# Community Chiropractic Care * New Patient Information Worksheet

**Name: _____ SS#: _____ Age: _____**
**Address: _____ City: _____State: _____ Zip: _____**
**Home Phone: _____ E-mail Address_____ Cell Phone: _____**
**Birth Date: _____ Martial Status S M W D How Many Children _____**
**Employer: _____ Occupation _____**
**Address_____ Work Phone_____**
**City_____ State _____ Zip _____**
**Spouse Name: _____ Spouse's Birth Date:_____**
**Spouse Employer:_____ Spouse Work Phone _____Occupation _____**
**Spouse's SS # : _____**

**Referred By:** (Friend) (Relative) (Newspaper Ad) (Yellow Pages) (Sign) (Other) _____

**Which one of our patient's should we thank for referring you?** _____

**Please circle your current symptoms:**
(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain)

(Mid-Back Pain) (Low Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain)

(Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) Other: _____

**My symptoms are due to :** (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

**List all surgeries in the past 5 years : _____**

**Have you ever had spinal surgery?** (No) (Yes): _____

**List any serious condition the doctor should be aware of: _____**

**Previous Chiropractor: _____ Were you satisfied?** (No) (Yes)

***Females: Are you pregnant at this time?** (No) (Yes) **Due Date: _____**

**Office Policies:** If I am accepted as a patient at Community Chiropractic Care I agree to pay for all services, including services not covered by my insurance company. I may suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.

**Consent To Treat:** I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Segal to proceed with any necessary treatment. I have read Dr Segal's office policies and consent to treat information, and agree with them by signing below:

**Signature: _____ Date: _____**

**Parent's/Guardian's Signature : _____ Date: _____**

**Community Chiropractic Care**
Dr Steve Segal * email: drsteve@libertyvillechiropractor.com
Phone: (847) 778-3627
**503 E. Park Ave.**
**Libertyville, IL 60048**

# Patient Health History Worksheet

Patient's Name:_____ _____Date:_____

### Present Health History

When did your present condition begin?
a) Gradual Onset (no specific date)
b) Date:_____

What caused your present condition?
a) No specific injury
b) Home accident
c) Work Accident
d) Auto Accident

What happened to cause your present pain?
_____
_____
_____
_____
_____

Have you ever had these symptoms before?
a) No
b) Yes: (Date:_____)

What time of day are your symptoms **better**?
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

What time of day are your symptoms **worse**?
a) Morning
b) Afternoon
c) Evening
d) All of the above (constant pain)

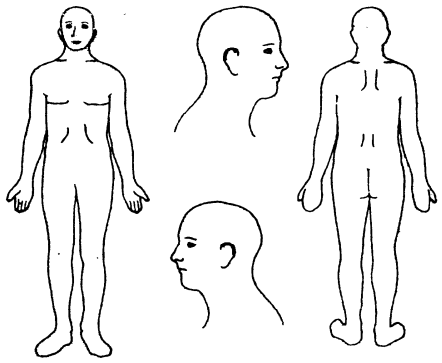
Have you missed any work from this condition?
a) No
b) Yes: (Date:_____)

What makes your pain **better**?
a) Rest
b) Ice packs/Heating pads
c) Prescription Medications
d) Drug store medications (Ibuprofen, Advil)
e) Other: _____

What makes your pain **worse**?
a) Activity (work, repetitive motions)
b) Ice packs/Heating pads
d) Driving (or riding) in car
e) Other: _____

What home remedies have you tried?
a) Ice packs
b) Heating pads/Hot tubs
c) Exercise
d) Other: _____

**Please Label The Area(s) Of Today's Pain**



_____
_____
_____
_____
_____

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# Patient Health History Worksheet

Patient's Name:_____ Date:_____

### Significant Past Health History

Have you ever been hospitalized?
a) No
b) Yes: (Year:_____) (Reason:_____)

Have you had any surgeries?
a) No
b) Yes: (Year:_____) (Reason:_____)

Do you have any significant health problems?
a) No
b) Yes: (_____)

### Significant Past Medical History

Have you seen another doctor for this condition?
a) No
b) Yes: (Name:_____)

Did this doctor recommend any treatment?
a) No
b) Yes: (_____)

Are you taking any medications?
a) No
b) Yes: (_____)

### Significant Past Social History

Do you play any sports or exercise?
a) No
b) Yes: (_____)

How many hours do you sleep a night? (_____)

How many hours a week do you work? (_____)

### Significant Family Medical History

Did your father have any health problems?
a) No
b) Yes: (_____)

Did your mother have any health problems?
a) No
b) Yes: (_____)

Did your brother(s) have any health problems?
a) No
b) Yes: (_____)

Did your sister(s) have any health problems?
a) No
b) Yes: (_____)

Did your grandpa have any health problems?
a) No
b) Yes: (_____)

Did your grandma have any health problems?
a) No
b) Yes: (_____)

### Health Risk Factors

Do you drink alcohol?
a) No
b) Yes: (_____)

Do you smoke?
a) No
b) Yes: (_____)

Anything else the doctor should know about?
a) No
b) Yes: (_____)

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**Patient's Name**_____ **Date:**_____

*[Please **circle the number** which most closely describes your chief complaint(s) today:*

**1. Pain Intensity**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain |

**2. Frequency Of Pain**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| No Pain | Occasional Pain 25% Of The Day | Intermittent Pain 50% Of The Day | Frequent Pain 75% Of The Day | Constant Pain 100% Of The Day |

**3. Personal Care (Washing, Dressing, etc.)**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| No Pain No Restrictions | Mild Pain No Restrictions | Moderate Pain Need to go slowly | Moderate Pain Need some assistance | Severe Pain Need 100% Assistance |

**4. Travel (Driving, Riding, etc.)**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| No Pain On Long Trips | Mild Pain On Long Trips | Moderate Pain On Long Trips | Moderate Pain On Short Trips | Severe Pain On Short Trips |

**5. Work**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| Can Do Usual Work Plus Extra Work | Can Do Usual Work No Extra Work | Can Do 50% Of Usual Work | Can Do 25% Of Usual Work | Cannot Work |

**6. Recreation**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| Can Do All Activities | Can Do Most Activities | Can Do Some Activities | Can Do A Few Activities | Cannot Do Any Activities |

**7. Sleeping**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| Perfect Sleep | Mildly Disturbed | Moderately Disturbed | Greatly Disturbed | Totally Disturbed |

**8. Lifting**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| No Pain With Heavy Weight | Increased Pain With Heavy Weight | Increased Pain With Moderate Weight | Increased Pain With Light Weight | Increased Pain With Any Weight |

**9. Walking**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| No Pain Any distance | Increased Pain After One Mile | Increased Pain After Half Mile | Increased Pain After Quarter Mile | Increased Pain With All Walking |

**10. Standing**

| (0) | (1) | (2) | (3) | (4) |
|---|---|---|---|---|
| No Pain After Several Hours | Increased Pain After Several Hours | Increased Pain After One Hour | Increased Pain After Half Hour | Increased Pain With Any Standing |