SPINE & SPORTS
CHIROPRACTIC CARE OF CT, LLC
Progressive Therapy, Rehabilitation, & Acupuncture

220 Farmington Ave., Farmington, CT 06032
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www.spinesportscare.com

Date _____

Patient Name _____ SS# _____ Date of Birth_____ Age_____

Home# _____ Work# _____ Cell#_____ Email_____

Mailing Address _____ City/State_____ Zip _____

Street Address (If different) _____ City/State _____ Zip _____

Primary Care Physician_____ City/State _____ Phone _____

Emergency Contact _____ Phone# _____ Relationship _____

Who referred you to this office? _____
(e.g., name of Physician, family/friend, website, advertisement)

Employment Information

Employer's Name _____ Phone _____

Employer's Address _____ City/State _____ Zip _____

Insurance Information

Primary Insurance _____ ID# _____ Group # _____

Subscriber's Name _____ DOB _____ Relationship_____

Subscriber's Employer _____ City/State _____ Zip _____

Secondary Insurance _____ ID# _____ Group# _____

Subscriber's Name _____ DOB _____ Relationship_____

Subscriber's Employer _____ City/State _____ Zip _____

Complete below if this injury is due to a motor vehicle or work injury

☐ Motor Vehicle ☐ Work Injury

Law Firm/Attorney Name _____ Phone# _____

Address _____ City/State _____ Zip _____

Insurance _____ ID# _____ Group# _____

Date of Injury _____ Claim Mailing Address _____

Worker's Comp. Carrier _____ Adjuster _____ Phone # _____

Has this injury been reported to someone at work? _____ Is this visit approved? _____

PATIENT TREATMENT CONSENT

AUTHORIZATION & FINANCIAL RESPONSIBILITY

I authorize this office to release any information concerning my diagnosis and medical records about any treatment or examination rendered to me or my child during the period of care to third party payers and/or health practitioners. I authorize and request my insurance company to pay the doctor directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered to me or my dependents. I understand that payment for services and/or applicable co-payment is due at the time of service.

X_____ _____
Patient Signature (or parent of minor) Date

CHIROPRACTIC TREATMENT CONSENT

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic treatment, there are some risks to treatment including, but not limited to, fractures, disc injuries, stroke, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of treatment concerning which treatment(s) are in my best interest, based upon the facts as they are then known.

X _____ _____
Patient Signature (or parent of minor) Date

PAIN QUESTIONNAIRE

When did your pain begin?_____

Is your pain related to an injury? ☐ Yes ☐ No

Please describe how it began:_____

_____

Where is your pain?

☐ Head	☐ Forearm Rt / Lt / Both	☐ Low Back Rt / Lt / Both	☐ Groin Rt / Lt / Both
☐ Neck Rt / Lt / Both	☐ Hand Rt / Lt / Both	☐ Buttocks Rt / Lt / Both	☐ Knee Rt / Lt / Both
☐ Shoulder Rt / Lt / Both	☐ Upper Back Rt / Lt / Both	☐ Hips Rt / Lt / Both	☐ Calf Rt / Lt / Both
☐ Upper Arms Rt / Lt / Both	☐ Chest Rt / Lt / Both	☐ Leg Rt / Lt / Both	☐ Foot Rt / Lt / Both

Describe your pain and specify where?

☐ Sharp_____	☐ Stabbing_____	☐ Dull_____	☐ Achy_____
☐ Shooting_____	☐ Throbbing_____	☐ Burning_____	☐ Cramping_____
☐ Numbness_____	☐ Tingling_____	☐ Pressure-like_____	☐ Other_____

How often do you experience the pain?

☐ Constantly_____ ☐ Intermittently (comes and goes) _____ ☐ Other_____

What aggravates your pain?

☐ Sitting Down	☐ Sitting for Long Periods	☐ Standing	☐ Standing for Long Periods
☐ Walking	☐ Walking for Long Periods	☐ Lying Down	☐ Flexing Forward
☐ Lifting	☐ Coughing	☐ Sneezing	☐ Straining
☐ Deep Breathing	☐ Sleeping	☐ Specific Movement(s)_____	

☐ Other_____

What relieves your pain?

☐ Sitting Down	☐ Standing	☐ Walking	☐ Lying Down	☐ Massage	☐ Therapy
☐ Moist Heat/Hot Shower	☐ Ice	☐ Sleeping	☐ Exercise	☐ Stretching	☐ Rest

☐ Medications_____ ☐ Other_____

What medications are you currently taking for your pain?_____

Since your pain began, is it: ☐ Better ☐ Worse ☐ About the same

Have you resumed your normal activities of daily living? ☐ Yes ☐ No

Are you disabled from your usual employment? ☐ Yes ☐ No Type of Work_____

If so, what is the date you were last able to work?_____

PREVIOUS TREATMENT

What type of treatment have you received so far?

☐ Physical Therapy_____

☐ Chiropractic_____

☐ Acupuncture_____

☐ Epidural Steroid Injections_____

☐ Trigger Point Injections or Nerve Blocks_____

☐ Surgery_____

☐ Massage_____

☐ Other_____

DIAGNOSTIC TESTING

What diagnostic tests have you had completed so far and when?

☐ MRI Cervical Spine_____	☐ MRI Lumbar Spine_____	☐ MRI Other_____
☐ X-Rays Cervical Spine_____	☐ X-Rays Lumbar Spine_____	☐ X-Rays Other_____
☐ CAT Scan_____	☐ EMG/NCV_____	☐ Other Tests_____

SOCIAL & FAMILY HISTORY

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Live with: ☐ Family ☐ Spouse ☐ Significant Other ☐ Friend ☐ Alone

Children: ☐ YES ☐ NO Ages:_____

Educational Level: ☐ Grade School ☐ High School ☐ College ☐ Other

Occupation:_____

Smoking History: ☐ Currently ☐ In the Past Years:_____ Amount:_____

Alcohol: ☐ YES ☐ NO Amount:_____ Substance Abuse: ☐ YES ☐ NO Type:_____

MEDICAL HISTORY

Do you have a past history of: *(Check all that apply)*

- ☐ Allergies to any medications
- ☐ Cancer or a tumor
- ☐ Radiation
- ☐ Chemotherapy
- ☐ Surgery
- ☐ Previous hospitalizations
- ☐ Diabetes
- ☐ Thyroid disease/problems
- ☐ Collagen vascular disease
- ☐ Lyme disease
- ☐ HIV or AIDS
- ☐ Hepatitis B
- ☐ Arthritis
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ History of tuberculosis
- ☐ Asthma
- ☐ Angina/Chest pain/Irregular heart beat
- ☐ Leg pain with walking
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Cardiac pacemaker
- ☐ Any other heart problem
- ☐ Blood clots/phlebitis
- ☐ Any blood disorder
- ☐ Ulcers
- ☐ Gastrointestinal disorders
- ☐ Recent unexplained weight change
- ☐ Kidney disease/problems
- ☐ Liver disease/problems
- ☐ Prostate disease/problems (Men)
- ☐ Ovarian/Uterine disease/problems (Women)
- ☐ Dizziness or Vertigo
- ☐ Stroke or TIA (Transient Ischemic Attack)
- ☐ Loss of consciousness (black out/fainting)
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ Migraine headache
- ☐ Chronic headache
- ☐ Glaucoma
- ☐ Blurred/double vision
- ☐ History of Depression/Anxiety disorder
- ☐ Other neurological problems
- ☐ Drug dependency
- ☐ Alcohol addiction
- ☐ Metal fragments in body
- ☐ Are You Currently Pregnant?
- ☐ Other Conditions?

_____

MEDICATION HISTORY

Are you taking medication for: (*Check all that apply)*

- ☐ Diabetes
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Reducing body fluids
- ☐ Thinning the blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Another lung problem
- ☐ Stomach or bowel problems
- ☐ Glaucoma
- ☐ Reducing your cholesterol
- ☐ Helping you sleep
- ☐ Calming your nerves
- ☐ Depression
- ☐ Pain
- ☐ Muscle spasm
- ☐ Bladder control
- ☐ Steroids
- ☐ Birth control pills
- ☐ Chemotherapy
- ☐ Other Conditions?

_____

_____

Please list all medications you are currently taking:_____

_____

_____