Rochester Sports Chiropractic, PLLC

Keven E. Hagen, DC

Patient Information

NAME: Date of Birth:

First Name:_____ _____

Last Name: _____

HOME ADDRESS:

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ E-Mail: _____

Height: _____ Weight: _____

MARITAL STATUS:

Married ☐ Single ☐ Divorced ☐ Other ☐

EMPLOYMENT STATUS:

Active Duty Military ☐ Employed ☐ Not Employed ☐ Retired ☐ Student ☐ Other ☐

Employer (if applicable): _____

Employee Phone Number: _____

FOR WOMEN ONLY -- Are you pregnant or trying to become pregnant?:

Yes ☐ Unsure ☐ No ☐

EMERGENCY CONTACT:

First Name: _____

Last Name: _____

Phone Number: _____

Insurance Information

POLICY HOLDER'S NAME:

First Name: _____

Last Name : _____

Policy Holder's Date of Birth: _____ Insured's ID: _____

POLICY HOLDER'S RELATIONSHIP TO PATIENT:

Self ☐ Spouse ☐ Child ☐ Other ☐

Health Summary

Describe major complaint(s):

_____

_____

Current allergies:

_____

_____

Describe compaint/intensity:
Sharp ☐ Stabbing ☐ Achy ☐ Dull ☐ Stiff & Sore ☐ Other ☐

Frequency of complaint:
Constant ☐ On/Off ☐

Since onset, symptoms are:
Better ☐ Worse ☐ Similar/Same ☐

Symptoms are better during:
Morning ☐ Mid-Day ☐ Evening ☐

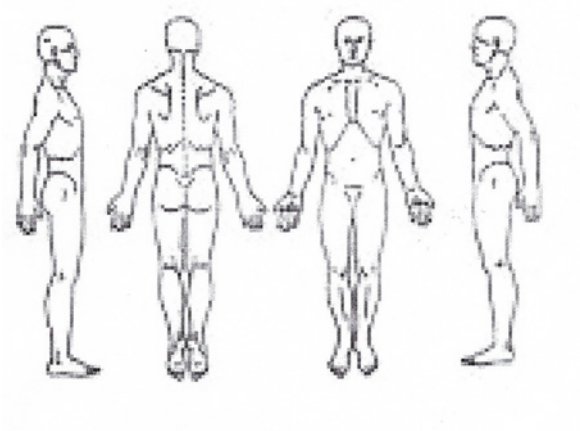
Symptoms are worse during:
Morning ☐ Mid-Day ☐ Evening ☐

Does it radiate to other areas of the body:
Base of Skull ☐ Forehead ☐ Sides of Head ☐ Temple ☐ Across Shoulder ☐ Elbows ☐
Hands/Fingers ☐ Hip ☐ Thigh/Knee ☐ Calf ☐ Foot/Toes ☐ Other ☐

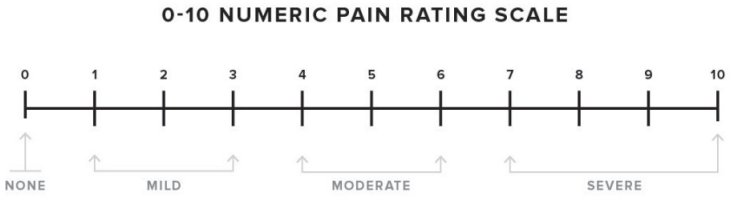
Does anything make the complaint better?:
Ice ☐ Heat ☐ Rest ☐ Movement ☐ Stretching ☐ Other ☐

Does anything make the complaint worse?:
Sit ☐ Stand ☐ Walk ☐ Laying Down ☐ Sleep ☐ Overuse ☐ Other ☐

Circle where you are experiencing pains:



Please rate your pain using the following:



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Which daily activities are being affected by this condition?:

_____

_____

Have you received treatment for this complaint?:

_____

_____

What medications have you taken (OTC/Prescriptions) for this complaint?:

_____

_____

Had any diagnostic testing?
X-Ray ☐ MRI ☐ CT ☐ Other ☐

Tobacco Use Status:
Never Smoked ☐ Former Smoker ☐ Social/Occasional Smoker ☐ Every Day ☐

Hours Sleep/Night_____ Times Exercise/Week_____

Ounces Water/Day_____ Alcoholic Drinks/Week_____

Urination/Day_____ Bowel Movements/Day_____

Family Health History: list relevant major health problems of immediate relatives:

_____

_____

List any major surgeries:

_____

_____

Check any symptoms you've ever had:

Arthritis ☐ Scoliosis ☐ Mental/Emotional Disorders ☐
Swollen or Painful Joints ☐ Skin Problems ☐ Bruise Easily ☐ Headaches ☐
Migraine Headaches ☐ Neck Pain ☐ Shoulder Pain ☐ Numbness or Tingling ☐
Carpal Tunnel Syndrome ☐ Dizziness ☐ Asthma ☐ Chest Pain ☐ Difficulty Breathing ☐
Heart Problems ☐ Heart Attack ☐ Low Blood Pressure ☐ High Blood Pressure ☐
Cancer ☐ Frequent Colds ☐ Upper Back Pain ☐ Blood Clots ☐ Constipation ☐
Diarrhea ☐ Kidney Problems ☐ Menstrual Problems ☐ Menopausal Issues ☐
Epilepsy/Convulsions ☐ Ringing in Ears ☐ Hearing Loss ☐ Loss of Balance ☐
Digestive Issues ☐ Depression ☐ ADD/ADHD ☐ Anxiety Disorder ☐ Eating Disorder ☐
Trouble Concentrating ☐ Loss of Memory ☐ Prostate Issues ☐ Varicose Veins ☐
Liver Issues ☐ Gall Bladder Issues ☐ Mid Back Pain ☐ Sciatica ☐ Fainting ☐ Stroke ☐
Vertigo ☐ Muscle Tightness ☐ Trouble Sleeping ☐ Diabetes ☐ Hyperthyroidism ☐
Hypothyroidism ☐ Changes in Weight ☐

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 answer which most closely describes your condition right now.**

1. Pain Intensity	No pain (0)	Mild pain (1)	Moderate pain (2)	Severe pain (3)	Worst possible pain (4)
2. Sleeping	Perfect sleep (0)	Mildly disturbed sleep (1)	Moderately disturbed sleep (2)	Greatly disturbed sleep (3)	Totally disturbed sleep (4)
3. Personal Care (washing, dressing etc.)	No pain no restrictions (0)	Mild pain no restrictions (1)	Moderate pain need to go slowly (2)	Moderate pain need some assistance (3)	Severe pain need 100% assistance (4)
4. Travel (driving, etc.)	No pain on long trips (0)	Mild pain on long trips (1)	Moderate pain on long trips (2)	Moderate pain on short trips (3)	Severe pain on short trips (4)
5. Work	Can do usual work plus unlimited extra work (0)	Can do usual work no extra work (1)	Can do 50% of usual work (2)	Can do 25% of usual work (3)	Cannot work (4)
6. Recreation	Can do all activities (0)	Can do most activities (1)	Can do some activities (2)	Can do few activities (3)	Cannot do any activities (4)
7. Frequency of pain	No pain (0)	Occasional pain 25% of day (1)	Intermittent pain 50% of the day (2)	Frequent pain 75% of the day (3)	Constant pain 100% of the day (4)
8. Lifting	No pain with heavy weight (0)	Increased pain with heavy weight (1)	Increased pain with moderate weight (2)	Increased pain with light weight (3)	Increased pain with any weight (4)
9. Walking	No pain any distance (0)	Increased pain after 1 mile (1)	Increased pain after ½ mile (2)	Increased pain after ¼ mile (3)	Increased pain any distance (4)
10. Standing	No pain after several hours (0)	Increased pain after several hours (1)	Increased pain after 1 hour (2)	Increased pain after ½ hour (3)	Increased pain with any standing (4)

Name: _____ _____ Total Score _____

PRINTED **Date**

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