

Adult Chiropractic Health Questionnaire

Welcome to Raheb Family Chiropractic

LAST Name _____ FIRST Name _____

Street _____ City, State, Zip _____

I LIVE HERE: ___12 months/ALL YEAR? Or ___Part-Time – When do you live here? _____

Phone Home (____) _____ Work (____) _____ EXT. _____ Cell (____) _____

Sex M or F Birth Date Month _____ /Day _____ /Year _____ Age _____ SS# _____

Marital Status: M W Sep. D S Spouse/Partner's Name _____ No. of Children _____

Your Occupation _____ Your Employer _____

E-mail Address _____

Would you like to receive our weekly health and wellness newsletter via e-mail? Yes No

1. Most patients are **referred** to our office by a caring family member or friend. What made you decide to visit our office?

Friend/Family Member Name _____ OR Radio Yellow Pages
 Dinner Breakfast Presentation Website Natural Awakening St. Pete Times E-mail Other

2. **Research shows** that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ Never

3. When was your last complete spinal examination including x-rays? _____ Never

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? YES NO

5. Spinal misalignments cause decay and degeneration which results in grinding or cracking. Do you ever hear noises when you move your head or neck? YES NO

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? YES NO

7. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Spinal health is especially important during pregnancy. Is there any chance that you are **pregnant?** YES NO

10. Have you ever been diagnosed with cancer? YES NO Type _____ Year _____

11. **If the doctor feels that chiropractic will help you, are you willing to follow his recommendations?** YES NO

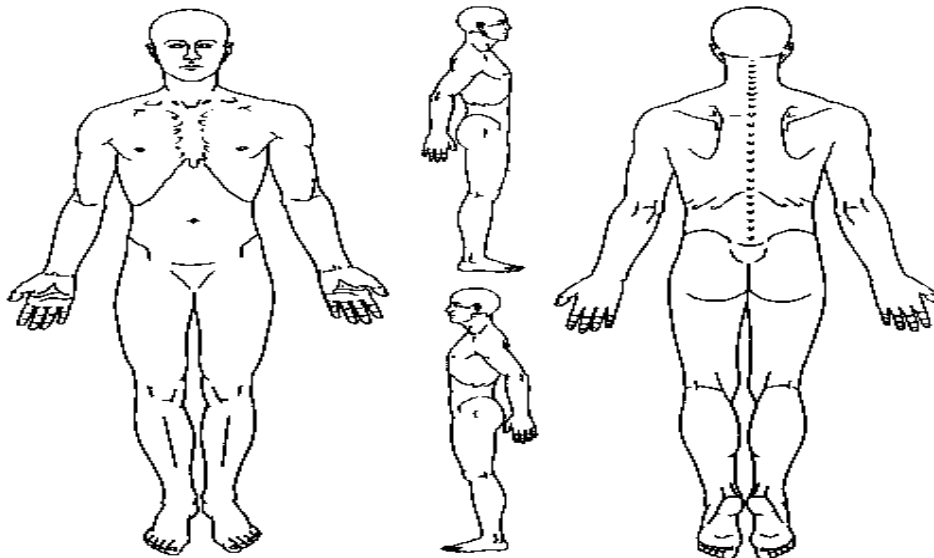
The above information is true and accurate to the best of my knowledge. I understand that I am financially responsible for any future treatment and understand that the doctor/office will discuss all future charges for recommended treatment.

Guardian Name(if any) _____

Patient/Guardian Signature _____ Date _____

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



1. List any health symptoms &/or complaints you are/have been experiencing. Ex. Headaches, Neck/Back Pain, Sciatica

1. _____ 2. _____ 3. _____ 4. _____

2. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. LIST current medications. _____

3. **Auto/Work-related Injuries can Cause Serious Spinal Problems. Is this visit related to an Auto accident or Injury?** YES NO Date of Accident _____ Date of last auto-accident _____

4. Did the problem begin with an Injury? YES NO Date _____ Injury details _____

5. When did this problem first begin? Date _____ Explain: _____

6. How long have you been in pain? Days _____ Wks. _____ Months _____ Years _____

7. When do you notice it most? AM PM Other: _____

8. What makes it feel better? Rest Exercise Sitting Standing Lying Down Hot Packs Cold Packs

9. What makes it feel worse? _____ Rest Exercise Sitting Standing Lying Down

10. Have you ever had this problem in the past? YES NO When was the last time Date _____

11. **I have:** never received care for this problem was hospitalized - Details: _____

Treated by **Chiropractor** If Yes: Date: _____ Details: _____

Treated by **other Specialty Provider:** Details: _____

12. This problem is: Improving or getting better. Remains the same or no change. Getting worse

13. I have pain when: Coughing Sneezing Straining Other _____

PRINT PATIENT NAME _____ GUARDIAN NAME: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE _____

PAIN INTENSITY AND FREQUENCY FORM

PATIENT NAME _____ GUARDIAN NAME _____

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. Circle 0 for no pain.

CURRENT PAIN <i>INTENSITY</i> 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 <i>FREQUENCY</i> 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 &/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 _____

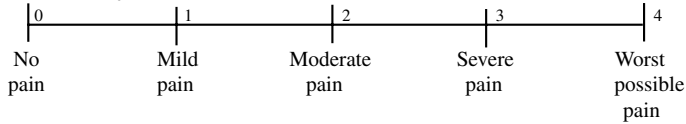


Functional Rating Index

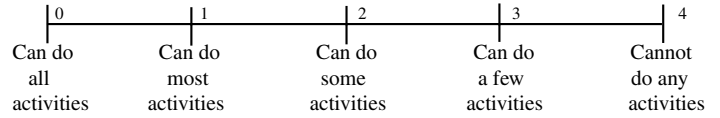
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

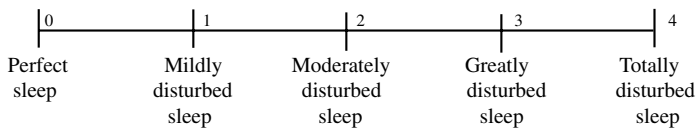
1. Pain Intensity



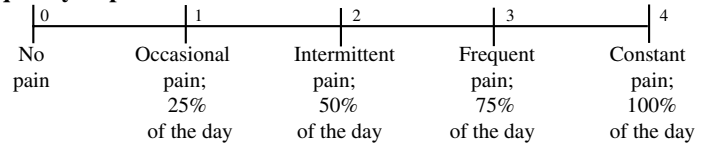
6. Recreation



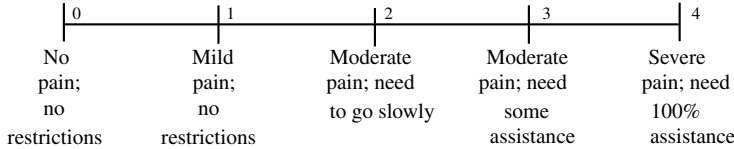
2. Sleeping



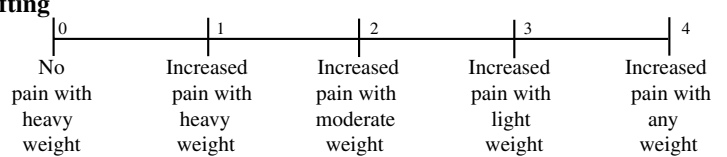
7. Frequency of pain



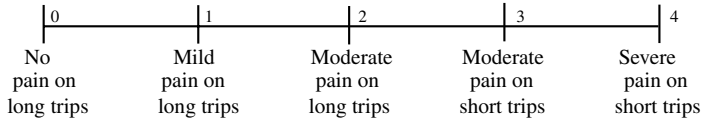
3. Personal Care (washing, dressing, etc.)



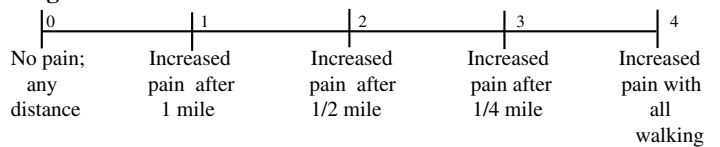
8. Lifting



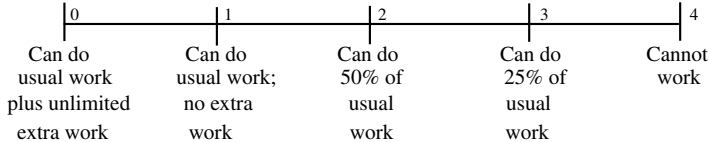
4. Travel (driving, etc.)



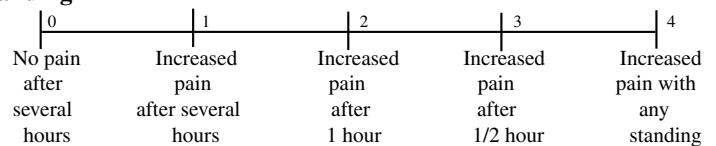
9. Walking



5. Work



10. Standing



Total Score _____

PRINTED _____

Signature _____

Date _____