

# GLOWAKI CHIROPRACTIC NEW PATIENT INTAKE

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Sex: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ HSA Flex

Insurance: Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Do you have one of the following? Amt \$ \_\_\_\_\_

Have you seen a Chiropractor before? Yes No If yes, when? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## YOUR HEALTH HISTORY

Please  check all symptoms you have ever had, even if they do not seem related to your current problems.

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in ears          | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Neck Stiff               | <input type="checkbox"/> Cold hands             | <input type="checkbox"/> Cold feet       |
| <input type="checkbox"/> Cold Sweats              | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Hot flashes     |
| <input type="checkbox"/> Mood Swings              | <input type="checkbox"/> Lights bother eyes       | <input type="checkbox"/> Problem urinating      | <input type="checkbox"/> Heartburn       |
|   | <input type="checkbox"/> Menstrual Pain           | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Ulcer           |

Main Complaint: \_\_\_\_\_

List any medications you are taking: \_\_\_\_\_

Have you been in a car accident recently? Yes No If so, when? \_\_\_\_\_

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: \_\_\_\_\_

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Use only CT#: \_\_\_\_\_

# Functional Rating Index

## Regarding your MAIN COMPLAINT

In order to properly assess your condition, we must understand how much your main complaint problems have affected your ability to manage everyday activities.

For each item below, please select the one choice which most closely describes your condition right now.

### 1. Pain Intensity

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No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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### 6. Recreation

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No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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### 2. Sleeping

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Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
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### 7. Frequency of Pain

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

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No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
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### 8. Lifting

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No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
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### 4. Travel (driving, etc.)

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No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on shorts trips	Severe pain on short trips
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### 9. Walking

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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
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### 5. Work

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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
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### 10. Standing

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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
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Name \_\_\_\_\_  
PRINTED

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date