Welcome To Quality Brain Rehab & Chiropractic Neurology

Patient Information

Last Name:_____

First Name:_____ MI:_____

Address:_____ **APT #**_____

City, State, Zip:_____

Home phone:_____

Cell Phone:_____

Email:_____

Sex: ☐M ☐F Age:_____ Birthdate:_____

Status: ☐ Married ☐ Single ☐Minor

Social Security Number:_____

Whom may we thank for referring you?_____

(Please be as specific as possible, name of friend, google, yelp etc.)

Occupation: _____

Employer:_____

_____

(Signature of patient, parent, guardian or personal representative)

_____ _____

(Date of 1st Visit) (Relaationship to patient)

List all Injuries:

_____

_____

_____

_____

_____

List of Health concerns:

_____

_____

_____

_____

_____

What are your health goals?

_____

_____

_____

_____

_____

In Case of Emergency

Name:_____

Relationship:_____

Home/cell phone: _____

Work Phone:_____

Any person listed on this form may be contacted regarding my account unless listed on a disclosure restriction form.

Responsibility

Who is responsible for this account?_____

Relationship to Patient:_____

How will you be paying? ☐ Cash ☐Check ☐ Card

IS THIS CONDITION DUE TO AN ACCIDENT LIKE?

AUTO ____ WORK ____ HOME ____ OTHER ____

DATE OF ACCIDENT: _____

Patient Condition

What's your chief complaint?_____

When did symptoms appear_____ **What type of injury/event triggered/brought on complaint?** _____

Ever had the exact symptoms during a prior episode? _____

Do you have any other complaints that you're hoping to be addressed? _____

Is this condition getting progressively worse? _____ Does pain move or stay localized? _____

How often do you have this pain?_____ **Is it constant or does it come & go?** _____

Is there a time of the day that's Especially bothersome? _____

Rate your pain on a scale from 1 (least pain) to 10 (severe pain) in the past 24 HR's:_____

Mark an X on the picture where you continue to have pain, numbness, or tingling:

Type of Pain: ☐Sharp ☐Shooting ☐Throbbing ☐Numbness ☐Aching ☐Dull
☐Burning ☐Tingling ☐Stiffness ☐Cramps ☐Swelling ☐Other

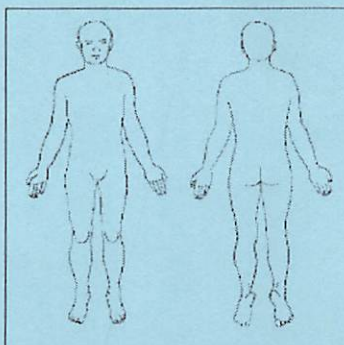
Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Please describe how its interferes: _____

_____

_____

Activities that especially aggravate the problem☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down



Health History

Name of primary care provider if you have one: _____

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic ☐None ☐Other_____

Name and city / state of other doctor(s) who have treated you for this condition _____

Have you been to a chiropractor before, if so, whom? _____

Date of last: Physical Exam_____ Spinal X-ray_____ Spinal Exam_____ Chest X-ray_____ Urine Test _____ Neuro Exam_____ MRI/CAT/bone scan_____

What are your concerns/questions regarding the exam or treatment? _____

Please Circle to indicate if you have had any of the following:

AIDS/HIV	Diabetes	Liver Disease	Rheumatic Fever
Alcoholism	Emphysema	Measles	Scarlet Fever
Allergy Shot	Epilepsy	Migraine Headache	Sexually Transmitted Disease
Anemia	Fractures	Miscarriage	Stroke
Anorexia	Glaucoma	Mononucleosis	Suicide Attempt
Appendicitis	Goiter	Multiple Sclerosis	Thyroid Problems
Arthritis	Gonorrhea	Mumps	Tonsillitis
Asthma	Gout	Osteoporosis	Tuberculosis
Bleeding Disorders	Heart Disease	Pacemaker	Tumors, Growths
Breast Lump	Hepatitis	Parkinson's Disease	Typhoid Fever
Bronchitis	Hernia	Pinched Nerve	Ulcers
Bulimia	Herniated Disk	Pneumonia	Whooping Cough **Are you pregnant?** ☐No ☐Yes Due Date:_____
Cancer	Herpes	Polio	Do you get ringing in the ears: **Y / N** Is it **constant / intermittent? R / L**
Cataracts	High Blood Pressure	Prostate Problem	Are you hypersensitive to smells? _____
Chemical Dependency	High Cholesterol	Psychiatric Care	Do you twitch/tremor in areas of your body? _____
Chicken Pox	Kidney Disease	Rheumatoid Arthritis	If you sweat or tear up more on 1 side of the body, which side? **R** or **L**

Do you notice that you sweat more on 1 side of your body? If so, which side? _____

How much sleep do you get daily? _____ Is it broken up? Do you feel rested afterwards?

Family Health History

Please list any significant health problems

Mother	Father	Siblings			Children		
Age:____	Age:____	Age:____	☐M	☐F	Age:____	☐M	☐F
		Age:____	☐M	☐F	Age:____	☐M	☐F
		Age:____	☐M	☐F	Age:____	☐M	☐F
		Age:____	☐M	☐F	Age:____	☐M	☐F

Are you here for? ☐Relief (pain management, symptom relief) ☐Corrective ☐ Maintenance ☐ Holistic Care Are you willing to follow a treatment plan? ☐Yes ☐No

Types of adjustment you prefer? ☐Manual ☐Instrument ☐Low force ☐Traditional Are you willing to ☐Change Diet ☐Exercise ☐Take Supplement ☐ Lab Work

How often do you have the urge to urinate? _____ How often do you have a bowl movement? _____ How much water do you drink? _____

Females: How regular are your menstrual cycles? _____ Is intercourse ever painful? _____ Any vaginal infections? _____

Males: Do you urinate with a split line? _____ Is it ever difficult to initiate/terminate urine flow? _____ Is it hard getting/sustaining an erection? _____

Life Style

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/week_____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	cups/day_____

Surgeries

Had any falls & do you fall frequently: _____

Have you ever sustained a concussion or injured your head (document details): _____

Had any Broken Bones (what type & year): _____

Had any surgeries (what type(s) & year(s)) : _____

Medications *Please list 'NONE' if no medications or supplements*

Medications	Vitamins/Herbs/Minerals