

# ADULT/MEDICARE MEMBER HEALTH RECORD UPDATE

## INFORMATION UPDATE

### PERSONAL INFORMATION

NAME:		DATE:
CHANGE OF ADDRESS:	CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:	
WORK PHONE:	EMAIL ADDRESS:	
HAS YOUR INSURANCE CHANGED SINCE YOUR LAST VISIT? (IF YES, PLEASE PRESENT YOUR NEW INSURANCE CARD TO THE FRONT DESK)		
<input type="checkbox"/> YES <input type="checkbox"/> NO		

## YOUR CURRENT HEALTH STATUS

IS THIS A:  
 NEW INJURY     RE-INJURY     EXACERBATION     OTHER  
 PLEASE EXPLAIN: \_\_\_\_\_

WHEN DID THIS EPISODE OR INJURY BEGIN? DATE: \_\_\_\_\_

WHAT ARE YOUR MAJOR CONCERNS? PLEASE WRITE BELOW AND DRAW ON THE DIAGRAM PROVIDED TO THE RIGHT

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DESCRIBE HOW THIS OCCURED?

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TYPE OF DISCOMFORT: CIRCLE ALL THAT APPLY

DULL /SHARP /ACHY /THROBING /NUMB /DEEP

DOES THE PAIN RADIATE?  NO  YES

IF YES, WHERE?  
 RADIATES TO THE RIGHT BUTTOCK/THIGH  
 RADIATES TO THE LEFT BUTTOCK/THIGH  
 RADIATES TO THE RIGHT ARM/HAND  
 RADIATES TO THE LEFT ARM/HAND  
 OTHER: \_\_\_\_\_

SEVERITY (CIRCLE RANGE) 1 2 3 4 5 6 7 8 9 10= EMERGENCY ROOM

HOW WOULD YOU DESCRIBE THE AMOUNT OF TIME THAT YOU EXPERIENCE THIS CONCERN:

CONSTANT (75-100%)     FREQUENT (50-75%)  
 OCCASIONAL (25-50%)     INFREQUENT (0-25%)

THINGS THAT MAKE IT WORSE?  
 \_\_\_\_\_

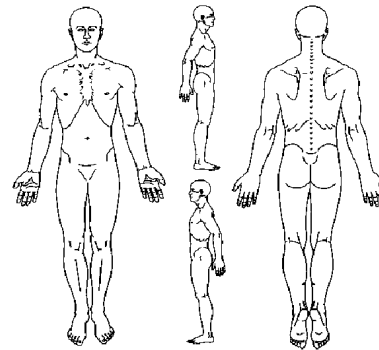
THINGS THAT MAKE IT BETTER?  
 \_\_\_\_\_

WHAT HAVE YOU DONE FOR THIS?  
 \_\_\_\_\_

HAVE YOU SEEN OTHER DOCTORS FOR THIS? IF SO, WHO?

**INTRUCTIONS:** Please mark the area and type of pain on the drawings using the codes listed below:

N=Numbness    P=Pain    A=Ache    T=Tingling    S=Stiffness/Soreness



## FAMILY PAST HISTORY REVIEW

CHECK OFF ANY OF THE FOLLOWING CONDITIONS THAT YOU OR ANYONE IN YOUR FAMILY HAS EXPERIENCED IN THE PAST AND TELL US IF IT IS YOU OR A RELATIVE WHO WAS AFFECTED

CANCER: \_\_\_\_\_

HIGH BLOOD PRESSURE: \_\_\_\_\_

LOW BACK: \_\_\_\_\_

HEART DISEASE: \_\_\_\_\_

NECK PAIN: \_\_\_\_\_

STROKE: \_\_\_\_\_

HEADACHES: \_\_\_\_\_

## MEDICATION UPDATE

PLEASE PROVIDE A CURRENT LIST OF THE MEDICATIONS AND DOSAGES THAT YOU ARE TAKING:

\_\_\_\_\_  
 \_\_\_\_\_

## FOR DOCTORS USE ONLY

NO CONTRAINDICATIONS FOR ADJUSTING? INITIAL: \_\_\_\_\_

\*\*\*Acute Arthropathies, Unstable Os, Malignancies of Vertebral column, infection of bone of vertebral column and significant major artery aneurysm near area of adjustment.

**Mouw Family Chiropractic**  
 20 Power Dr. #1  
 Council Bluffs, IA 51501

# Review of Health Systems Adult

Have you ever suffered from: (check all that apply)

- 1. General**
- Headaches/Migraines
  - Convulsions/Epilepsy
  - Tremors
  - Loss of Balance
  - Dizziness/Vertigo
  - Fainting
  - Sleeping Problems
  - Colic
  - Cold Sweats
  - Weight Problems
  - Loss or gain of a significant amount of weight within 6 months
  - Jaw/TMJ Problems
  - Ruptures/Hernias
  - Fever
  - Fatigue

- 2. Cardiovascular System**
- Poor Circulation
  - High Blood Pressure
  - Aortic Aneurysm
  - Heart Disease
  - Heart Attack
  - Chest Pain
  - High Cholesterol
  - Pace-Maker
  - Jaw Pain
  - Irregular Heartbeat
  - Swelling of Legs
  - Diabetes Type I or II

- 3. Gastro-Intestinal System**
- Gall Bladder Problems
  - Bowel Problems
  - Constipation
  - Liver Problems
  - Ulcers
  - Diarrhea
  - Nausea/Vomiting
  - Bloody Stools
  - Poor Appetite

- 4. Integumentary System**
- Skin Ulcers
  - Skin Disease
  - Eczema
  - Psoriasis
  - Rashes

- 6. Ears, Eyes, Nose, Throat**
- Dizziness
  - Hearing Loss
  - Sinus Infection
  - Nosebleed
  - Sore Throat
  - Difficult Swallowing
  - Bleeding Gums
  - Glaucoma
  - Double Vision
  - Blurred Vision

- 5. Allergic/Immunologic**
- Immune Disorder
  - HIV/AIDS
  - Hives
  - Steroids/Corticosteroid Use

- 7. Hematology/Lymph**
- Hepatitis
  - Blood Clots
  - Cancer
  - Easy Bruising
  - Easy Bleeding
  - Fevers/Chills/Night Sweats
  - Enlarged Glands

- 9. Musculoskeletal System**
- Gout
  - Arthritis
  - Joint Stiffness

- 11. Reproductive System**
- Urinary Tract Infections
  - Pelvic Pain
- MALES ONLY:
- Prostate/Sexual Dysfunction
- FEMALES ONLY:
- Menstrual Cramping
  - Menstrual Irregularity
  - Vaginal Pain/Infection
  - Breast Pain/Lumps

- 12. Neurological**
- Numbness/Tingling/Pain in (Arm/Hands/Fingers)
  - Numbness/Tingling/Pain in (Buttocks/Thighs/Legs/Feet/Toes)
  - Loss of Strength
  - Headaches

Other:

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- 10. Respiratory System**
- Asthma
  - Tuberculosis
  - Shortness of Breath
  - Emphysema
  - Cold/Flu
  - Cough/Wheezing

- 8. Genito-Urinary System**
- Recurring Infections
  - Difficulty Urinating
  - Burning/ Frequency
  - Blood in Urine
  - Erectile Dysfunction

Is there any chance the patient might be pregnant?  
 Yes    No    Not Sure

- 13. Psychological**
- Anxiety
  - Hyperactivity(ADD)
  - Learning Disorders
  - Depression
  - Memory Loss
  - Phobias
  - Mood swings

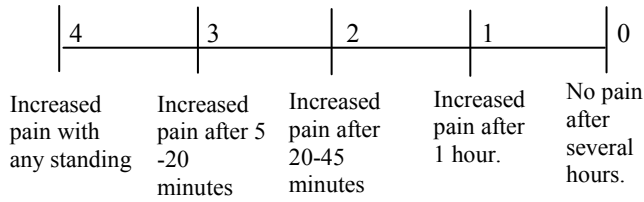
**\*X-rays may be taken during the exam & x-rays can damage fetal development.**

Signature verifying patient is NOT pregnant:  
 \_\_\_\_\_

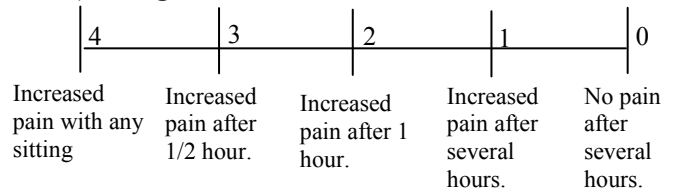
# Functional Rating Index

In order to properly assess your condition, we must understand how much your neck 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.

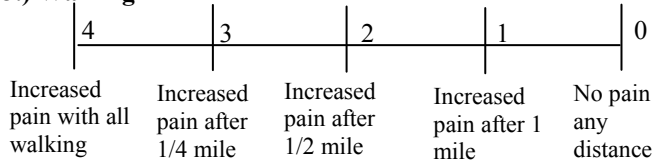
## 1.) Standing



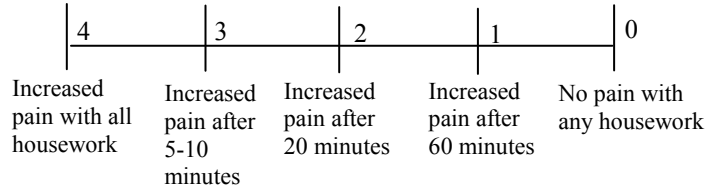
## 2.) Sitting



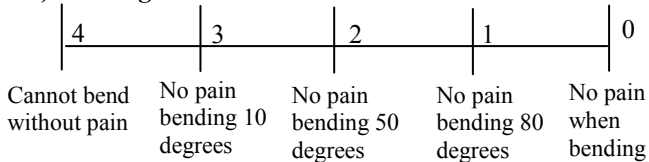
## 3.) Walking



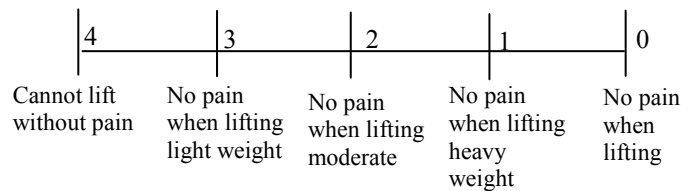
## 4.) Housework/ Work



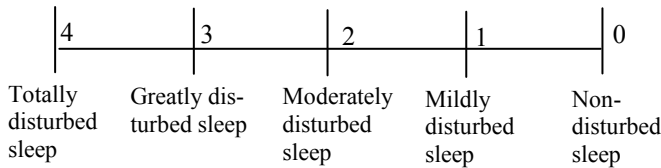
## 5.) Bending



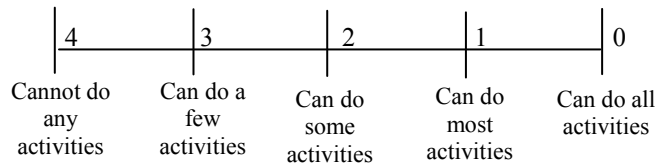
## 6.) Lifting



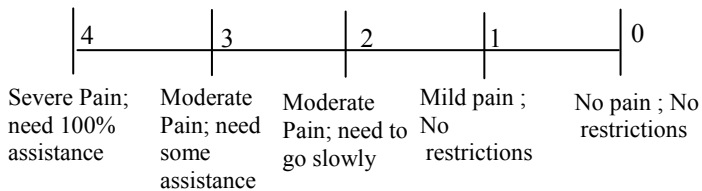
## 7.) Sleeping



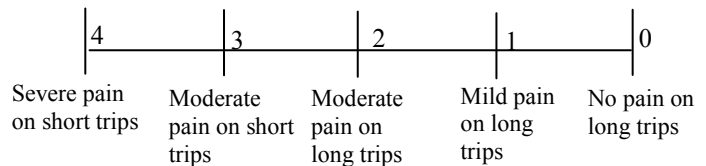
## 8.) Recreation



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



## 10.) Travel (driving, etc.)



### DOCTORS USE ONLY

INITIAL FREQUENCY  3 X A WEEK  2 X A WEEK  \_\_\_ X A WEEK/MONTH FOR \_\_\_ WEEKS/MONTHS

CMT  1-2 AREAS  3-4 AREAS

### PAIN INTENSITY GOAL:

SHORT-TERM: TO DECREASE THE BORG SCALE PAIN INTENSITY RATING TO A \_\_\_ OUT OF 10  
 LONG-TERM: TO DECREASE THE BORG SCALE PAIN INTENSITY RATING TO A \_\_\_ OUT OF 10

### FUNCTIONAL GOAL:

1. SHORT-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF \_\_\_\_\_ TO \_\_\_\_\_.  
 (TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)  
 LONG-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF \_\_\_\_\_ TO \_\_\_\_\_.  
 (TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)  
 2. SHORT-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF \_\_\_\_\_ TO \_\_\_\_\_.  
 (TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)  
 LONG-TERM: FOR THE PATIENT TO INCREASE FUNCTIONAL MOVEMENT OF \_\_\_\_\_ TO \_\_\_\_\_.  
 (TYPE OF ACTION # 1-10) (# 4-0 ON SCALE)