

Raheb Family Chiropractic
Jeffrey E. Raheb D.C., P.A.
6705 38th Ave. N. Ste. B, St. Petersburg, FL 33710
Phone 727-381-3456 Fax 727-381-3761

Patient Information

Today's Date _____ **Patient Full Name(Print)** _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Email Address _____

Date of Birth _____ - _____ - _____ Age _____ Marital Status _____ Male _____ Female _____

Social Security # _____ - _____ - _____ Claim #: _____

Attorney's Name for PIP _____ Attorney's Phone #: _____

Injury Description

Date of Injury/Accident _____ Location of Injury: _____ State _____

Were you the: () **Driver** or () **Passenger**. Were you sitting in the: () **Front Seat** or () **Back Seat**

Were you struck from: () **Behind** () **Front** () **Left Side** () **Right Side**

Did the air bags deploy? () **Yes** () **No** Were there any other passengers in the car? () **Yes** or () **No**

Approximate speed your vehicle was traveling _____ mph. OR; were you stopped () **Yes** or () **No**

Make and Model of the other vehicle: _____

Were the police notified? () **Yes** or () **No** Did the police give you a report? () **Yes** or () **No**

If yes, you must provide a copy of this report to this office within 5 business days of today's date

What was the approximate damage to the vehicle: () **Moderate** () **Extensive** () **Totaled**

Amount of damage \$ _____ Was your vehicle towed from the scene? () **Yes** () **No**

Hospital

Did you go to the hospital? () **Yes** () **No** If yes; which hospital? _____

When did you go? () **Immediately** () **Same Day** () **Next Day** () **Other** _____

How did you get there? () **Ambulance** () **Self** () **Someone else took me**

Hospital Continued

What type of treatment was given at the hospital? _____

Were you examined? () Yes () No Were x-rays taken? () Yes () No Did you have a MRI () Yes () No

Were you given any prescriptions? () Yes () No

If yes; what type of medications? _____

Did you see any other doctor after your accident OTHER than at the hospital? () Yes () No

Doctor's Name: _____ Phone #: _____ Fax #: _____

What treatment did you receive from the OTHER doctor? () Medications () Physical therapy () X-Rays () MRI

How often do you see the doctor or receive physical therapy? _____

Details of Your injuries

Did you strike any part of your body on any part of the car? () Yes () No () I don't remember

If yes; please describe: _____

Did you lose consciousness? () Yes () No If yes; for how long? _____

Where did you feel pain immediately after the accident? () Head () Neck () Mid back () Low back
() shoulder () arm () hands () knees () hips () legs () feet

Where did you feel pain later that day? () Head () Neck () Mid back () Low back () shoulder () arm
() hands () knees () hips () legs () feet

When did you first start to have pain after your accident? () Immediately after accident () Later that day
() Later the next week () Later the next month

Any cuts? () Yes () No If yes; where? _____ Any bruises? () Yes () No If yes; where? _____

Since the accident are your injuries () Improving () Getting Worse () Staying the Same

Social & Work History

What is your occupation? _____ What are your physical requirements on the job? _____

Have you lost any time at work? () Yes () No If yes how many? Days _____ Weeks _____

What were your activities prior to the accident: Exercise () Yes () No If yes; how many times per week? _____

Sports () Yes () No If yes; how many times per week? _____

Patient Name: _____

Date: _____

Past Medical History

Have you ever been treated for any of the following:

	NO	YES		NO	YES
Anemia	_____	_____	Bleeding Disorders	_____	_____
High Blood Pressure	_____	_____	Heart Attack or MI	_____	_____
Thyroid Disease	_____	_____	Osteoporosis	_____	_____
Ulcer	_____	_____	HIV or AIDS	_____	_____
Cancer	_____	_____	Hepatitis	_____	_____
Asthma	_____	_____	Liver Disease	_____	_____
Epilepsy or Seizures	_____	_____	Kidney Disease	_____	_____
Stroke or CVA or TIA	_____	_____	Emphysema or COPD	_____	_____
Diabetes Mellitus	_____	_____	Alcohol or Drug Abuse	_____	_____
Claustrophobia	_____	_____	Anxiety or Panic Disorder	_____	_____

If YES, Explain details or list any other serious medical conditions not listed above: _____

Do you have any health problem or disorders that the doctor should know about? () Yes () No

If yes; explain _____

Current Medications: Please list ALL medications you currently take to include vitamins, herbal supplements, over-the-counter medications as well as pain medications, muscle relaxors or anti-inflammatories:

Medication	Dosage	Frequency	Reason Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SURGICAL HISTORY

Type of Surgery	Date	Surgeon	City
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name _____ **Date:** _____

HOSPITALIZATIONS

Please Print

<u>Date</u>	<u>Reason</u>
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Please list any serious family illness to include cancer(type), heart disease, heart attack stroke, diabetes, high blood pressure and/or cholesterol, mental illness, Alzheimer's dementia, ECT:

Family Member	Family Illness	Living (circle)	Additional Details
Father	_____	YES NO	
Mother	_____	YES NO	
Siblings	_____	YES NO	
Children	_____	YES NO	

Other Serious Family Illness: YES____ **NO**____ **Relation**_____

Please Explain: _____

Patient Name: _____

Date: _____

Patient's Pain Drawing

PATIENT'S NAME _____ DATE _____

Date of Accident (If Any) _____

Where is your Pain? Use the letters to mark on the body drawings where you feel sensation(s). Include all affected areas. *Sign and date at the bottom of the page. Please use ink only.*

A = ACHE

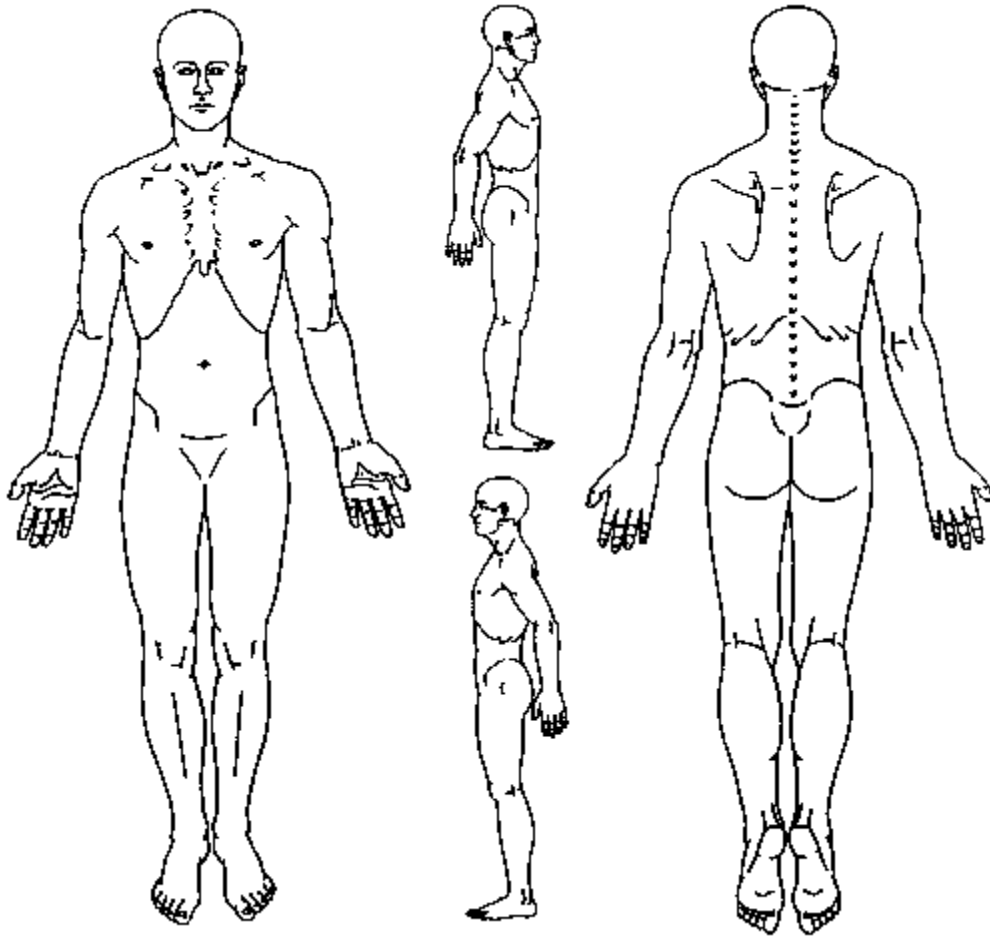
P = PINS & NEEDLE

B = BURNING

S = STABBING

N = NUMBNESS

O = OTHER



PATIENT/GUARDIAN SIGNATURE: _____ DATE _____

PAIN INTENSITY & FREQUENCY FORM

PATIENT'S NAME _____ DATE _____

On a scale of zero to 10 (0-10) indicate for EACH PART OF THE BODY your pain intensity. On a scale from 0%-100% indicate your pain frequency for EACH PART OF THE BODY. Circle right, left or both.

CURRENT PAIN INTENSITY LEVELS FOR EACH PART OF THE BODY											
CIRCLE THE BOX THAT BEST INDICATES YOUR OVERALL AVERAGE PAIN INTENSITY.											
PAIN INTENSITY	NONE	MILD DISCOMFORT/ ACHE/STIFF			MODERATE/HURTS/SORE/ BEARABLE SENSATION				SEVERE/SHARP/ INTENSE PAIN		
HEADACHE	0	1	2	3	4	5	6	7	8	9	10
NECK PAIN	0	1	2	3	4	5	6	7	8	9	10
HAND/WRIST/ARM/SHOULDER RIGHT / LEFT / BOTH	0	1	2	3	4	5	6	7	8	9	10
MID BACK	0	1	2	3	4	5	6	7	8	9	10
LOW BACK	0	1	2	3	4	5	6	7	8	9	10
TOES/FOOT/LEG/HIP RIGHT / LEFT / BOTH	0	1	2	3	4	5	6	7	8	9	10

CURRENT PAIN FREQUENCY LEVELS FOR EACH PART OF THE BODY												
CIRCLE THE BOX THAT BEST INDICATES YOUR AVERAGE PERCENTAGE OF TIME YOU HAVE PAIN.												
PAIN FREQUENCY	NONE	OCCASIONAL			INTERMITTENT			FREQUENT			CONSTANT	
HEADACHE	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
NECK PAIN	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
HAND/WRIST/ARM/SHOULDER RIGHT / LEFT / BOTH	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
MID BACK	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
LOW BACK	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
TOES/FOOT/LEG/HIP RIGHT / LEFT / BOTH	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	

HEADACHE and/or MIGRAIN Frequency and Duration

Indicate how frequent you have headaches or migraines. Be sure to indicate how many hours or day long each headache typically lasts.

How frequently do you currently have headaches? _____ times a week _____ times a month

How many hour or days do your typical headaches currently last? _____ hours _____ days

How many headache pills do you typically take _____ pills a day _____ pills a month

PATIENT/GUARDIAN SIGNATURE: _____ DATE _____

PATIENT NAME (LAST, FIRST) _____

DATE OF INJURY/ACC: _____

DATE OF SERVICE _____

Please Read: this questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by checking the **ONE CHOICE** that most applies to you. We realize the you may feel that more than one statement may relate to you, but Please **just check one choice which closely describes your problem right now.**

SECTION 1 – Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 –Personal Care

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty and stay in bed.

SECTION 3—Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned .e.g. on the table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights
- I cannot lift or carry anything.

SECTION 4—Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than ½ mile.
- I can only walk while using a cane or on crutches.
- I am in bed most of the time.

SECTION 5 – Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all.

SECTION 6--Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

SECTION 7--Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

SECTION 8—Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sports
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

SECTION 9—Traveling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain restricts prevents me from traveling except to receive treatment

/45 X 100 (formula for disability index)

DISABILITY INDEX SCORE: % _____

DOCTOR / CA SIGNATURE _____

PATIENT SIGNATURE _____

RAHEB FAMILY CHIROPRACTIC
6705 38TH AVE. N, STE. B
ST. PETERSBURG, FL 33710

Patient Name: _____

Date: _____

REVIEW OF SYSTEMS

Do you currently have or have had any problems with: *Circle One*

Details

Constitutional

Fever or Chills.....	YES	NO
Weight Loss or Gain (circle).....	YES	NO
Chronic Fatigue.....	YES	NO
Night Sweats.....	YES	NO

Eyes

Wear Glasses or Contacts.....	YES	NO
Dry Eyes.....	YES	NO
Double Vision.....	YES	NO
Blurred Vision.....	YES	NO
Vision Loss.....	YES	NO
Glaucoma.....	YES	NO
Cataracts.....	YES	NO
Previous Injuries.....	YES	NO

Ear, Nose, Throat and Mouth

Wearing Hearing Aids.....	YES	NO
Hearing loss.....	YES	NO
Balance Disturbance.....	YES	NO
Speech Difficulties.....	YES	NO
Post Nasal Drip.....	YES	NO
Sinus Headaches.....	YES	NO
Sore Throats.....	YES	NO
Swallowing Problems.....	YES	NO

Cardiovascular

Chest Pain or Angina.....	YES	NO
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Date of last EKG: _____ Stress Test: _____

High Blood Pressure.....	YES	NO
Irregular Heart Rate.....	YES	NO
History of Heart Murmur.....	YES	NO
High Cholesterol.....	YES	NO
Swelling in Ankles/Feet.....	YES	NO
History of DVT.....	YES	NO
Cardiac Stents.....	YES	NO
Cardiac Catheterization.....	YES	NO
Pacemaker.....	YES	NO

REVIEW OF SYSTEMS CONTINUED: PATIENT NAME: _____

Respiratory

Shortness of Breath..... YES NO
Chronic Cough..... YES NO
Bloody Sputum..... YES NO
History of Pneumonia..... YES NO
History of PE (pulmonary embolism)..... YES NO

Gastrointestinal

Indigestion or Heartburn..... YES NO
Nausea..... YES NO
Vomiting..... YES NO
Abdominal Pain..... YES NO
Diarrhea..... YES NO
Constipation..... YES NO
Blood in Stool..... YES NO

Genitourinary

Frequent Urinary Tract Infections..... YES NO
Blood in Urine..... YES NO
Difficulty Starting or Stopping Stream..... YES NO
Loss of Urine..... YES NO
Loss of Urine with Cough or Sneeze Only..... YES NO
Kidney Stone..... YES NO

Musculoskeletal

Neck Pain..... YES NO
Back Pain..... YES NO
Arm Pain..... YES NO
Arm Numbness and Tingling..... YES NO
Arm Weakness..... YES NO
Loss of Range of Motion in Arm/ Shoulder Joints..... YES NO
Leg Pain..... YES NO
Leg Numbness and Tingling..... YES NO
Leg Weakness..... YES NO
Loss of Range of Motion in Leg Joint..... YES NO
Arm or Leg Length Discrepancy..... YES NO
Joint Pain or Swelling..... YES NO
Osteoporosis..... YES NO

Last Bone Density (DEXA) Test: _____

Skin (Integumentary)

Skin Disease..... YES NO
Rashes..... YES NO

REVIEW OF SYSTEMS CONTINUED:

Neurological

Headaches.....	YES	NO
Disorientation.....	YES	NO
Difficulty with Speech.....	YES	NO
Fainting Spells or "Blacking Out".....	YES	NO
Problems with Memory.....	YES	NO

Psychiatric

Anxiety.....	YES	NO
Depression.....	YES	NO
Suicidal Thoughts.....	YES	NO
Hallucinations.....	YES	NO
History of Dementia.....	YES	NO
Other Psychiatric Disorders:_____		

Endocrine

Excessive Thirst or Urination.....	YES	NO
Hormone Problems.....	YES	NO

Hematologic/ Lymphatic

Persistent Swollen Glands or Lymph Nodes.....	YES	NO
Blood Transfusion.....	YES	NO
If Yes, When?_____		

Allergic/ Immunologic

Food Allergies.....	YES	NO
Immunologic Disorders.....	YES	NO

Male Reproduction

Difficulty with Erection.....	YES	NO
Diminished Sexual Drive.....	YES	NO
Prostate Enlargement.....	YES	NO

Female Reproduction

Pregnant.....	YES	NO
Menopause.....	YES	NO
Tubal Ligation or Hysterectomy.....	YES	NO

The above information is accurate to the best of my knowledge:

Print Name	Patient Signature	Date
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I have reviewed the above medical information:_____

Provider Signature	Date
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