

Date _____

First Name: _____ Last Name: _____ Initial _____

Major Complaint Information

What is your major complaint(s)? _____

When did this symptom(s) begin? _____

If this is an injury, describe what happened: _____

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.

Pain Index

- D** Dull Nagging Ache
- B** Burning
- S** Sharp / Stabbing
- N** Numbness / Tingling

For example: The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.

SEVERITY

On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain imaginable, use the key to the right to rate the severity of your pain.

Sitting here today, right now, what is the intensity of your pain on a scale of 0-10? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?

0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? Yes No

When? _____

What aggravates this condition? _____

What decreases the symptoms / pain? _____

Key

- 0** = None
- 1** = Minimal
- 2** = Very Mild
- 3** = Mild
- 4** = Mild to Moderate
- 5** = Moderate
- 6** = Moderate to Severe
- 7** = Moderately Severe, Restricts some activity
- 8** = Severe, Limits most activity
- 9** = Very Severe
- 10** = Excruciating

Have you seen another doctor for this condition? Yes No Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? Yes No If so, how many times do you wake up in pain per night? _____

In what position do you sleep? Back Side Stomach

Do you sleep with a pillow? Yes No How many? _____

Does heat affect the pain? Yes No If so, how? _____

Does cold affect the pain? Yes No If so, how? _____

Do you wear a heel lift? Yes No If so, which side? Right Left

Does it cause pain to cough, grunt, or sneeze? Yes No If so, where? _____

Check those activities below during which you experience difficulty or pain:

- | | | | | |
|---------------------------------------------|---------------------------------------------|--------------------------------|----------------------------------------|-------------------------------------------------|
| <input type="radio"/> Lying on back | <input type="radio"/> Getting in/out of car | <input type="radio"/> Pulling | <input type="radio"/> Sitting | <input type="radio"/> Standing for long periods |
| <input type="radio"/> Lying on side | <input type="radio"/> Dressing Self | <input type="radio"/> Reaching | <input type="radio"/> Bending forward | <input type="radio"/> Sneezing |
| <input type="radio"/> Turning over in bed | <input type="radio"/> Sexual Activity | <input type="radio"/> Kneeling | <input type="radio"/> Bending backward | <input type="radio"/> Coughing |
| <input type="radio"/> Lying flat on stomach | <input type="radio"/> Pushing | <input type="radio"/> Stooping | <input type="radio"/> Walking | <input type="radio"/> Other: _____ |

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Lower Back Pain

Does pain radiate into the leg? Yes No Where: _____ Does pain radiate to the abdomen? Yes No

Do you ever have impairment of bowel or urinary function? Yes No Explain: _____

Do you have numbness or tingling into the legs? Yes No Explain: _____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) Hearing Vision Balance Cause ringing in your ears

Do you hear grating sounds? Yes No Do you feel pressure or pain behind your eyes? Yes No

Does pain radiate into the arm? Yes No Where: _____

Do you have difficulty lifting or turning your head? Yes No If so, in which direction? Right Left Up Down

Headaches

Do you get headaches? Yes No Frequency _____ Do you have a family history of headaches? Yes No

Do you experience the following along with your headaches: Pain or cracking in your jaw? Yes No

Abnormal blood pressure? Yes No High Low Nausea, Vomiting or Visual disturbances? Yes No

When was your last eye exam by a doctor? 1 - 6 months 6 - 12 months 1 - 2 years over 2 years Results: _____

If female, are you pregnant? Yes No Not Sure If no or not sure, date of your last menstrual period: _____

List all medications you are taking now, including over the counter medication. _____

Are you allergic to any medications? Yes No Not Sure Please list: _____

Have you ever had any surgeries or hospitalizations? Yes No Please list:

Type of Hospitalization/Surgery: _____ Date: _____ Type of Hospitalization/Surgery: _____ Date: _____

Have you been x-rayed or received MRI, CAT scan in the last 12-18 months? Yes No When?: _____

Have you ever been seen by a chiropractor before? Yes No Please list:

Name of Chiropractor: _____ Dates: _____ Name of Chiropractor: _____ Dates: _____

Do you have a family physician? Yes No Name of physician: _____ Phone: _____

Address: _____

City/State/Zip: _____

Additional Complaints

Please check all additional complaints that you have at this time:

- | | | | | |
|-----------------------------------------------|---------------------------------------------------|-------------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="radio"/> Loss of Concentration | <input type="radio"/> Neck Stiffness | <input type="radio"/> Shortness of Breath | <input type="radio"/> Cold Hands | <input type="radio"/> Heart Disease |
| <input type="radio"/> Eyes Sensitive to Light | <input type="radio"/> Neck Motion Restricted | <input type="radio"/> Irritable | <input type="radio"/> Cold Feet | <input type="radio"/> Arthritis |
| <input type="radio"/> Memory Loss | <input type="radio"/> Upper Back Pain / Stiffness | <input type="radio"/> Anxiety | <input type="radio"/> Jaw pain | <input type="radio"/> HIV (Aids) |
| <input type="radio"/> Heavy Feeling of Head | <input type="radio"/> Mid Back Pain / Stiffness | <input type="radio"/> Depression | <input type="radio"/> Hypertension | <input type="radio"/> Other (Please List) |
| <input type="radio"/> Dizziness | <input type="radio"/> Right / Left Shoulder Pain | <input type="radio"/> Insomnia | <input type="radio"/> Diabetes | _____ |
| <input type="radio"/> Ringing in Ears | <input type="radio"/> Right / Left Arm Pain | <input type="radio"/> Fatigue | <input type="radio"/> Convulsions | _____ |
| <input type="radio"/> Loss of Balance | <input type="radio"/> Pins & Needles Arms / Legs | <input type="radio"/> Excess Perspiration | <input type="radio"/> Allergies (Please List) | _____ |
| <input type="radio"/> Loss of Smell | <input type="radio"/> Right / Left Leg Pain | <input type="radio"/> Digestive Trouble | _____ | Please Specify Location: |
| <input type="radio"/> Loss of Taste | <input type="radio"/> Low Back Pain/Stiffness | <input type="radio"/> Nausea | _____ | <input type="radio"/> Numbness _____ |
| <input type="radio"/> Pain Behind Eyes | <input type="radio"/> Sinus Trouble | <input type="radio"/> Vomiting | _____ | <input type="radio"/> Swelling _____ |
| <input type="radio"/> Fainting | <input type="radio"/> Nervousness | <input type="radio"/> Diarrhea | <input type="radio"/> Vision Problems | <input type="radio"/> Cuts _____ |
| <input type="radio"/> Palpitation | <input type="radio"/> Chest Pain | <input type="radio"/> Constipation | <input type="radio"/> Anemia | <input type="radio"/> Bruising _____ |

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If so, please list: _____

Have you ever had? Motor Vehicle Injury Sports Injury Work Injury Slip and Fall Injury

If yes, please explain: _____

Is there any additional information you would like the doctor to know about before beginning care? _____

Emergency Contact

Name: _____ Relation: _____

Home Phone: () _____ Work Phone: () _____

Address: _____

Areas of Interest

Please mark areas of interest or if you desire more information:

- | | | |
|--------------------------------------------------|--------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Nutritional Supplements | <input type="checkbox"/> Neck/Body Pillows | <input type="checkbox"/> Ear infection/colic/ADD |
| <input type="checkbox"/> Detoxification | <input type="checkbox"/> Decompression | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Others (list) |
| <input type="checkbox"/> Weight Loss Information | <input type="checkbox"/> Wellness Care | _____ |
| <input type="checkbox"/> Women's Health | <input type="checkbox"/> Children's Care | _____ |

Personal Information

Address: _____
City / State / Zip: _____
Home Phone: () _____ Work Phone: () _____
Mobile Phone: () _____ Email: _____
Social Security #: _____ Birth Date: _____ Age: _____ Sex: M F
Occupation: _____ Employer's Name: _____
Work Address: _____
City / State / Zip: _____
Marital Status: S M D W Spouse's Name: _____ # of Children: _____
Children's information: _____
How were you referred to Lyn Lake Chiropractic? _____

Authorization & Assignment

I authorize Lyn Lake Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Lyn Lake Chiropractic authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date _____ Patient's Signature _____

Informed Consent

I hereby authorize physicians and staff at Lyn Lake Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Lyn Lake Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date _____ Patient's Signature _____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

IMPACT

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No

If yes, explain _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain _____

Was impact from :

Front Rear Left Right Other _____

At the time of impact were you:

Looking straight ahead Looking to the right

Looking to the left Looking down

Looking up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Right Left

Was your foot on the brake? Yes No

If yes, which foot was on the brake? Right Left

Were you: Surprised by impact Braced for impact

VEHICLE

Make and model of vehicle you were in: _____

Were you wearing a seatbelt? Yes No

If yes, what type? Lap Shoulder

Was vehicle equipped with airbags? Yes No

If yes, did it/they inflate properly? Yes No

Did your seat have a headrest? Yes No

If yes, what was the position of the headrest?

Low Midposition High

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? Yes No

When did you go? Immediately after accident Next day 2 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? Yes No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes No

If you have had any of the following symptoms since your injury, please check:

- | | | |
|--------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

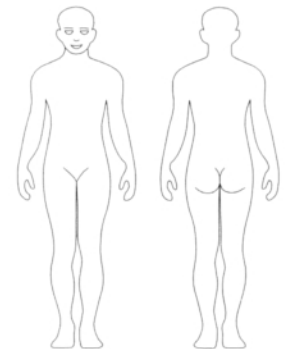
Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Movements that are painful to perform: Sitting Standing Walking
 Bending Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient