Welcome to Our Office!

We're looking forward to meeting you and promise to work hard to make this a great experience.

Since you are going to be sharing some personal information with us on the next few pages, I thought it only fair that I share a few things about myself with you.

My wife and I moved from Chicago in early 2007 to start our family and The Chiropractic People. Prior to that, I practiced at a clinic for about six years right in the heart of the city. Our first born was on the way and we were eager to move out of our one-bedroom condo and get into an actual home. We now live in Batavia and have since had two more boys. We absolutely love the area and plan to be here for quite some time.

The Chiropractic People is my dream fulfilled and stands for everything that I believe a Family Chiropractic Wellness office should be. It's what I would expect for myself and my family if we were looking for a chiropractor. If you notice a lot of people having a good time with a smile on their face, don't worry, this is a typical day here and we're glad you're a part of it. Most everyone you see was referred by someone else. I hope you feel inclined to do the same for your family and friends after experiencing your own positive results.

I promise to listen to you and to fully understand the reason why you are here to see us. Our exam is very thorough and involves the latest cutting-edge technology that is endorsed by NASA and has been used on the Space Shuttle to measure the health of our astronauts. We also use digital x-ray to assure the best quality images and minimal wait time. I will make sure that you completely understand what I believe is the cause for the reason you came to see us and if I think that I can help you. If not, I will help you find someone that can.

I appreciate you trusting in me and my team with your health and the goals you have. I'm grateful to be part of your journey as you move towards a longer, healthier and happier life.

My team and I work and train hard to make sure that you feel comfortable here and that you're sure that you're in the right place. If you ever feel otherwise, please let me know personally and I'll do my best to make it right.

Before your first visit, I encourage you to spend a few minutes on our website. It's a great way to learn more about us to answer any questions you might have about chiropractic care.

Again, welcome to our office. I look forward to meeting you.

In Health.

Dr. Nathan Conroy, D.C.

Clinic Director

Welcome To The Chiropractic People

First Name_____ MI____ Last_____ Birth Date____/____/____ Age_____ Today's date____/____/____

Address_____ City_____ State_____ Zip_____

____ Male ____ Female # of Children _____ oSingle oMarried oSignificant Other oWidowed oSeparated oDivorced

Cellular #_____ Home #_____ E-mail Address_____

Your employer_____ Your occupation_____

Name of Spouse _____Birth Date of Spouse (For insurance verification)____/____/____

Who may we thank for referring you to our office?_____

Your Health Profile

Have you ever been to a chiropractor? Y/ N When was your last adjustment? _____ Have you ever had massage therapy before: Y / N

Current Health Condition

Primary Complaint (secondary complaint on next page):

_____

_____

When did condition begin? _____ Has it ever occurred before: Y / N First Time Ever Experienced? _____

Was this due to an accident/trauma? Y / N If Yes, explain (fall, sports, auto, work) _____

Quality: (mark all that apply)

□ Sharp □ Dull □ Aching □ Throbbing □ Crushing □ Stabbing □ Burning

Is there anything that makes it better? _____

Is there anything that makes it worse? _____

What solutions have you tried to solve this problem(s)?_____

Severity: Please circle a level from 0 (no pain) to 10 (disabling pain)

0 1 2 3 4 5 6 7 8 9 10

Does the pain travel or radiate into the arms or legs? Y / N

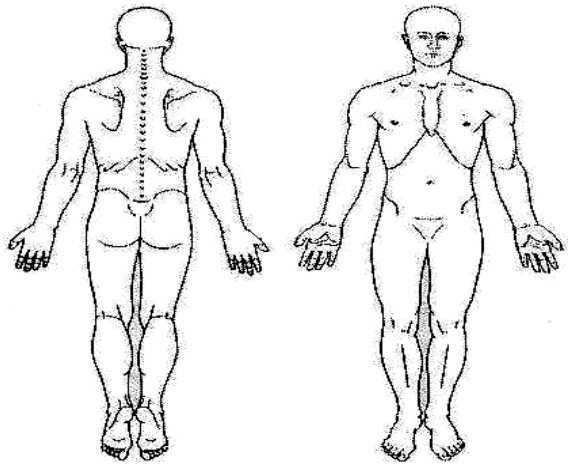
Is there any numbness or tingling: Y / N

Timing:

Is the pain: □ Constant (75 - 100% of the time)
□ Frequent (50-75% of the time)
□ Occasional (25-50% of the time)
□ Infrequent (0-25% of the time)

Is the pain worse in: □ Morning □ Midday
□ Night □ Consistent all day

Please circle on diagram the areas of discomfort.



What activity(s) does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again?

_____

What area (s) of your life has this problem affected the most? □Family □Relationships □Work □Exercise □Recreation

On a scale of 1 to 10, with 10 being the highest, rate your level of commitment to get rid of this problem: _____

Name: _____ **Date:** _____

Secondary Complaint:

_____

_____

When did condition begin? _____Has it ever occurred before: Y / N First Time Ever Experienced? _____

Was this due to an accident/trauma? Y / N If Yes, explain (fall, sports, auto, work) _____

Quality: (mark all that apply)
□ Sharp □ Dull □ Aching □ Throbbing □ Crushing □ Stabbing □ Burning

Is there anything that makes it better? _____
Is there anything that makes it worse? _____

What solutions have you tried to solve this problem(s)?_____

Severity: Please circle a level from 0 (no pain) to 10 (disabling pain)
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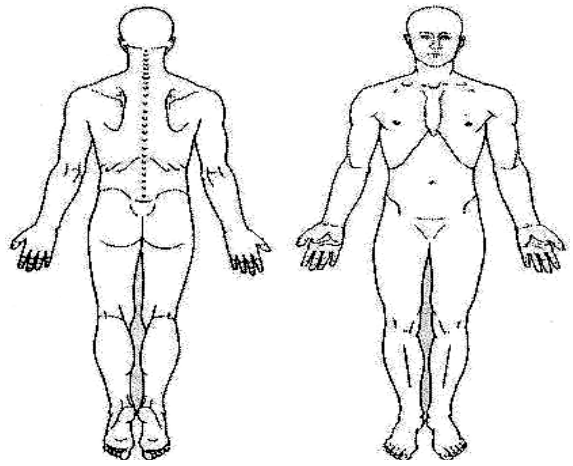

What activity(s) does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again?

_____

What area(s) of your life has this problem affected the most? □ Family □ Relationships □ Work □ Exercise □ Recreation

On a scale of 1 to 10, with 10 being the highest, rate your level of commitment to get rid of this problem: _____

What do you do in a typical day - describe postures, positions and repetitive movements: _____

_____

Do you have any other health conditions, regardless of whether you think it's related to the spine? If so, list & describe**:**

_____

_____

Every trauma is recorded in the spine. Please give a brief description of any significant injuries or accidents over the course of your life (auto accidents, falls, concussions, broken bones, childhood injuries, etc.) and approximate date:

1. _____ 3. _____
2. _____ 4. _____

Please list any concerns you may have about getting this problem(s) corrected such as time or transportation:_____

_____

_____

Name: _____ **Date:** _____

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life:

□ Lack of Energy □ Sleep Problems □ Sinus/Allergy Problems □ Digestive Problems □ Frequent Colds
□ Heartburn/Reflux □ Tension/Stress □ Depression □ Anxiety

□ Heart Condition □ Cancer □ Diabetes □ Other _____

Please list any surgeries you have had over the course of your life (with approximate date):

_____

_____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? Y / N **If yes, please list:** _____

List any medications you are taking (dosage if known): _____

_____

Do you smoke? Y / N If yes, how much, how often and how long? _____

PERSONAL HEALTH GOALS

□Improve Nutrition/Eating Habits	□Lower Cholesterol	□Get off Medications
□Weight Loss/Fat Loss	□Lower Blood Pressure	□Improved Sleep
□Increase Lean Muscle Mass	□Start Exercising	□Improved Energy
□Increase Bone Density	□Look Better	□Improved Posture
□Reduce Stress	□Feel Better	□Improved Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:

Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____

Do you take: Omega 3 (Fish Oil)? Yes No Vitamin D3? Yes No Probiotics? Yes No

Who is your Family Physician or Primary Doctor that monitors you_____

When was the last time you had blood work done? _____

I hereby certify the statements & answers given on this form are accurate to the best of my knowledge. I agree to allow this office to perform an evaluation.
Signature_____ Date_____/_____/_____

(FOR FEMALES) *This is to certify that, to the best of my knowledge, I am not pregnant, and give my permission to have a diagnostic x-ray examination if necessary.*
Signature_____ Date_____/_____/_____

Functional Rating Index

In order to properly assess your condition, we must understand how much your **chief complaint** has affected your ability to manage everyday activities. For each item, 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 ½ mile	Increased pain after ¼ 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 ½ hour	Increased pain with any standing

Name: _____ Date: _____ Total Score: _____