PRACTICE MEMBER HEALTH ASSESSMENT

ABOUT YOU

Your Name_____**Date**_____
SS#:_____**Date of Birth**_____/_____/____ **Age**_____ ❑Male ❑Female
Home Address_____
❑ single ❑ married ❑ divorced ❑ separated ❑ widowed *City* *State* *Zip*
Home Phone ( )_____ **Work Phone** ( )_____
Cell Phone ( )_____ **Email:**_____
Employer_____ **Occupation**_____
Referred by_____ **Primary Physician**_____

REASON FOR VISIT

- **The Primary Reason for your visit today is:** ❑ **Spinal Check up** ❑ **Current Complaint**
  Other _____
- **Your Primary Concern/Complaint**_____
  _____
- **When did it begin?**_____ **Date of onset**_____

- **How did it begin?**
  ❑ Gradual ❑ Sudden ❑ Auto Accident ❑ Work Accident ❑ Sports injury ❑ Other_____

- **How would you describe the sensation?** *(check all that apply)*
  ❑ Sharp ❑ Soreness ❑Throbbing ❑ Tingling ❑Stiffness ❑ Spasm
  ❑ Burning ❑ Weakness ❑ Numbness ❑ Shooting ❑ Ache ❑Dull

- **How often is the complaint present?**
  ❑ Constant (80-100%) ❑ Frequent (50-80%) ❑ Occasional (25-50%) ❑ Intermittent (25% or less)

- **How would you rate the intensity?** *(circle the appropriate number)*
  0 1 2 3 4 5 6 7 8 9 10
  (no discomfort) *(moderate discomfort)* *(unbearable)*

- **Since the problem began, is your complaint getting:** ❑ better ❑ same ❑ worse

- **What relieves your complaint?**
  ❑ Nothing ❑ Walking ❑ Standing ❑ Sitting ❑ Moving around/exercise ❑ Lying down ❑ Inactivity

- **What aggravates your complaint?**
  ❑ Nothing ❑ Walking ❑ Standing ❑ Sitting ❑ Moving around/exercise ❑ Lying down ❑ Inactivity

- **Is your complaint affecting your ability to work or do other routine daily activities?**
  ❑ No effect ❑ Need some assistance with daily activities ❑ Cannot function without assistance
  ❑ Cannot work ❑ Have some limited physical restrictions, but can function ❑ Totally disabled

- **What important things does it prevent you from doing?** _____
  _____
- **Have you had this complaint before?** ❑ Yes ❑ No When?_____
- **Have you seen a physician for this complaint?** ❑ Yes ❑ No Name_____
  What were the dates, treatment and results?_____
  _____

Please complete reverse side ⇒⇒⇒⇒⇒⇒

PAST AND PRESENT CONDITIONS

	Past	Present		Past	Present
Headaches	❑	❑	Condition of uterus or ovaries	❑	❑
Dizziness	❑	❑	Prostate condition	❑	❑
Fainting spells	❑	❑	Diabetes	❑	❑
Convulsions	❑	❑	Arthritis	❑	❑
General fatigue	❑	❑	Skin condition	❑	❑
High blood pressure	❑	❑	Stroke	❑	❑
Heart condition	❑	❑	Cancer	❑	❑
Respiratory condition	❑	❑	Allergies/asthma	❑	❑
Digestive problems	❑	❑	Sinus conditions	❑	❑
Menstrual problems	❑	❑	Kidney/bladder problems	❑	❑

Other serious conditions: _____

- **Pertinent Family Health History:**_____
- **Pregnancy :** ❑ Past ❑ Present Number of children _____
- **List all surgeries and dates:**_____
  _____
- **Have you had spinal x-rays or other tests:** ❑ Yes ❑ No Dates_____
- **Have you had any serious motor vehicle or other accidents:** ❑ Yes ❑ No
  If yes, please explain_____
- **Are you currently taking medications?** ❑ Yes ❑ No *(if yes, please list all)*
  _____

YOUR LIFESTYLE

- **What is your physical activity at work?**
  ❑ Mostly sitting ❑ Mostly standing ❑ Light manual labor ❑ Moderate manual labor ❑ Heavy manual labor
- **Do you exercise?** *(Check all that apply)*
  ❑ No regular exercise ❑ 1-2 times per week ❑ 3-4 times per week ❑ 5-7 times per week
  ❑ Cardiovascular ❑ Stretching ❑ Weight machines ❑ Free weights ❑ Sports Activities
- **Are there any barriers to you increasing or maintaining your exercise level?**
  ❑ Time ❑ Cost ❑ Lack of facility/equipment ❑ No one to exercise with ❑ Physical incapacity ❑ None
- **How would you describe your nutritional habits?**
  ❑ Three square meals a day ❑ Sports nutrition ❑ I eat when I can ❑ I love junk ❑ Well balanced ❑ Vegetarian
- **What is your current stress level?**
  ❑ No stress ❑ Minimal stress ❑ Moderate stress ❑ Greatly stressed
- **What methods do you use to manage stress?** *(Check all that apply)*
  ❑ Chiropractic ❑ Massage ❑ Meditation ❑ Fun leisure activities ❑ Yoga ❑ Tai chi ❑ Other_____
- **How has your energy levels been lately?**
  ❑ Extremely energetic ❑ Very energetic ❑ Somewhat energetic ❑ Not very energetic ❑ Lack energy
- **How would you describe your predominant mood lately?**
  ❑ Calm and peaceful ❑ Happy ❑ Excited ❑ Well balanced ❑ Tense and anxious ❑ Blue and down ❑ Angry and upset
- **Have you had a recent gain or loss of weight?** ❑ Yes ❑ No
- **How do you feel about your current weight?** ❑ Want to lose ❑ Want to gain ❑ Satisfied
- **Do you take nutritional supplements?** ❑ Yes ❑ No
- **Do your current sleep patterns promote health?** ❑ Yes ❑ No
- **Tobacco use :** ❑ Past ❑ Present ❑ Occasional ❑ Moderate ❑ Heavy
- **Alcohol use :** ❑ Past ❑ Present ❑ Occasional ❑ Moderate ❑ Heavy
- **Caffeine use :** (coffee,tea and soft drinks) ❑ Past ❑ Present ❑ Occasional ❑ Moderate ❑ Heavy

Signature_____Date_____