Welcome To The Abrankian Back & Neck Center

PATIENT INFORMATION (Please Print)

FIRST NAME_____ LAST NAME _____ DATE_____

ADDRESS_____ APT. #_____ CITY_____ ZIP_____

PHONE_____ SOC. SEC. NO._____ DATE OF BIRTH_____

E-MAIL ADDRESS:_____

CELL PHONE #:_____ CELL CARRIER: ☐ VERIZON ☐ AT&T ☐ T-MOBILE ☐ SPRINT OTHER_____

MARITAL STATUS: ☐ M ☐ S ☐ D ☐ W SEX: M ☐ F ☐ AGE:_____ # OF CHILDREN_____

OCCUPATION_____EMPLOYER_____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

PATIENT CONDITION:

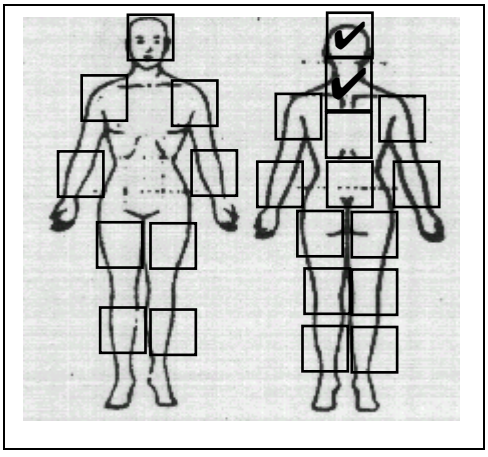
HAVE YOU HAD CHIROPRACTIC CARE BEFORE? ☐ YES ☐ NO WHEN? _____ DR. NAME: _____

DESCRIBE YOUR SYMPTOMS:_____ HOW LONG?_____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ☐ YES ☐ NO ☐ UNKNOWN

ARE YOU TAKING MEDICATIONS ? ☐ NO ☐ YES, (LIST):_____

MARK AN (X) ON THE PICTURE WHERE YOU HAVE PAIN:



TYPE OF PAIN ☐ SHARP ☐ DULL ☐ THROBBING ☐ ACHING
☐ STIFFNESS ☐ TINGLING ☐ NUMBNESS ☐ SHOOTING
☐ OTHER:_____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS ?
☐ Constantly (76-100% of day) ☐ Frequently (51-75% of day)
☐ Occasionally (26-50% of day) ☐ Intermittently (0-25% of day)

CIRCLE HOW BAD ARE YOUR SYMPTOMS FROM 0 -10:
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐
(NO PAIN) - - -(MODERATE)- - -(SEVERE PAIN)

WHAT ACTIVITIES MAKE YOUR SYMPTOMS *WORSE:*
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Lying Down ☐ Other: _____

WHAT ACTIVITIES MAKE YOUR SYMPTOMS *BETTER*:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Lying Down ☐ Other: _____

DOES YOUR SYMPTOMS INTERFERE WITH YOUR? ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ RECREATION

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? ☐ No ☐ Yes Explain:_____

WOMEN: I have been advised that if I am pregnant and have x-rays taken which may expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for X-ray examinations. With those factors in mind, I am advising my doctor that:

	YES	NO	Don't Know
I am pregnant.	☐	☐	☐
I am late with my menstrual period.	☐	☐	☐
I am taking oral contraceptives.	☐	☐	☐
I have an IUD.	☐	☐	☐
I have had a tubal ligation.	☐	☐	☐
I have had hysterectomy.	☐	☐	☐

HEALTH HISTORY ***(Have you ever suffered from any of these? Please ✓ below)***

☐Aids/HIV ☐Anemia ☐Arthritis ☐Asthma ☐Bleeding Disorders ☐Breast Lumps ☐Cancer ☐Diabetes ☐Epilepsy

☐Gout ☐Heart Disease ☐Kidney Disease ☐Dizziness ☐Digestive Disorders ☐Headaches ☐High Blood Press ☐ Osteoporosis

☐ Pace Maker ☐Prostate Problems ☐Stroke ☐Tumors ☐ Other:_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____ _____ _____

FAMILY HISTORY

Mother: ☐ **Living** ☐ **Deceased -** List any medical problems: _____

Father: ☐ **Living** ☐ **Deceased -** List any medical problems: _____

List any problems common in your family: ☐Cancer ☐Diabetes ☐ Heart Disease ☐High Blood Pressure ☐Stroke ☐Arthritis ☐Thyroid Disease ☐Osteoporosis ☐Scoliosis ☐ Disc condition ☐ Back condition

IMPACT OF YOUR SYMPTOMS

**How much have your symptoms interfered with your daily activities?

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

WORK ACTIVITY INCLUDE: ☐Sitting ☐Standing ☐ Light Labor ☐Heavy Labor

EXERCISE: ☐None ☐Light ☐Moderate ☐Daily ☐Heavy

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐

PATIENT WELLNESS ASSESSMENT

Do you drink alcohol? ☐ Yes ☐ No - How much and how often? _____

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

On the arrow diagram above:

E. What number do you think represents your health today?_____

F. In what direction is your health currently headed ?_____

G. What are your health goals?

IMMEDIATE:_____

_

SHORT TERM _____

LONG TERM_____

How committed are you to correcting this issue? ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Not committed — Very committed

**In general, would you say your overall health right now is…

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you take vitamins? ☐ Yes ☐ No _____

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

Height: _____ Weight: _____ lbs. Name of Primary Care Physician: _____

DO YOU HAVE HEALTH INSURANCE? ☐ Yes ☐ No *IF YES:* ***Please print below & Give us a copy of the card.***

Name of Insurance Company(s)_____

GROUP#_____ MEMBER ID#_____

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Signature:_____ Date:_____