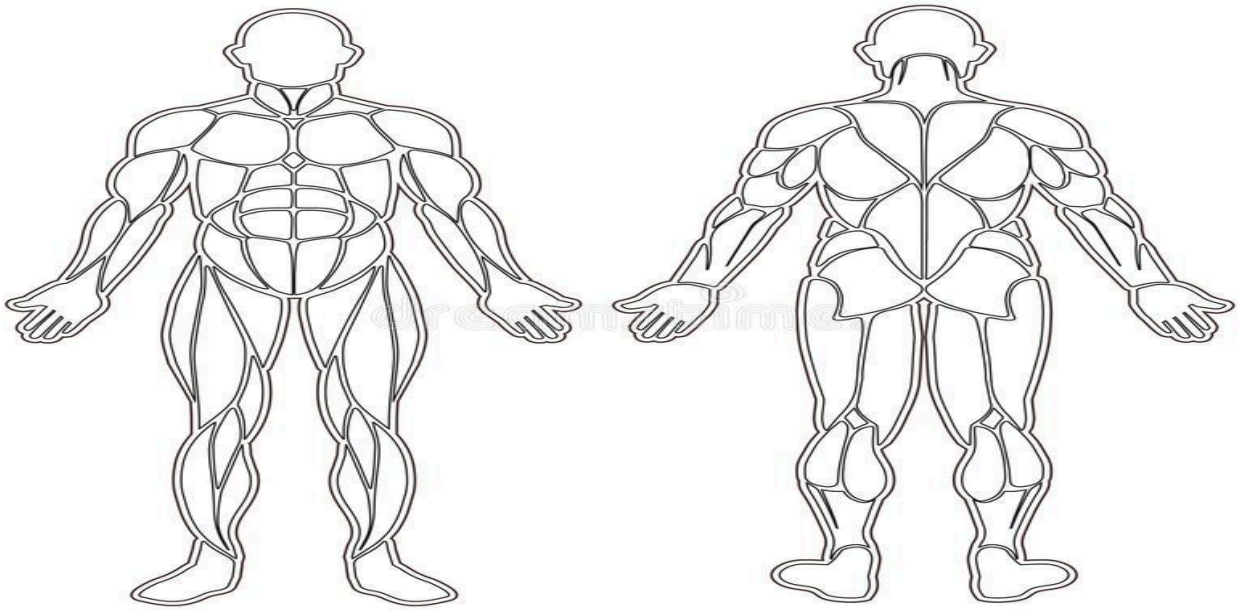
WITH THAT IN MIND QUESTION 2 ASKES FOR A
DATE OF ONSET FOR YOUR CONDITION.
IF IT IS AN OLD INJURY, CHOOSE A RECENT DATE
THAT THE PROBLEM BECOME WORSE
THIS DOES NOT APPLY FOR CAR ACCIDENTS AND
WORKERS COMPENSATION
ANSWER ONLY IN MONTH/ DAY/ YEAR FORMAT

Port Jervis Chiropractic – Dr Joseph J Spano – 27 East Main Street – Port Jervis NY 12771 – 845-858-8000

Medical History / Intake

1] Please mark on the diagram the exact area where the problem is located.
(Be Specific) If there is more than area label them 1, 2 and so on from worst pain to least pain.
IF PAIN IS TRAVELING INTO AN ARM OR LEG MARK IT DOWN !!!

Front of Body **Back of Body**



2] Date of Onset [When problem Began] **(Answer in this Format Only)** _____/_____/_____
Month Day Year

3] How Problem Began: [repetitive motions] [auto accident] [yard work] [Sleeping in a bad position] [Falling] [walking] [standing] [lifting] [Bending] [driving] [housework] [shoveling] [chopping fire wood] [sitting] [exercise] [Twisting] [vacuuming] [coughing] [sneezing] [Getting out of bed] [Getting out of vehicle] [Childbirth] [lifting children]
Other:_____

4] Frequency of Symptoms Constant (**76-100%**) Frequently (**50-75%**) Occasionally (**26 -50%**) Intermittently (**1-25%**)

5] Please Rate the Intensity of Pain (0 least pain 10 most pain)

0 .5 **1** 1.5 **2** 2.5 **3** 3.5 **4** 4.5 **5** 5.5 **6** 6.5 **7** 7.5 **8** 8.5 **9** 9.5 **10**

6**] Have you been treated by another medical for this injury?** ***Yes*** ***No*** What treatments have you received and by whom?
_____

7] Have you been treatment with Chiropractic Care in the past? ***Yes*** ***No*** **If Yes was treatment successful?** ***Yes*** ***No***
8] Describe the type of symptoms you are experiencing
Aching Dull Throbbing Stabbing Shooting Stinging Burning Pulling
Tugging Taut Tension Numbness Tingling Cramping Other:_____

9] Is the problem causing symptoms to travel into an Arm or a Leg? ***Yes*** ***No***
Location of traveling Pain Left Arm Right Arm Left Leg Right Leg

Patient Name _____ _____ _____/_____/_____
(printed) ***Signature*** ***Month Day Year***

10] What position of the body makes pain better?
Neutral posture Leaning forward Leaning backward Leaning right Leaning left Nothing Changes Pain

11] What position of the body makes pain worse?
Neutral posture Leaning forward Leaning backward Leaning right Leaning left Nothing Changes Pain

12] What Does this issue prevent you from doing?_____

13] How Much Does this problem interfere with your work? None A little bit Moderately Quite a bit Extremely

14] How Much Does Problem interfere with your Social Activities? None A little Moderately Quite a bit Extremely

15] How Would you Rate your Overall Health? Excellent Very Good Good Fair Poor

16] Height _____ **Weight** _____ **Age** _____ **Last Blood pressure** _____/ _____ 120/80 is normal

17] Occupation _____ **Are you a Smoker?** *Yes* *No* **Packs per day**_____

18] What Type of Exercise do you do? Strenuous Moderate Light None

19] Do you had any of the following ?

Spinal Fusion C1/C2 C2/C3 C3/C4 C4/C5 C5/C6 C6/C7 C7/T1 T1/T2 T2/T3 T4/T5 T5/T6 T6/T7 T7/T8 T8/T9 T9/T10 T10/T11 T11/T12 T12/L1 L1/L2 L2/L3 L3/L4 L4/L5 L5/S1 **NONE**

Disc Removal C1/C2 C2/C3 C3/C4 C4/C5 C5/C6 C6/C7 C7/T1 T1/T2 T2/T3 T4/T5 T5/T6 T6/T7 T7/T8 T8/T9 T9/T10 T10/T11 T11/T12 T12/L1 L1/L2 L2/L3 L3/L4 L4/L5 L5/S1 **NONE**

Herniated / Bulging Disc C1/C2 C2/C3 C3/C4 C4/C5 C5/C6 C6/C7 C7/T1 T1/T2 T2/T3 T4/T5 T5/T6 T6/T7 T7/T8 T8/T9 T9/T10 T10/T11 T11/T12 T12/L1 L1/L2 L2/L3 L3/L4 L4/L5 L5/S1 **NONE**

Other _____

20] Do you have a History of Cancer? ***Yes*** ***No*** **Indicate Location of Cancer**
Bladder Breast Colorectal Kidney Lung Lymphatic Skin Oral Oropharyngeal Pancreatic Prostate Thyroid Uterine **Other** _____

21] Have you had any joint replacements? ***Yes*** ***No***
Location Left Shoulder Right Shoulder, Left Hip Right Hip, Left Knee Right Knee
Other _____

22] Do you have a Pacemaker? ***Yes*** ***No*** **Other implanted devices** ***Yes*** ***No*** _____

23] Do you have a history of Stroke? ***Yes*** ***No*** **Date that Stroke occurred** _____

24] Do you have or have had an Aneurysm? (burst or distended blood vessel) ***Yes*** ***No***
Location Abdominal Aorta Illiac Arteries Femoral Arteries Carotid Arteries Brain
Other _____

25] Do you have a history of Blood Clots? ***Yes*** ***No*** **Location of Clot and date that Clot occurred** _____
_____

26] Do you have a history of Carotid and or Vertebral Artery blockage or surgery? ***Yes*** ***No***
_____

27] Have you had Stents placed into any vessel in the body? ***Yes*** ***No*** **Location** _____
_____

Patient Name _____ _____ _____/_____/_____
(printed) **Signature** **Month** **Day** **Year**

28] Please write down a complete list of surgical procedures /hospitalizations /traumas_____

_____

_____

_____

29] Do you Experience night sweats? ***Yes*** ***No***

_____

30] Have you been diagnosed with a bone infection (Osteomyelitis) ***Yes*** ***No***

Explain: _____

31] Please circle any of the following that apply to your medical history

Headaches Neck Pain Upper Back Pain Mid Back Pain Low Back Pain Shoulder Pain Elbow Pain Wrist Pain
Hand Pain Hip Pain Leg Pain Knee Pain Ankle Foot Pain Jaw Pain Arthritis Cancer
Rheumatoid Arthritis Tumors Asthma High Blood Pres Stroke Angina Kidney Stone
Kidney Disorder Bladder Infection Ulcers Loss Of Bladder Control Hepatitis Gall Bladder
Prostate Disorder Dizziness Fatigue Weight Gain / Loss Diabetes Depression
Lupus Epilepsy Dermatitis Visual Disturbances Liver Disorder
Hormone Replacement Allergies Cysts Alcohol Dependency Drug Dependency
Lung Disease Gout Psychological Intestinal Disorders Urinary Disorders
Loss of Bowl Control Parkinsons ALS MS CP HIV/Aids Dementia
Loss of Appetite Blood Disorders

32] Please circle any of the following you are taking. Please provide the front desk with a complete list of Medications

Over the counter pain Meds Prescription Pain Meds Muscle Relaxers Blood Thinners Cholesterol Meds
Anti inflammatories Anti anxiety Antibiotics insulin
Other : _____

33] Family Medical History (Circle all that apply)

Father: Heart Disease Diabetes Lupus MS RA ALS Parkinson Stroke Cancer (Location _____)

Mother: Heart Disease Diabetes Lupus MS RA ALS Parkinson Stroke Cancer (Location _____)

Brother: Heart Disease Diabetes Lupus MS RA ALS Parkinson Stroke Cancer (Location _____)

Sister: Heart Disease Diabetes Lupus MS RA ALS Parkinson Stroke Cancer (Location _____)

34] Do you have any Legal Cases Pending? ***Yes*** ***No*** If Yes Explain:_____

_____

35] Do you have a disability Rating? ***Yes*** ***No*** Location _____ Rating % _____

36] <u>FOR WOMEN:</u> Are you Pregnant? ***Yes*** ***No*** **# of weeks?** _____ **Have you Seen an Obstetrician?** ***Yes*** ***No***

Is this pregnancy high risk? ***Yes*** ***No*** Explain: _____

 # Of Previous Births ? _____ **Have you had an epidural?** ***Yes*** ***No***

Signing below indicates that all information given on the above medical history is true and factual to the best of your knowledge and you have read and understand the Consent To Treatment form provided by our office and understand all risks in said treatment and consent to care.

Patient Name _____ _____ _____/_____/_____

(printed) ***Signature*** ***Month*** ***Day*** ***Year***