

Required for Your Case History File: All Information Is Confidential

Full Legal Name _____ Name you prefer _____

Mailing Address _____

City _____ State _____ Zip Code _____

Telephone (Home) _____ Telephone (Work) _____

Email _____ Cell _____ Fax _____

Employer _____ Address _____

Name of Spouse _____ Number of Children _____

Spouse's Address _____ Telephone _____

Emergency Contact _____ Telephone _____

Referred by _____

Age _____ Date of Birth _____ Sex _____ Years of Education _____

Circle one: Married Single Widowed Divorced Separated

Occupation _____

Past chiropractic care? Yes No If yes, who? _____

Who is your primary care physician? _____

Last Physical Examination _____ Have you been treated for any health condition by a physician in the last year? Yes No If yes, explain _____

What medications/vitamins/herbs are you taking? _____

Are you allergic to any medications? Yes No If yes, list _____

Previous serious illness/ hospitalization: (Please date & describe) _____

Have ever had: Surgery Yes No Fractures Yes No Car Accidents Yes No
Falls Yes No On-Job Injury Yes No Describe: _____

Family history of: Heart disease Yes No Cancer Yes No Diabetes Yes No
Arthritis Yes No Back problems Yes No Other _____

If you are female, are you possibly pregnant? Yes No Date of last menstrual period _____

Major Symptom/Problem for this visit _____

Date symptoms first began _____

How did your symptoms first begin? _____

Other Symptoms _____

Pains is: Constant Intermittent Is your condition getting? Worse Better Same

What activities aggravate your condition? _____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? Yes No sleep? Yes No routine? Yes No

Other doctors seen for this condition _____

List home remedies tried _____

Do you have any of the following?

Constitutional

- ___ Unexplained Weight Loss
- ___ Fatigue or Weakness
- ___ Fever

Eyes

- ___ Glaucoma
- ___ Cataracts
- ___ Double Vision

Ears, Nose, Throat

- ___ Difficulty Hearing
- ___ Buzzing or Ringing in Ears
- ___ Dizziness
- ___ Loss of Smell
- ___ Sinus Trouble
- ___ Difficulty Swallowing
- ___ Loss of Taste

Skin

- ___ Rashes
- ___ Hives
- ___ Itching

Allergic/Immunologic

- ___ Hives/Hay Fever

Respiratory

- ___ Cold/Flu/Cough
- ___ Coughing Blood
- ___ Wheezing

Gastrointestinal

- ___ Nausea or Vomiting
- ___ Constipation
- ___ Diarrhea
- ___ Digestive Problems

Genitourinary

- ___ Blood in Urine
- ___ Bladder Leakage
- ___ Burning/Frequent Urination

Musculoskeletal

- ___ Spinal Pain
- ___ Joint Swelling
- ___ Joint Stiffness

Cardiovascular

- ___ Chest Pain
- ___ Shortness of Breath
- ___ Racing Heartbeat
- ___ Fainting Spells

Neurological

- ___ Headaches
- ___ Memory Loss
- ___ Tremors
- ___ Numbness
- ___ Loss of Strength
- ___ Seizures

Mental Status

- ___ Anxiety/Depression
- ___ Mood Swings
- ___ Difficult Sleeping
- ___ Stress

Endocrine

- ___ Loss of Hair
- ___ Heat/Cold Intolerance
- ___ Diabetes
- ___ Excessive Sweating
- ___ Change in Appetite

Hematologic/Lymphatic

- ___ Ease of bruising
- ___ Gums Bleed Easily
- ___ Enlarged Glands

Check if you have had any of the following symptoms in the last 30 days:

- Pain worse at night Constant pain unrelated to motion Unexplained weight loss
- Loss of bowel or bladder control Bacterial infection Surgery Fever or chills

Check if you have ever had any of the following:

- History of Cancer History of HIV Use of Steroids Use of IV Drugs Blood Transfusions

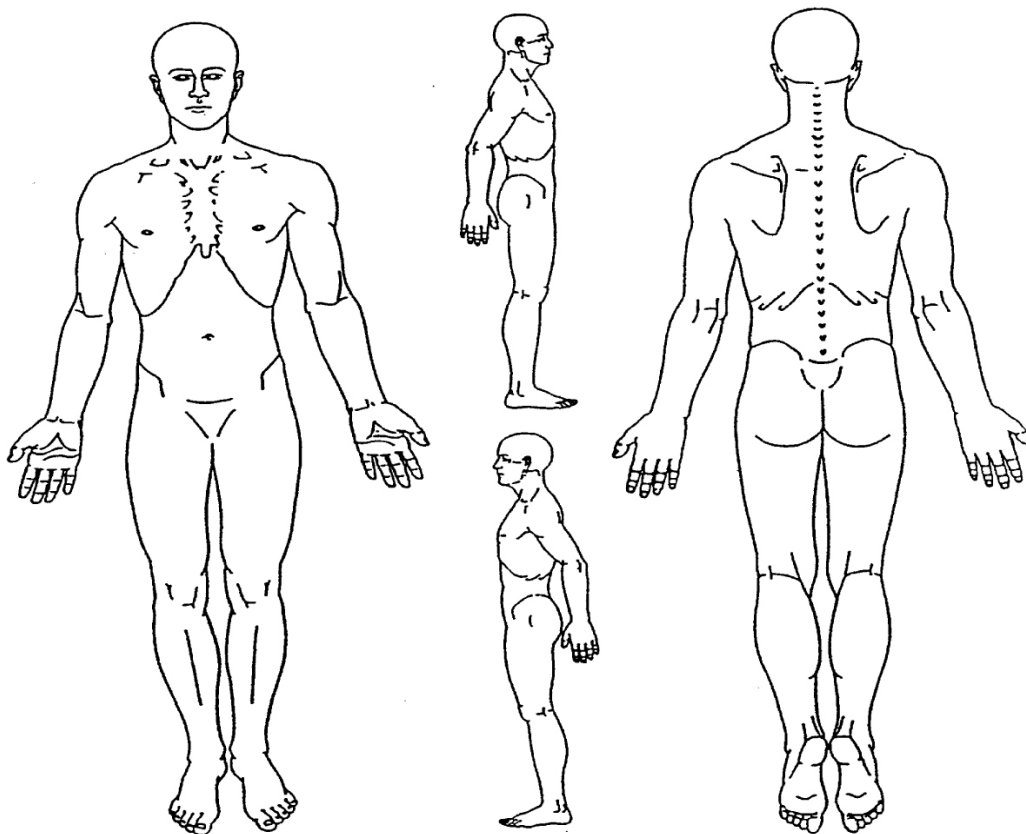
*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information you deem appropriate to any insurance company.

Signature _____ Date _____ form 105 a

Where is your pain now? Mark the areas where you feel sensations using the appropriate symbols. Please mark an X on the area where the pain is now worst.

Aching Numbness Pins and Needles Burning Sharp/stabbing Stiff/tight
 yyyyy === oooo zzzz ///// ***



How bad is your pain? On the scale below circle your pain.

Right now..... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

On average..... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

At its very worst... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Overall, is your pain generally: improving same worsening

Name _____ Date _____



Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized chiropractic care in a timely manner. Missed appointments and late cancellations inconvenience those individuals who need access to care. Our office policy regarding missed appointments enables us to better utilize available appointments for the needs of our patients.

Cancellation of an appointment: In order to be respectful of the needs of other patients, please be courteous and call us promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we ask that you call, email or text the office at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another patient the opportunity to be treated.

Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee.

Missed appointment/no-show policy: A "no-show" is someone who misses an appointment without notifying the office in advance to cancel. "No-shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". **The first time there is a "no-show" there will be no charge to the patient. Any additional "no-shows" will result in a fee of \$40.**

I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments. Additional information is available in the Notice of Privacy Practices which is available at the front desk and online at www.peakperformancencr.com.

Patient Signature (or responsible financial party)

Signature Date

Printed Patient Name

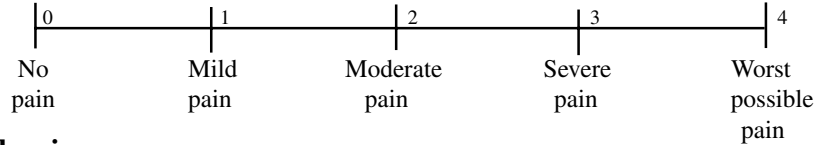
Functional Rating Index

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

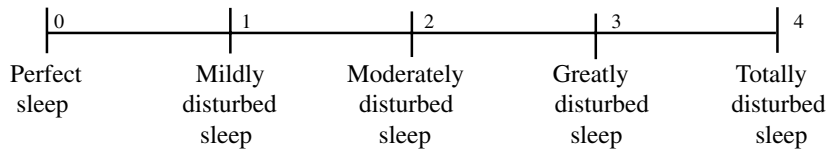
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

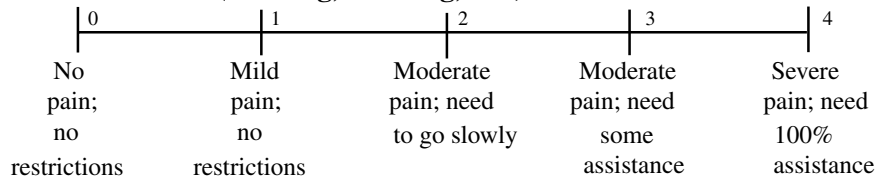
1. Pain Intensity



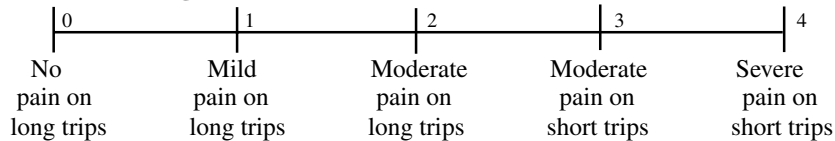
2. Sleeping



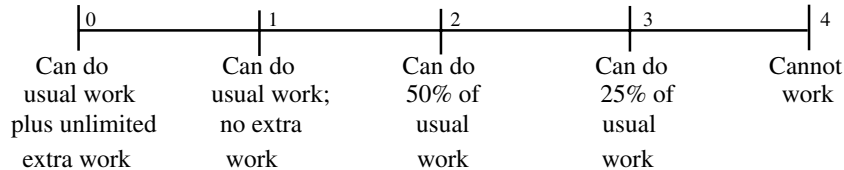
3. Personal Care (washing, dressing, etc.)



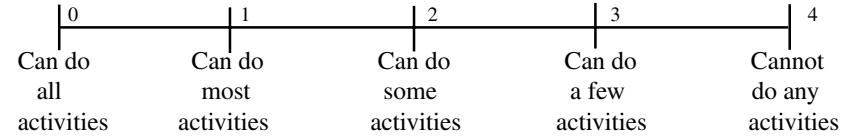
4. Travel (driving, etc.)



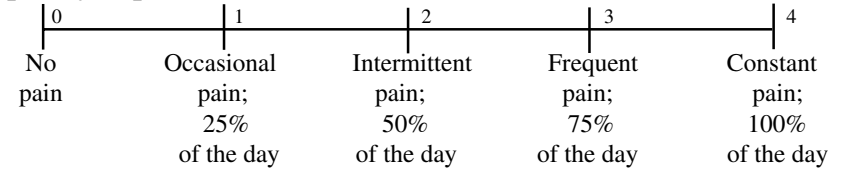
5. Work



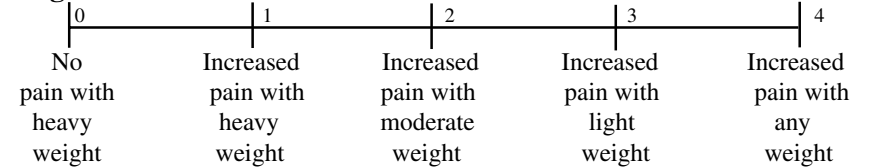
6. Recreation



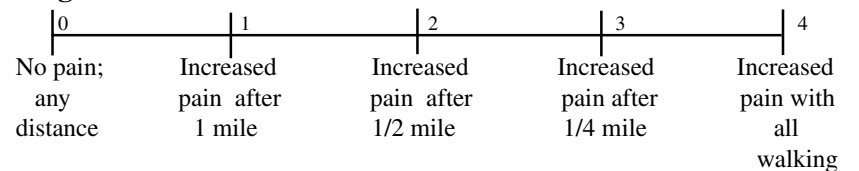
7. Frequency of pain



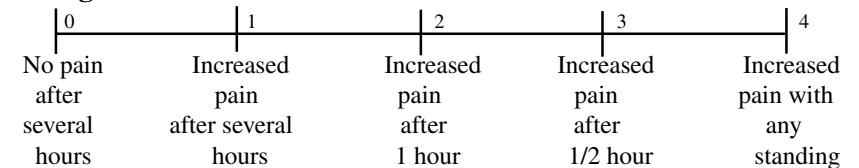
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature

Total Score _____

Date