

ABOUT YOU:

Today's Date: ___/___/___ Name: _____

How would you like to be addressed by our staff? _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone # (____) _____ - _____ Mobile Phone#: (____) _____ - _____ Daytime Phone#: (____) _____ - _____

Occupation: _____ Employer: _____

Referred by: _____ Your primary care (medical physician) is: _____

Phone # (physician) (____) _____ - _____ May we send a report to him/her about your examination and treatment? Yes No

Social Security #: _____ - _____ - _____ DOB: ___/___/___ Age: _____ Sex: Male Female

Hand Dominance: Right Left Ambidextrous

What is your complaint? _____

Is your complaint related to a car accident or work injury? Yes No If yes, date of injury? _____

PLEASE CHECK EITHER YES OR NO IN THE SPACES PROVIDED BELOW

Surgeries: None Yes - *Please list on blank spaces below with approximate year (if known)*

Surgery	Year Performed	Surgery	Year Performed
<i>Example: Gall bladder removed</i>	1992		

Previous Illness or Diseases (i.e. Cancer): None Yes *Please list with approximate year of diagnosis:*

Disease/Disorder	Year Diagnosed	Disease/Disorder	Year Diagnosed
<i>Example: Diabetes</i>	1992		

Past/Present Injuries: None Yes *Please describe with approximate date* (may include injury for which you are here today)

Injury	Approx. Date	Injury	Approx. Date
<i>Example: Car Accident</i>	1980		

List below any FRACTURES, along with the date/year of the injury: None Yes

INJURY	DATE	INJURY	DATE

Past Treatments for **current** condition: NONE Chiropractic Physical Therapy Medications
 Massage Trigger Point Injections Epidural Injections Surgery Herbal or homeopathic remedies

Current Medications: None Non-steroidal anti-inflammatory drugs Muscle relaxants Pain relievers
 Contraceptives **Other - Please List** _____

Vaccinations: Received no immunizations/vaccinations Received typical childhood immunizations Unknown

Family History of Health Problems: Please indicate Paternal (Father's side) or Maternal (Mother's side)

Family Member	Maternal or Paternal	Disease (and date or year of onset)	Deceased?
<i>Example: Grandpa</i>	<i>Maternal</i>	<i>Prostate Cancer-1983</i>	<i>Yes</i>

Exercise: None Frequent Infrequent Occasional Regular

Family Status: Married Single Divorced Widowed Children - How many do you have?: _____
 Are you currently expecting? (Check for yes)

Substance Usage: Alcohol: None Rare Social/light Moderate Heavy Recovered alcoholic

Tobacco: None Cigarettes __ Packs per week Previous, but quit Cigar Pipe Chewing Tobacco

Work environment: Requires prolonged sitting Requires prolonged standing Computer work Typing
 Constant standing Constant sitting Repetitive lifting Stressful Phone usage Headset for phone

Please check the box/boxes below if you have experienced any of the following:

QUESTION	YES	QUESTION	YES	QUESTION	YES
Open sore that does not heal		Headaches		ringing in the ears	
Difficulty swallowing		Family history of stroke		Loss of consciousness or momentary black	
Nagging hoarseness		Pain wakes me from a deep sleep		Temporary loss of understanding	
Vertigo, dizziness or lightheadedness		Loss of bladder or bowel control		Problems with balance, gait or coordination	
Night Sweats		Loss of weight without trying		Sensation problems - i.e. numbness	
Coughing up blood or noticing it in your stools		Weakness or strength loss		Problems or changes in vision	

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also understand that no guarantee or assurance has been made as to the results that may be obtained.

Signature of Patient (parent/guardian if minor) _____ Date ___/___/___

Print Name _____

How would you like to be reminded of future appointments?

Email: _____

Text Message: (Circle Mobile Carrier: Atel AT&T Nextel Qwest Sprint T-Mobile US Cellular Verizon Virgin Mobile)

Phone: _____

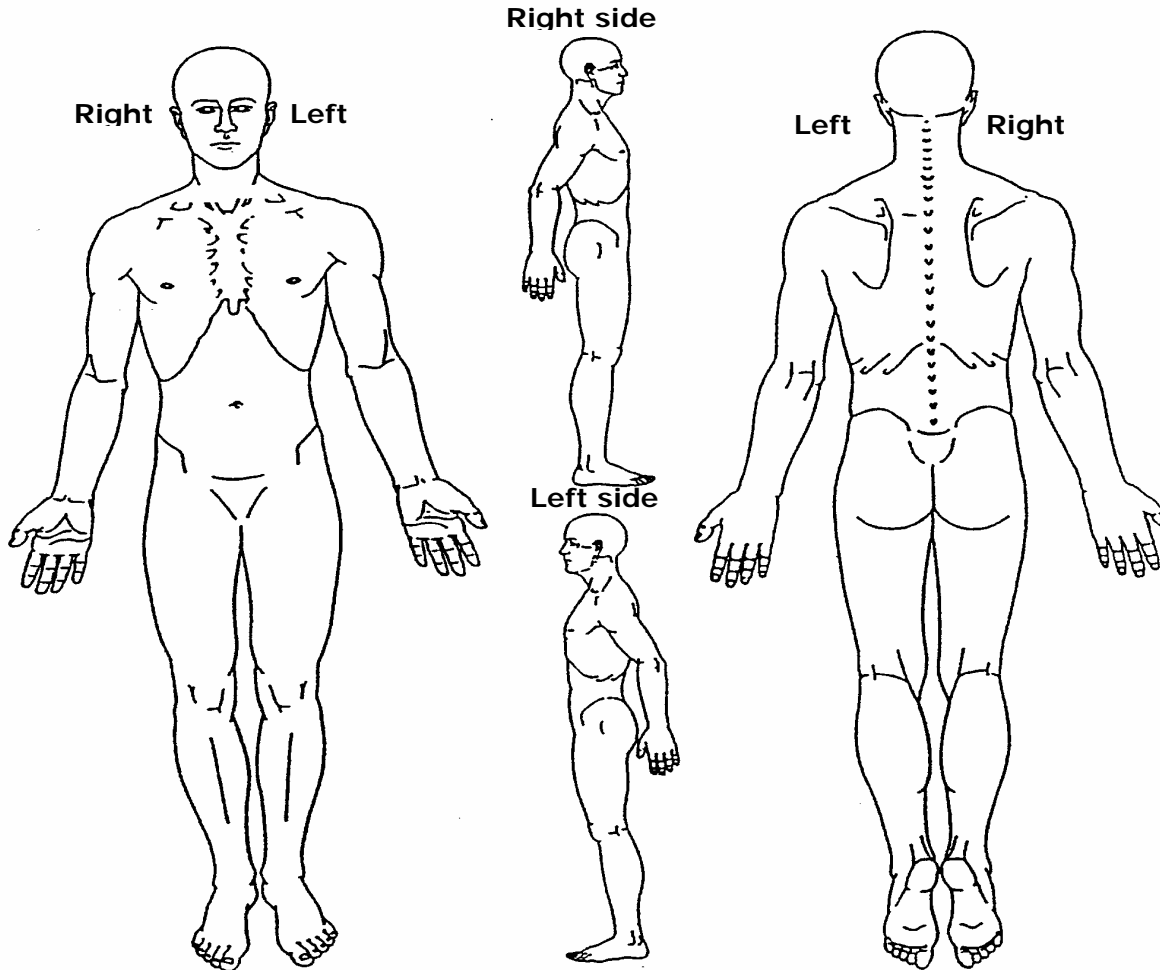
keyed Initials _____

PATIENT NAME _____

Instructions: Use the symbols in the “key” below to indicate the type and location of the discomfort AS IT FEELS TODAY. Place the letters on the part of the body that you feel the discomfort.

KEY

A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER
S = SORE	T = TIGHT	ST = STIFF

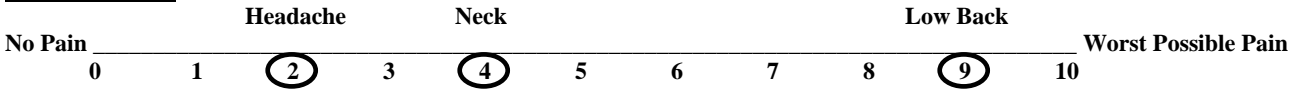


Patient Signature _____ Date _____

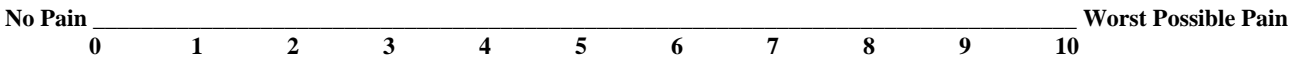
INSTRUCTIONS: Please circle the number that best describes the question being asked. Please indicate your pain level right now, average pain, and pain at its best and worst.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

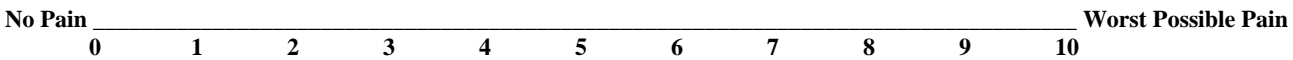
EXAMPLE:



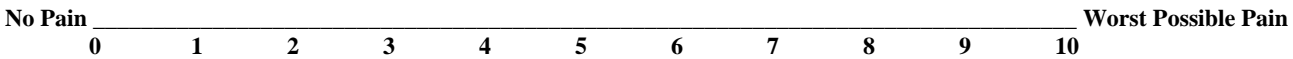
1 – What is your pain RIGHT NOW?



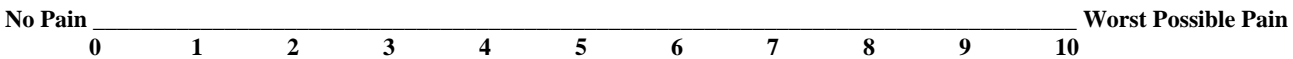
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best?)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst?)?



OTHER COMMENTS:

Patient signature

Date

Examiner Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Rear-end collision only:

Does your vehicle have the following:

- Movable headrests
- No headrests
- Fixed, non-moveable headrests

At the time of the impact, the headrest was in the following position:

- In the highest position
- In the middle position
- In the lowest position

Estimated distance between the back of your head & front of head restraint _____ inches

Pain and Medical care:

How soon after the collision did you begin to notice symptoms?

- Immediately
- _____ Hours after collision
- _____ Days after collision

Emergency Department

Yes No

- Did you go to the emergency department after the collision?

If yes, name of the ER: _____

Date and Time: _____

- Did you go to the ER in an ambulance?

- Did you or another person drive you to the ER?

- Were you hospitalized overnight?

- Did the ER doctor take x-rays?

Skull Lower back Other: _____

Neck Arm or leg

- Did the ER doctor give you pain medication?

- Did the ER doctor give you muscle relaxants?

- Did you have any cuts or lacerations?

- Did you require any stitches for cuts?

- Were you given a neck collar or back brace to wear?

Have you sought medical care (other than in an Emergency Room) for complaints related to this collision?

- Yes** **No**

If yes, whom have you seen?

If you did not see a doctor within the first week following your collision, indicate why:

- No pain was noticed
- No transportation
- I thought the pain would go away
- I self-treated with over-the-counter medication
- No appointment available
- Work/home schedule conflicts
- I had no insurance or money
- I took a hot shower, used ice, heat

By signing this form I attest that the above provided information is true and accurate to the best of my knowledge.

X _____
Signature

Date

Witness

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

As required by the Federal Privacy Regulations, I hereby acknowledge that I have received a current copy of **Russeau Team HealthCare, Ltd.'s** "**NOTICE OF PRIVACY PRACTICES**," revision date MAY 17, 2005.

I have read the Privacy Notice and understand my rights contained in the notice.

Patient's Name (print)

Patient's Signature

Date

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____
