Commonwealth Chiropractic

480 Washington Street
Brighton MA 02135
P: 617.739.0046
F: 617.738.9441
Info@commchiro.com

Pn: _____

GENERAL INFORMATION:

Name: _____ ❒ Male ❒ Female SS# _____

Date of Birth: _____ Marital Status (circle one): S M W D #Children: _____

Local Address: _____ Emergency Contact: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Phone#: _____ Work: _____ Relationship: _____

Cell: _____ Email: _____

❒ Check if Permanent Address is the same as Local Address

Your occupation: _____

Permanent Address: _____ Employer: _____

City: _____ State: _____ Zip: _____ Are you a student? ❒ Full Time ❒ Part Time

Permanent Phone #: _____ ❒ I am not a student

CURRENT COMPLAINTS:

When did your present conditions start? _____ Is this the first occurrence? ❒ Yes ❒ No

What aggravates your conditions: _____

What decreases the symptoms or pain? _____

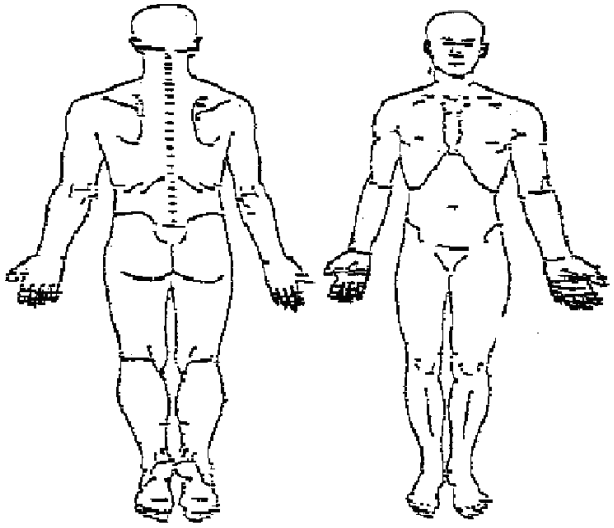
SYMPTOMS:

❒ Shoulder Pain	❒ L ❒ R	❒ Knee Pain	❒ L ❒ R	❒ Neck Pain	
❒ Elbow Pain	❒ L ❒ R	❒ Leg Pain	❒ L ❒ R	❒ Mid Back Pain	
❒ Wrist Pain	❒ L ❒ R	❒ Ankle Pain	❒ L ❒ R	❒ Low Back Pain	
❒ Hand Pain	❒ L ❒ R	❒ Foot Pain	❒ L ❒ R	❒ Abdominal Pain	
❒ Hip Pain	❒ L ❒ R	❒ Jaw Pain	❒ L ❒ R	❒ _____	
❒ Thigh Pain	❒ L ❒ R	❒ Headaches		❒ _____	

PAIN INDEX:

On a scale of 0 to 10, how strong is the pain now? (0 being no pain and 10 being severe pain)

PLEASE CIRCLE: 0 1 2 3 4 5 6 7 8 9 10



Using the symbols provided below, mark the areas on the illustrations where you are experienceing these sensations.

BURNING	XXXXXXXXX
STABBING	///////////
PINS & NEEDLES	**********
ACHING	00000000000
NUMBNESS	- - - - - - - - - - -

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DAILY ACTIVITIES (please rate) :

Please rate the following from 0 to 10; where 0 indicates no difficulty performing the activity and 10 indicates severe pain/no ability.

____ Sitting	____ Bending forward	____ Pulling	____ Lying on Back
____ Standing for over 1hr	____ Bending backward	____ Dressing self	____ Lying on side with knees bent
____ Reaching	____ Climbing stairs	____ Pushing	____ Coughing
____ Getting in/out of the car	____ Turning over in bed	____ Kneeling	____ Personal grooming
____ Lifting	____ Sleeping	____ Jogging	
____ Sneezing	____ Carrying small items	____ Walking	____ Other _____

PAST MEDICAL HISTORY:

Gastrointestinal

- ❒ Black/tarry stools
- ❒ Constipation
- ❒ Diarrhea
- ❒ Excessive thirst
- ❒ Frequent nausea
- ❒ Gall bladder issues
- ❒ Indigestion
- ❒ Liver Problems
- ❒ Poor/excessive appetite
- ❒ Ulcers
- ❒ Vomiting
- ❒

Ears, Nose, Throat, Eyes

- ❒ Difficulty swallowing
- ❒ Earaches
- ❒ Hearing difficulties
- ❒ Sore throat
- ❒ Taste/smell problems
- ❒ Vision difficulties

Nervous System

- ❒ Cold/tingling extremities
- ❒ Confusion/depression
- ❒ Convulsions
- ❒ Fainting
- ❒ Forgetfulness
- ❒ Paralysis

Cardio/Respiratory

- ❒ Ankle Swelling
- ❒ Blood Pressure problems
- ❒ Chest Pain
- ❒ Cold hands/feet
- ❒ Shortness of breath
- ❒ Lung problems/congestion
- ❒ Varicose veins

Women Only

- ❒ Menstrual cramping/pain
- ❒ Vaginal pain
- ❒ Irregular period
- ❒ Currently pregnant

Integumentary

- ❒ Dry skin
- ❒ Itching
- ❒ Rashes
- ❒ Unusual masses

Genitourinary

- ❒ Breast pain
- ❒ Difficult urination
- ❒ Genital pain
- ❒ Genital herpes
- ❒ Urine discoloration

Men Only

- ❒ Prostate/sexual dysfunction

SOCIAL HISTORY:

Alchohol	❒ Never	❒ Rarely	❒ Weekly	❒ Daily
Drug Use	❒ Never	❒ Rarely	❒ Weekly	❒ Daily
Tobacco Use	❒ Never		Packs/Day	
Coffee	❒ Never		Cups/Day	
Excercise	❒ Never	❒ 1x Week	❒ 2x Week	❒ 3x Week
What kind of exercise do you participate in?				

MEDICATIONS/ALLERGIES:

Do you have any drug allergies? ❒ Y ❒ N

If yes, please list:

List current medications and their use:

PAST MEDICAL HISTORY:

Review the listed conditions. Check the appropriate box if you have ever had that particular condition. Although these problems may be unrelated to your current condition, these problems may either affect your diagnosis, your treatment plan or even whether or not you are accepted for care.

General

- ❒ Allergies
- ❒ Dizziness
- ❒ Fever
- ❒ Headaches
- ❒ Loss of Sleep
- ❒ Weight gain/loss

Medical Conditions

- ❒ Anemia
- ❒ Arthritis
- ❒ Cancer
- ❒ Diabetes
- ❒ Epilepsy
- ❒ Heart Disease
- ❒ Hypertension
- ❒ Low Back Pain
- ❒ Mental Disorder
- ❒ Pneumonia
- ❒ Tuberculosis
- ❒

Family History

	Mother	Father	Sibling
❒ Cancer	❒	❒	❒
❒ Heart Disease	❒	❒	❒
❒ Hypertension	❒	❒	❒
❒ Diabetes	❒	❒	❒
❒ Stroke	❒	❒	❒
❒ Back Problems	❒	❒	❒

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AUTHORIZATIONS:

Please read the following statements carefully and check each one after reading:

❒ **1. Authorization to Release Medical Information**

I hereby authorize the release of medical information pertinent to my case to the insurance company or to the attorney involved in my case. I further authorize the release of my medical records and reports to Commonwealth Chiropractic.

❒ **2. Privacy Notice Acknowledgment**

With my signature below, I acknowledge that I have had the opportunity to read a copy of the Commonwealth Chiropractic Notice of Privacy Practices.

I agree to the authorizations listed above and I certify that all the information is complete and true to the best of my knowledge.

Signature of Patient: _____ Date: _____

Patient Name (print): _____

ACCOUNT INFORMATION:

If you would like us to keep your payment information on file, please complete the following:

❒ Visa ❒ MC ❒ AmEx ❒ Discover Card #: _____ Exp. Date _____

❒ I authorize Commonwealth Chiropractic to bill my balance to my credit card monthly.

WELCOME!

It is our pleasure to have you as a new patient! Please help us thank the person or organization who referred you!

How were you referred to our office? _____

Thank you very much and welcome to Commonwealth Chiropractic!