SPINE & JOINT
CENTRAL OHIO

PATIENT DEMOGRAPHICS (Please Print)

First Name:	Last Name:	Middle Initial:
Home Address:		
City:	State:	Zip Code:
Home Phone:	Home Fax:	
Mobile Phone:	Work Phone:	
SSN:	Gender:	
Patient's Email:		
Do you want us to send you valuable information via email?	☐ Yes ☐ No	
Would you like to receive text reminders?	☐ Yes ☐ No	
Date of Birth: Age:	Marital Status:	Student:
Employer:	Occupation:	
Employer Address:		
City:	State:	Zip Code:
Spouse's Name (if applicable):		
Emergency Contact:	Relationship:	
Home Phone:	Mobile Phone:	
How did you hear about us?	**My Primary Care Physician is:**	
Whom may we thank for **referring you** to our office?		

Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent Guardian or Personal Representative | Please Print

_____ _____
Policy Holder Name | Policy Holder DOB

_____ _____
Date | Relationship to Patient

CHIROPRACTIC HEALTH HISTORY

SPINE & JOINT CENTRAL OHIO

PATIENT CONDITION:

Reason for visit:

When did your symptoms appear?

Symptoms are: ☐ Same ☐ Getting Worse ☐ Better

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting
☐ Burning ☐ Tingle ☐ Stiffness ☐ Numbness ☐ Cramps
☐ Other:

How often do you have these symptoms: ☐ Come and Go ☐ Constant?

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Activities ☐ Recreation
☐ Other:

Rate pain: 1 (mild) to 10 (severe) Neck: Thoracic: Low Back: Other:

Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Lying Down ☐ Walking ☐ Bending ☐ Lifting
☐ Other:

HEALTH HISTORY:

What treatment have you already received for your condition?

☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None
☐ Other:

Names of other doctor(s) who have treated your condition:

Date of last: Physical exam: Spinal x-ray: Blood Test:
Spinal Exam: MRI: CT:

Do you currently get massage therapy? ☐ Yes ☐ No
If yes, where:

Do you currently have an exercise routine? ☐ Yes ☐ No
What does it consist of?

Do you exercise at a gym? ☐ Yes ☐ No
If yes, name:

Do you have a personal trainer? ☐ Yes ☐ No
If yes, name:

Does pain currently keep you from exercising at the level you'd like? ☐ Yes ☐ No

ACCIDENT INFORMATION:

Is this condition due to an accident? ☐ Yes ☐ No

Date of accident: Brief description:

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other:

To whom have you made a report of your accident? ☐ Auto Ins. ☐ Employer ☐ Work Comp ☐ Other:

NOTES:

MEDICATIONS	ALLERGIES	NUTRITIONAL SUPPLEMENTS

HEALTH HISTORY:

Select "Y" for Yes or '"N" for No to indicate if you have had any of the following:

AIDSII-DV	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Liver Disease	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N
Alcoholism	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Measles	☐ Y ☐ N	Rheumatoid Arthritis	☐ Y ☐ N
Allergy Shots	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Migraines	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Anemia	☐ Y ☐ N	Fractures	☐ Y ☐ N	Miscarriage	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Anorexia	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Mononucleosis	☐ Y ☐ N	Stroke	☐ Y ☐ N
Appendicitis	☐ Y ☐ N	Goiter	☐ Y ☐ N	Multiple Sclerosis	☐ Y ☐ N	Suicide Attempt	☐ Y ☐ N
Asthma	☐ Y ☐ N	Gonorrhea	☐ Y ☐ N	Mumps	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N
Bleeding Disorders	☐ Y ☐ N	Gout	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Tonsilitis	☐ Y ☐ N
Breast Lump	☐ Y ☐ N	Heart Disease	☐ Y ☐ N	Pacemaker	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Bronchitis	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Parkinson's Disease	☐ Y ☐ N	Tumor's Growths	☐ Y ☐ N
Bulimia	☐ Y ☐ N	Hernia	☐ Y ☐ N	Pinched Nerve	☐ Y ☐ N	Typhoid Fever	☐ Y ☐ N
Cancer	☐ **Y** ☐ **N**	Herniated Disc	☐ Y ☐ N	Pneumonia	☐ Y ☐ N	Ulcers	☐ Y ☐ N
Cataracts	☐ Y ☐ N	Herpes	☐ **Y** ☐ **N**	Polio	☐ Y ☐ N	Vaginal Infections	☐ Y ☐ N
Chemical Dependency	☐ Y ☐ N	High Cholesterol	☐ Y ☐ N	Prostate Problems	☐ **Y** ☐ **N**	Venereal Disease	☐ Y ☐ N
Chicken Pox	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Prosthesis	☐ Y ☐ N	Whooping Cough	☐ **Y** ☐ **N**

Other:

Exercise:	☐ None	☐ Moderate	☐ Daily	☐ Heavy
Work Activity:	☐ Sitting	☐ Standing	☐ Light Labor	☐ Heavy Labor
Habits:	☐ Smoking	☐ Alcohol	☐ Coffee / Caffeine Drink	☐ High Stress Level
	Packs / day:	Drinks / day:	Cups / day:	Reason:

Are you pregnant? ☐ Yes ☐ No Due Date:

INJURIES / SURGERIES HISTORY:

	Description	Date
Falls:		
Head Injuries:		
Broken Bones:		
Surgeries:		

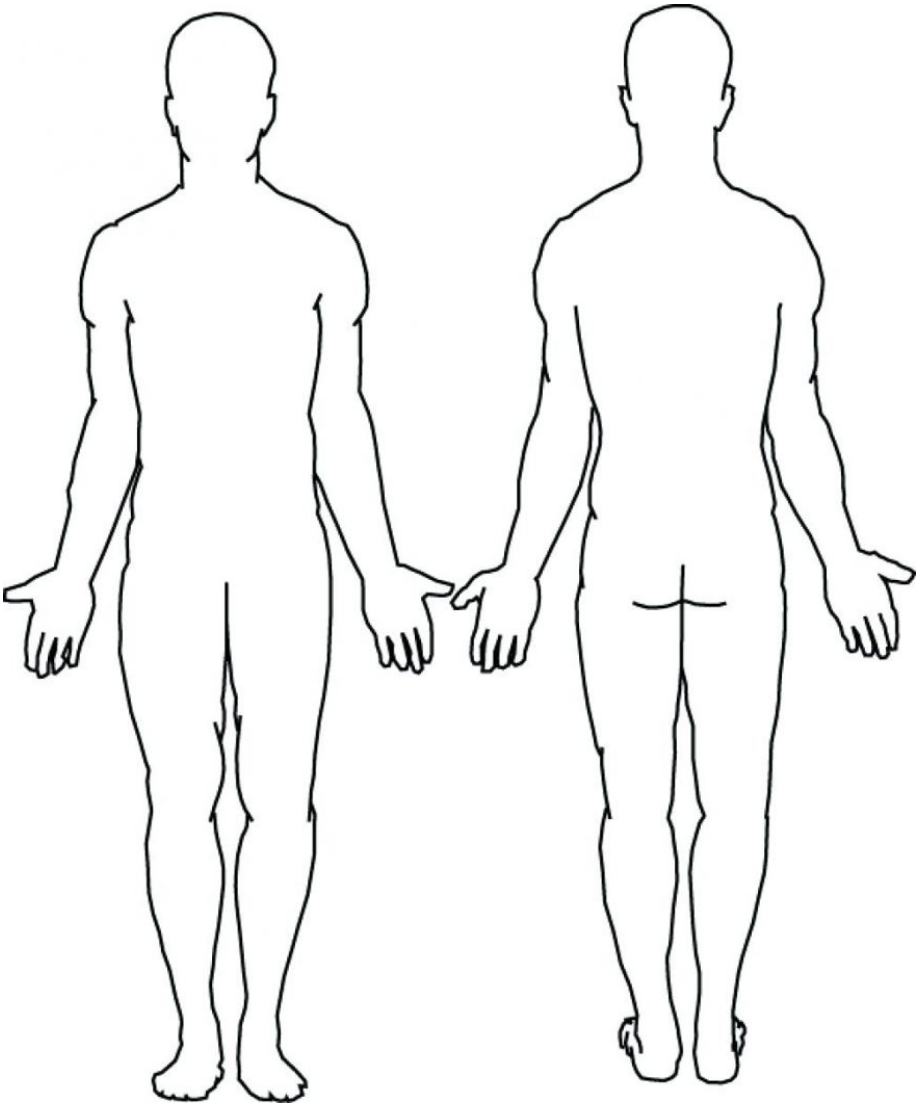
NOTES:

AREA(S) OF PAIN

Please mark the areas of the body where you feel the desired sensations.
Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins and Needles	Burning	Aching	Stabbing
- - - - - - - - - - - - - - - -	o o o o o o o o o o o o o o	x x x x x x x x x x x x x x	* * * * * * * * * * * * * *	/ / / / / / / / / / / / / /

Pain Chart



1.

Rate pain: 0 (No Pain) to 10 (Severe Pain)

2.

Rate pain: 0 (No Pain) to 10 (Severe Pain)

3.

Rate pain: 0 (No Pain) to 10 (Severe Pain)

4.

Rate pain: 0 (No Pain) to 10 (Severe Pain)

5.

Notes

Date

Signature

Yellow Flags Questionnaire (YFQ)

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Please check the appropriate response for each of the following statements or questions:

1. Please indicate your usual level of pain during **the past week:**

No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst Possible Pain

2. Does pain, numbness, tingling or weakness extend into your leg (from the low back) &/or arm (from the neck)?

None Of The Time ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 All Of The Time

3. How would you rate your general health?

Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?

Delighted ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Terrible

5. How anxious (tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during **the past week:**

Not At All ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely Anxious

6. How much you have been able to control (reduce/help) your pain/ complaint on your own during **the past week:**

I Can Reduce It ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 I Can't Reduce It At All

7. Please indicate how depressed (eg. Down-in-the-dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in **the past week:**

Not Depressed At All ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely Depressed

8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in six months?

Very Certain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Not Certain At All

9. I can do light work for an hour.

Completely Agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Disagree

10. I can sleep at night.

Completely Agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Disagree

11.An increase in pain is an indication that I should stop what I am doing until the pain decreases.

Completely Disagree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Agree

12.Physical activity makes my pain worse.

Completely Disagree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Agree

13. I should not do my normal activities including work with my present pain.

Completely Disagree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Completely Agree

_____

Patient Signature