

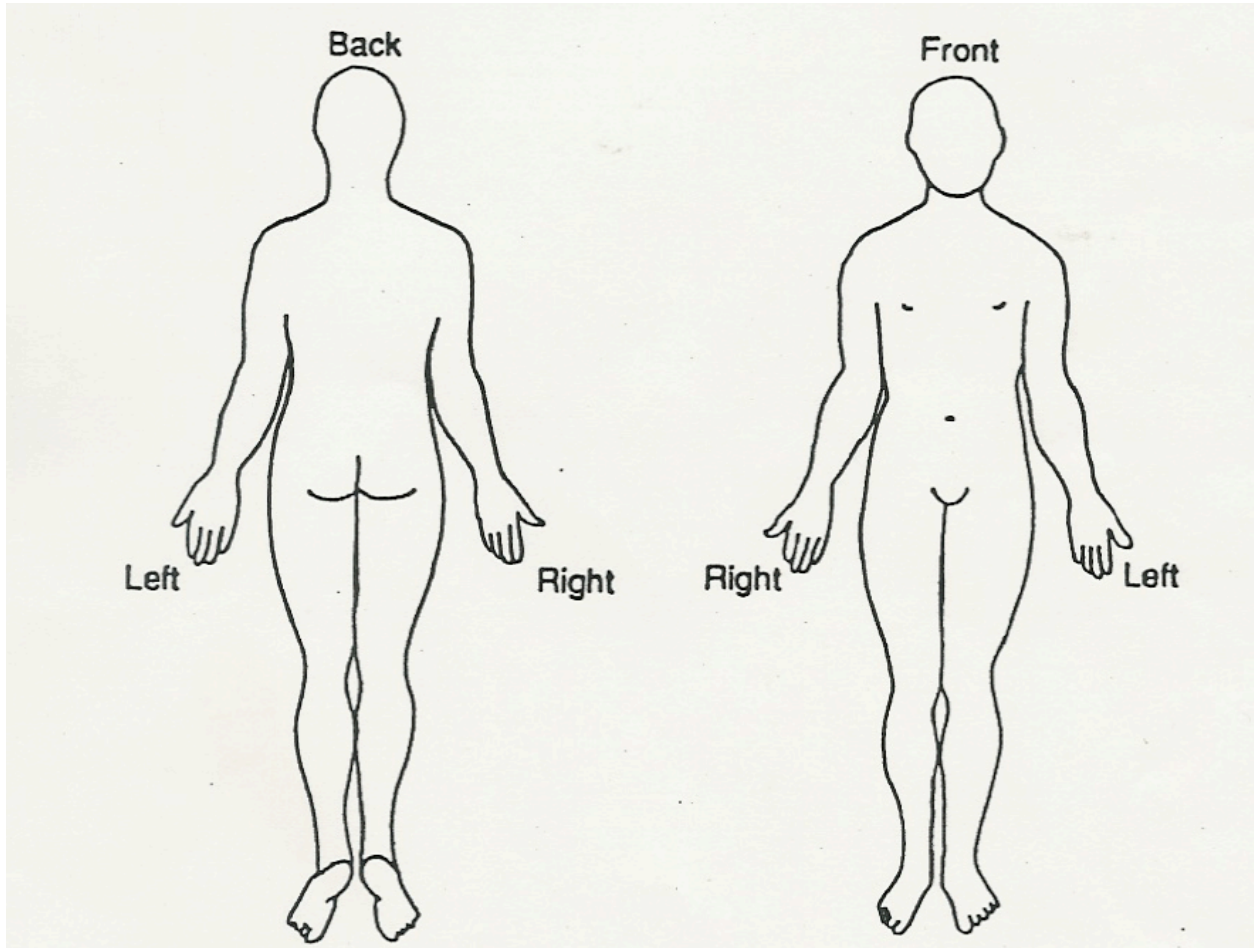
PAIN DIAGRAM

Name: _____ Date: _____

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

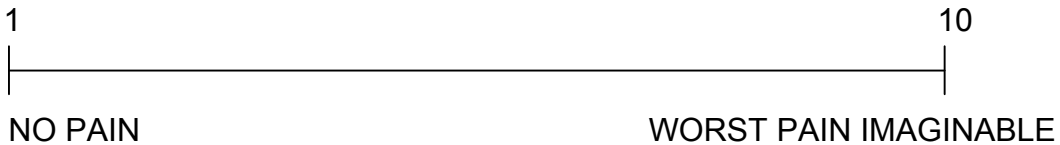
Ache-A
Burning-B
Numbness-N

Pins and Needles-P
Stabbing-S
Other-O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling **at this time**.

Date: _____



PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____
Street City State Zip

Email: _____ Referred by: _____

Home Phone: _____ Work (daytime) Phone: _____

Cell Phone: _____ Employer: _____

Gender: Male Female Social Security #: _____

Marital Status: _____ Spouse's Name: _____

Date of Last Exam: _____ Dr: _____ Phone #: _____

Insured's Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Employer: _____

In case of emergency, whom shall we contact?

Name: _____ Phone: _____

Cell: _____ Relationship: _____

FINANCIAL POLICY

As a courtesy to our patients, we offer the following billing options. Please initial the one that applies to you and sign at the bottom of the page.

PRIVATE PAY

____ I will pay for all services, as they are rendered and submit my own insurance claims

PPO & Group / Health

____ This office is a unique practice offering chiropractic, physical therapy, and laboratory services. I understand that the office will submit my insurance companies, and take the necessary steps to work with the insurance companies to insure payment. The office does not guarantee payment by any insurance company. I am responsible for payment of deductible, co-payments, and non-covered services. **If for any reason my insurance has not paid within 90 days, I will pay the entire balance and collect funds from the insurance company on my own.** I assign my benefits to this office.

Auto Accident / Personal Injury

____ I understand this office does not accept 3rd party reimbursement. This office will bill my health insurance or my auto insurance and I am responsible for any deductible, co-payments, or non-covered services. I will pay any outstanding balance 45 days after submission. I assign my benefits to this office.

Medicare

____ This office does accept assignment and will bill Medicare as described in my Medicare benefits.

Signature of Insured / Guardian

Date

FirstLineTherapy[®] Health Profile

NAME _____

DATE _____

Rate each of the following symptoms based upon your typical health profile for: Past 30 days Past 48 hours

Point Scale	0	Never or almost never have the symptom	3	Frequently have it, effect is not severe
	1	Occasionally have it, effect is not severe	4	Frequently have it, effect is severe
	2	Occasionally have it, effect is severe		

HEAD

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

_____ TOTAL

DIGESTIVE TRACT

_____ Nausea, vomiting

_____ Diarrhea

_____ Constipation

_____ Bloating feeling

_____ Belching, passing gas

_____ Heartburn

_____ Intestinal/stomach pain

_____ TOTAL

EYES

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision (does not include near- or far-sightedness)

_____ TOTAL

JOINTS / MUSCLE

_____ Pain or aches in joints

_____ Arthritis

_____ Stiffness or limitation of movement

_____ Pain or aches in muscles

_____ Feeling of weakness or tiredness

_____ TOTAL

EARS

_____ Itchy ears

_____ Earaches, ear infections

_____ Drainage from ear

_____ Ringing in ears, hearing loss

_____ TOTAL

WEIGHT

_____ Binge eating/drinking

_____ Craving certain foods

_____ Excessive weight

_____ Compulsive eating

_____ Water retention

_____ Underweight

_____ TOTAL

NOSE

_____ Stuffy nose

_____ Sinus problems

_____ Hay fever

_____ Sneezing attacks

_____ Excessive mucus formation

_____ TOTAL

ENERGY / ACTIVITY

_____ Fatigue, sluggishness

_____ Apathy, lethargy

_____ Hyperactivity

_____ Restlessness

_____ TOTAL

MOUTH / THROAT

_____ Chronic coughing

_____ Gagging, frequent need to clear throat

_____ Sore throat, hoarseness, loss of voice

_____ Swollen or discolored tongue, gums or lips

_____ Canker sores

_____ TOTAL

MIND

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

_____ TOTAL

SKIN

_____ Acne

_____ Hives, rashes, dry skin

_____ Hair loss

_____ Flushing, hot flashes

_____ Excessive sweating

_____ TOTAL

EMOTIONS

_____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression

_____ TOTAL

HEART

_____ Irregular or skipped heartbeat

_____ Rapid or pounding heartbeat

_____ Chest pain

_____ TOTAL

OTHER

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

_____ TOTAL

LUNGS

_____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing

_____ TOTAL

GRAND TOTAL _____

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

- diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
 other _____

Do you experience any of these general symptoms EVERY DAY?

- | | | | | |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Debilitating fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Nausea | <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Disinterest in sex | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Itching/rash |

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? _____

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Age of first period _____
- Date - last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
- Cigarettes: #/day _____
- Cigars: #/day _____
- Alcohol:
- Wine: #glasses/d or wk _____
- Liquor: #ounces/d or wk _____
- Beer: #glasses/d or wk _____
- Caffeine:
- Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk - #days/wk _____
- Run, jog, other aerobic - #days/wk _____

Weight lift - #days/wk _____**Stretch - #days/wk _____****Other _____****Nutrition & Diet**

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip meals - which ones _____
- _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Others _____

I Would Like To:ENERGY - VITALITY

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

BODY COMPOSITION

- Loose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

STRESS, MENTAL, EMOTIONAL

- Learn how to reduce stress
- Think more clearly and be more-focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

LIFE ENRICHMENT

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle