

NEW PATIENT CONSULTATION / HISTORY

Please answer all questions completely, Thank you!

Name _____ Address _____
 Apt # _____ City _____ State _____ Zip _____ Home Phone _____
 Work _____ Cell Phone _____
 E-Mail Address _____ Sex: M F Marital Status: S D M W

Children: _____
 Age _____ Date of Birth ____/____/____ SS# _____ Spouses Name: _____
 Employer _____ Occupation _____
 Duration of Employment _____ How did you hear about the clinic? _____

What is your Chief Complaint? _____

Have you had
 Chiropractic Care before? _____ Yes _____ No
 Is it possible you are
 Pregnant? _____ Yes _____ No

Are you here because of: _____ An auto accident?
 _____ An on the job injury?
 Date Injured? _____
 Do you have an attorney? _____ Yes _____ No
 Date of last physical exam: _____
 Reason: _____

Hobbies: _____
 Sports: _____

LIST ALL accidents, falls, injuries, surgeries, and major illnesses.

| TYPE | MONTH/YEAR | DESCRIBE / COMMENTS |
|------|------------|---------------------|
| | | |
| | | |

LIST ALL MEDICATIONS

| NAME OF DRUG | AMOUNT | CONDITION / HOW LONG |
|--------------|--------|----------------------|
| | | |
| | | |

PLEASE CHECK ANY OF THE FOLLOWING THAT GIVE YOU DIFFICULTY

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Constipation | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Nerves & nervousness |
| <input type="checkbox"/> Sinus pain | <input type="checkbox"/> Heart palpation | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Neuritis arms/shoulders | <input type="checkbox"/> Irregular sleep |
| <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Inflammation in throat |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Face flushed |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Leg/feet pain |
| <input type="checkbox"/> Slipped disc | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pins & needles | <input type="checkbox"/> Tight shoulder muscles | <input type="checkbox"/> Tightness in throat | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arms/hand pain | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Twitching of face |
| <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart pain |

Does your spouse (or children) complain about back, neck or shoulder pain (past 3 years)? Yes _____ No _____

Please list your top 3 major health concerns in order of importance:

1. _____
2. _____
3. _____

Patient Signature _____ Date _____

AUTOMOBILE ACCIDENT HISTORY FORM

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____

City of Accident: _____ Street of Accident: _____

Was anyone else in the Vehicle with you? YES NO Road Condition: WET DRY

Did the police come to the scene? YES NO Was a citation issued? YES NO
If yes, who received it? Self Other driver

Did you go to the hospital? YES NO

Name and city of hospital: _____

How did you get there? _____

Were you X-Rayed? _____

What treatment did you receive? _____

How long were you at the hospital? _____

Please explain any cuts, bleeding or bruising you received:

Where were you seated in the vehicle? _____

Were you aware of the approaching collision or was it a surprise? AWARE SURPRISE

Did you black out upon impact? YES NO; How long were you unconscious? _____

Did you experience a flash of light or explosion in your head? YES NO

As a result of the accident did you become:

CONFUSED DISORIENTED LIGHT HEADED DIZZY

NAUSEATED BLURRED VISION RINGING IN EARS

Are you still experiencing any of these symptoms? YES NO What ones? _____

Are you currently suffering from any of the following:

RESTLESSNESS IRRITABILITY

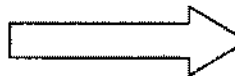
DIFFICULTY CONCENTRATING MEMORY LOSS

SLEEPLESSNESS FORGETFULNESS

REDUCED HEAT TOLERANCE REDUCED ALCOHOL TOLERANCE

How far is the top of the headrest or seatback from the top of your head: _____
inches above or below.

Were you wearing a seatbelt? YES NO; Full lap/shoulder belt or Lap belt only



Please list the make, model and year of the vehicle you were in:

Year _____ Make _____ Model _____

Please list the make, model and year of the other vehicle:

Year _____ Make _____ Model _____

Was your car stopped at moment of impact? YES NO

If Yes- Was the drivers foot on the brake? YES NO

If No- estimate the speed of the vehicle you were in: _____ MPH

If your vehicle was moving at impact, was it:

SLOWING DOWN SPEEDING UP STEADY SPEED

Please indicate where the following body parts may have hit the car:

Head hit _____ Chest Hit _____

Rt/Lt shoulder _____ Rt/Lt arm _____

Rt/Lt Hip _____ Rt/Lt leg _____

Rt/Lt Knee _____ Other _____

Did you sustain an injury from the seat belt? YES NO

Please Describe: _____

Total estimated damage to the vehicle I was in was: \$ _____

Which of the following car parts broke during the accident?

WINDSHIELD

FRONT SEAT BACK

RIGHT/LEFT WINDOWS

STEERING WHEEL

OTHER _____

In what direction was the trunk of your body facing at moment of impact?

In what direction was your head pointed at moment of impact? _____

Was the other vehicle: Stopped Accelerating Decelerating Steady Speed

What was estimated speed? _____ MPH

Please describe, to the best of your knowledge, what happened during this accident:

Signature : _____ Date: _____

Personal Injury Questionnaire

Name _____ Date of Accident _____ Time _____

Where did accident happen? _____

Describe the accident in your own words: _____

Were you the: Driver Passenger If passenger, were you sitting in: Front Right rear Left Rear

Was your car struck by other vehicle? Yes No Did your car strike other vehicle? Yes No

Was citation issued? Yes No If so, who received it? Other driver Me

Was the impact from the: Front Right Side Left Side Rear

At the time of impact, were you looking: Straight Ahead Right Left

Were both hands on the steering wheel? Yes No Was your foot on the brake? Yes No

Were you braced for impact? Yes No Where in the car were you after the accident? _____

Were you wearing seat belts? Yes No Did air bag inflate? Yes No

Did you strike anything in vehicle at time of impact? Yes No

If yes, specify: Steering Wheel Dashboard Windshield Side Door Arm Rests Side Window Other _____

What Part of your body: Chest Chin Knee Shoulder Hand Head Other _____

Immediately following the accident: Were you unconscious Yes No In a daze Yes No

Did you go to hospital Yes No If yes, Immediately Next Day

How did you get to hospital? Ambulance Private Transportation

Did attendants place you in Neck Collar Splint Brace Name of Hospital _____

Attended by Dr. _____ Were you x-rayed Yes No What was the diagnosis _____

Were you admitted into the Hospital Yes No How long did you stay _____

What treatment was rendered? _____

What recommendations were made? _____

Have you lost any time from work due to this accident? Yes No

If yes, give dates of lost time: From _____ To _____

Do you feel that you cannot perform any physical work activity? Yes No

Do you feel that you cannot perform any mental work activity? Yes No

Do you believe that your inability to perform these functions are due to: Pain Weakness Nerves

Do you have normal sexual function? Yes No

Have you seen any other doctor as a result of this accident? Yes No Doctors Name _____

Is your pain Constant On and Off Sharp Dull Other _____

Is pain made worse by Arising From A Chair Straining Coughing Sneezing Straining when Moving Bowels

Do you have any numbness or tingling in your: Arms Hands Fingers Legs Feet Toes

Most comfortable position is: Sitting Lying on Right Side Lying on Left Side Standing On Back On Stomach

Does stretching or twisting worsen the pain? Yes No Is it difficult to move around in bed? Yes No

Do any of the following relieve the pain? Heating Pad Hot Bath Shower Ice Pack Moving Around Resting

Are you able to take care of your personal self? Yes No

Do you feel your present condition is: Temporary Permanent

Please Check Your Ability To Perform These Functions Both Before And After The Accident

| | | Before | After | | | Before | After | | | Before | After | | | Before | After |
|----------|--------|--------------------------|--------------------------|---------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|--------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Walking | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Sitting | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Stooping | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Lifting | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Pushing | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Pulling | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Climbing | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Reaching | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Gripping | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Kneeling | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Balance | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | Normal | <input type="checkbox"/> | <input type="checkbox"/> | Limited | <input type="checkbox"/> | <input type="checkbox"/> | Difficult | <input type="checkbox"/> | <input type="checkbox"/> | Pain | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature _____ Date _____

PAIN ASSESSMENT

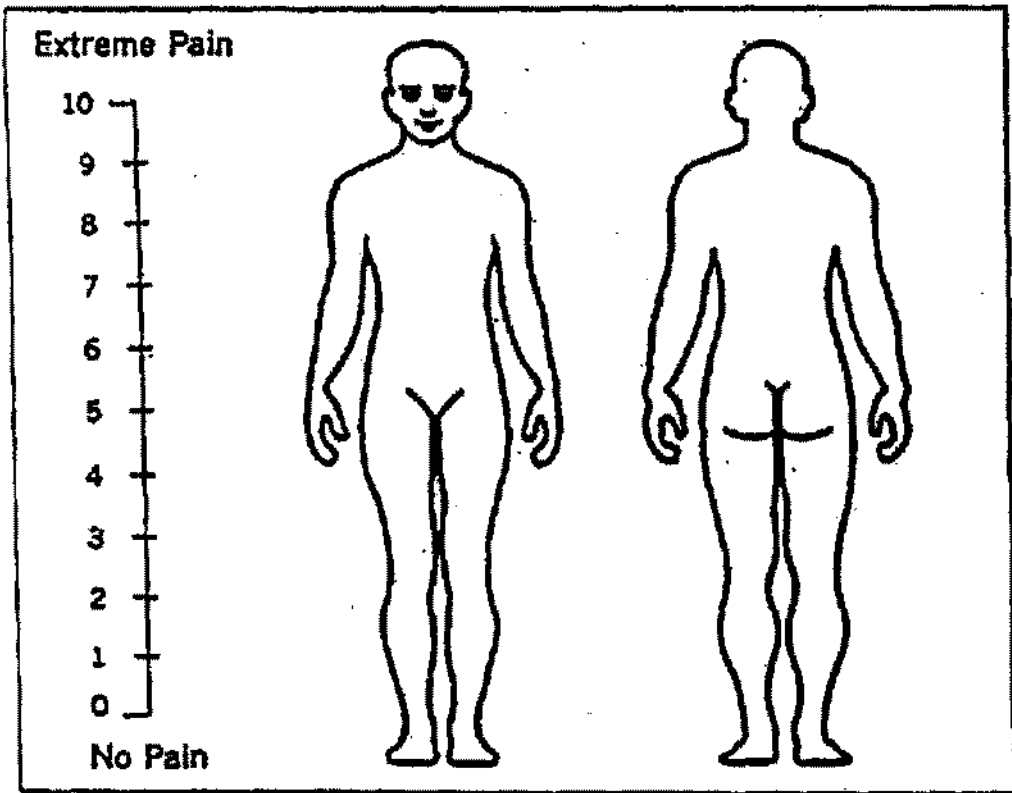
Name _____ Date _____

Please mark the severity of your pain on the scale 0 - 10.

Please indicate the areas where you have pain or altered sensation on the figures below.

P = Pain
B = Burning
S = Stiffness

T = Tingling
N = Numbness



Describe any changes in your condition or any new concerns:

Patient Signature _____

ACTIVITES DISCOMFORT SCALE

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

| Activity | Doesn't hurt at all | Hurts a little | Hurts very much | Almost unbearable | Unbearable pain prevents activity |
|-------------------------|---------------------|----------------|-----------------|-------------------|-----------------------------------|
| 1. Walking | | | | | |
| 2. Sitting | | | | | |
| 3. Bending | | | | | |
| 4. Standing | | | | | |
| 5. Sleeping | | | | | |
| 6. Lifting | | | | | |
| 7. Running or jogging | | | | | |
| 8. Climbing stairs | | | | | |
| 9. Carrying | | | | | |
| 10. Pushing and pulling | | | | | |
| 11. Driving | | | | | |
| 12. Dressing | | | | | |
| 13. Reading | | | | | |
| 14. Watching TV | | | | | |
| 15. Household Chores | | | | | |
| 16. Gardening | | | | | |
| 17. Sports | | | | | |
| 18. Employment | | | | | |
| TOTAL | | | | | |

COMMENTS: _____

NAME: _____ **DATE:** _____ **SCORE:** _____

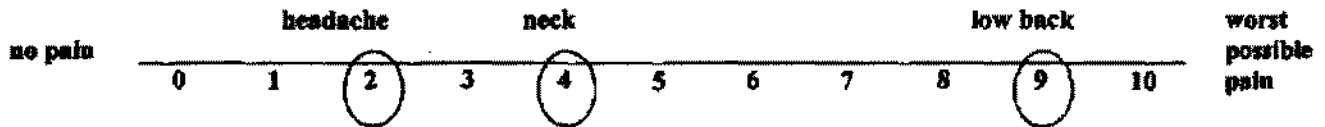
Turner JA, Robinson J, McCreary CP. Chronic low back pain: Predicting response to nonsurgical treatment. Arch Phys Med Rehabil 64:560-563, 1983.

QUADRUPLE VISUAL ANALOGUE SCALE

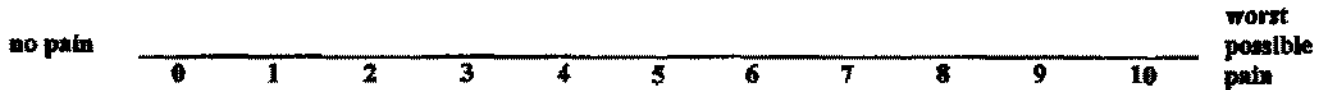
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

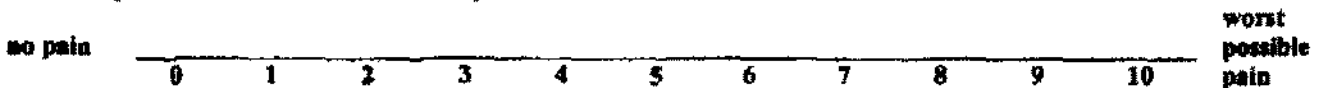
EXAMPLE:



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)?



What percentage of your awake hours is your pain at its best? _____ %

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



What percentage of your awake hours is your pain at its worst? _____ %

NAME _____ AGE _____ DATE _____ SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Mercado Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to Mercado Chiropractic will be credited to my account by receipt. However, 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, any fees for professional services rendered will be immediately due and payable. A service charge will be added after 30 days unless predetermined arrangements have been made.

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. 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 offer limited Power of Attorney in the event a payment is made to doctors office on my behalf and requires my signature. You may endorse and apply payment to my account.
3. In the event of any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demanding by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. This authorization and assignment shall be valid and effective for all charges and fees hereafter incurred unless retracted and revoked by me in writing.
5. I hereby authorize the doctors at the doctor's office to care for my condition as they deem medically necessary. It is understood and agreed that the amount paid for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen. The doctor's office will not be held responsible for any pre-existing medically diagnosed conditions. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

DATE _____ SIGNED _____

WITNESS _____

FEMALE PATIENTS: PREGNANCY STATUS

I verify that my last menstrual period was _____ and that I am not pregnant at this time. The doctors and staff at Mercado Chiropractic have been informed of my condition and are not responsible for any future condition as a result of diagnostic x-rays taken on _____

SIGNATURE _____ DATE _____