SPINE & SPORTS
CHIROPRACTIC CARE OF CT, LLC

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www.spinesportscare.com

PATIENT INFORMATION

Patient Name (Last, First, MI)		Date of Birth / /	Age
Mailing Address	City/State		Zip
Street Address (if different)	City/State		Zip
SS#	Marital Status ☐ S ☐ M ☐ D ☐ W	Name of Spouse	Language ☐ English ☐ Spanish Other; ☐ Specify
Race ☐ White ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Other Pacific Islander ☐ Black/African American ☐ Decline to Answer Other; ☐ Specify			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer			
Home Telephone # ( )	Work # ( )	Cell # ( )	Email
Emergency Contact	Phone # ( )	Relationship	
Who referred you to this office? (e.g., Name of physician, family/friend, website, advertisement)			
Primary Care Physician	City/State	Phone	

EMPLOYMENT INFORMATION

Occupation	Employer's Name	Phone
Employer's Address	City/State	Zip

INSURANCE INFORMATION

Primary Insurance	ID#	Group #
Subscriber's Name	Date of Birth	Relationship
Subscriber's Employer	City/State	Zip
Secondary Insurance	ID#	Group #
Subscriber's Name	Date of Birth	Relationship
Subscriber's Employer	City/State	Zip

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

☐ **Motor Vehicle Accident** ☐ **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 NAME: _____ **DATE:** _____

SOCIAL & FAMILY HISTORY

Live with: ☐ Family ☐ Spouse ☐ Significant Other ☐ Child/Children ☐ Friend ☐ Alone

Children: ☐ YES ☐ NO Ages:_____

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

Smoking History: ☐ Never ☐ Former Smoker ☐ Current Smoker Years:_____ Amount:_____

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

MEDICAL HISTORY

Recent Vitals: Height _____ Weight_____ Blood Pressure _____

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

CARDIOVASCULAR	Current	Past
Angina/Chest pain/Irregular heart beat	[ ]	[ ]
Leg pain with walking/Leg swelling	[ ]	[ ]
Heart murmur	[ ]	[ ]
Rheumatic fever	[ ]	[ ]
Heart attack	[ ]	[ ]
Congestive heart failure	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Cardiac pacemaker	[ ]	[ ]
Any other heart problem	[ ]	[ ]

MUSCULOSKELETAL	Current	Past
Arthritis: Osteoarthritis, Rheumatoid, Psoriatic, Inflammatory	[ ]	[ ]
Gout	[ ]	[ ]
Osteoporosis / Osteopenia	[ ]	[ ]
Fractured Bones	[ ]	[ ]
Hernia	[ ]	[ ]

EYES	Current	Past
Glaucoma	[ ]	[ ]
Blurred/double vision	[ ]	[ ]

ALLERGIC	Current	Past
Allergies: Food / Environmental /Medication	[ ]	[ ]
Type:_____		

ENDOCRINE	Current	Past
Diabetes: Type I ____ or Type II_____	[ ]	[ ]
Thyroid disease/problems	[ ]	[ ]

GASTROINTESTINAL	Current	Past
Ulcers / Acid reflux	[ ]	[ ]
Gastrointestinal disorders	[ ]	[ ]
Liver disease/problems	[ ]	[ ]

URINARY / GENITOURINARY	Current	Past
Kidney disease/problems	[ ]	[ ]
Prostate disease/problems (Men)	[ ]	[ ]
Ovarian/Uterine disease/cysts/fibroids (Women)	[ ]	[ ]

RESPIRATORY	Current	Past
Emphysema	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Chronic cough	[ ]	[ ]
Asthma	[ ]	[ ]

HEMATOLOGIC	Current	Past
Blood clots/phlebitis	[ ]	[ ]
Anemia	[ ]	[ ]
Any blood disorder	[ ]	[ ]

NEUROLOGICAL	Current	Past
Dizziness or Vertigo	[ ]	[ ]
Stroke or TIA (Transient Ischemic Attack)	[ ]	[ ]
Loss of consciousness (black out/fainting)	[ ]	[ ]
Seizures	[ ]	[ ]
Multiple sclerosis	[ ]	[ ]
Headache: Migraine, Cluster, Tension, Chronic	[ ]	[ ]
Other Neurological problems	[ ]	[ ]

PSYCHIATRIC / BEHAVIORAL	Current	Past
Drug Dependency	[ ]	[ ]
Alcohol Addiction	[ ]	[ ]
History of depression/anxiety	[ ]	[ ]

CONSTITUTIONAL	Current	Past
Recent unexplained weight change	[ ]	[ ]
Cancer: _____ Radiation therapy? Chemotherapy?	[ ]	[ ]
Lyme Disease	[ ]	[ ]
Tuberculosis	[ ]	[ ]
HIV/AIDS	[ ]	[ ]
Hepatitis	[ ]	[ ]
Surgery	**YES**	**NO**
Previous hospitalizations	**YES**	**NO**
Are you currently pregnant?	**YES**	**NO**
Other conditions or serious injuries?		

_____

_____

Please list any surgeries, date performed, and by whom

_____

_____

MEDICATION

Please list current prescriptions, vitamins, supplements, and herbals

_____

_____

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_____

_____

_____

PATIENT NAME: _____ **DATE:** _____

PAIN QUESTIONNAIRE

When did your pain begin?_____

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

Please describe how it began: _____

_____

What do you hope to accomplish or gain from treatment?_____

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_____ ☐ Frequently_____ ☐ Intermittently_____ ☐ Occasionally_____

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_____
☐ Massage_____
☐ Chiropractic_____
☐ Acupuncture_____
☐ Epidural Steroid Injections / Trigger Point Injections or Nerve Blocks_____
☐ Surgery_____
☐ 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_____

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