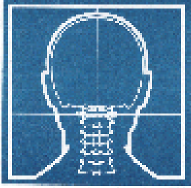


East Detroit Chiropractic Center

John M. DiMasi, DC, BCAO — Theodore M. Koukles, DC, CCSP

Name____Date__________________

Preferred Name____________________ Age_________ Birth Date________________

Marital Status: S M D W Height ________ Weight_________ Sex M F

Address____

City______________________________ State__________ Zip Code__________________

Telephone (________)_________________ Social Security #_______-_______-___________

Occupation_____________________________Work Phone__(_______)_________________

Place of Employment____

Address____

Referred By:_____________________________________Relationship_______________

With my signature below, I certify that I have completed this form accurately and completely to the best of my knowledge. I understand that though I may have health insurance coverage under a group health plan, medicare, workman's compensation or personal injury-type policy, I am ultimately responsible for all charges of services rendered to me, should my claim be denied, disallowed, terminated, or payment not made in full by the insurance carrier for any reason. If I have no health coverage, payment is to be made in cash, as services are rendered. ***I understand that if I am divorced, the parent signing below for the child is financially responsible .***

I understand and agree all services rendered me are charged directly to me, and any health or accident insurance policies are between the insurance carrier and myself. This clinic will assist in preparing any necessary forms or reports in making collection of my account. **All x-rays are the property of this chiropractic clinic.** Should you require films, copies will be made at a nominal fee and require a 48 hour notice.

____

Date Signature of Patient, Parent of Patient (if minor child), or Legal Guardian

____

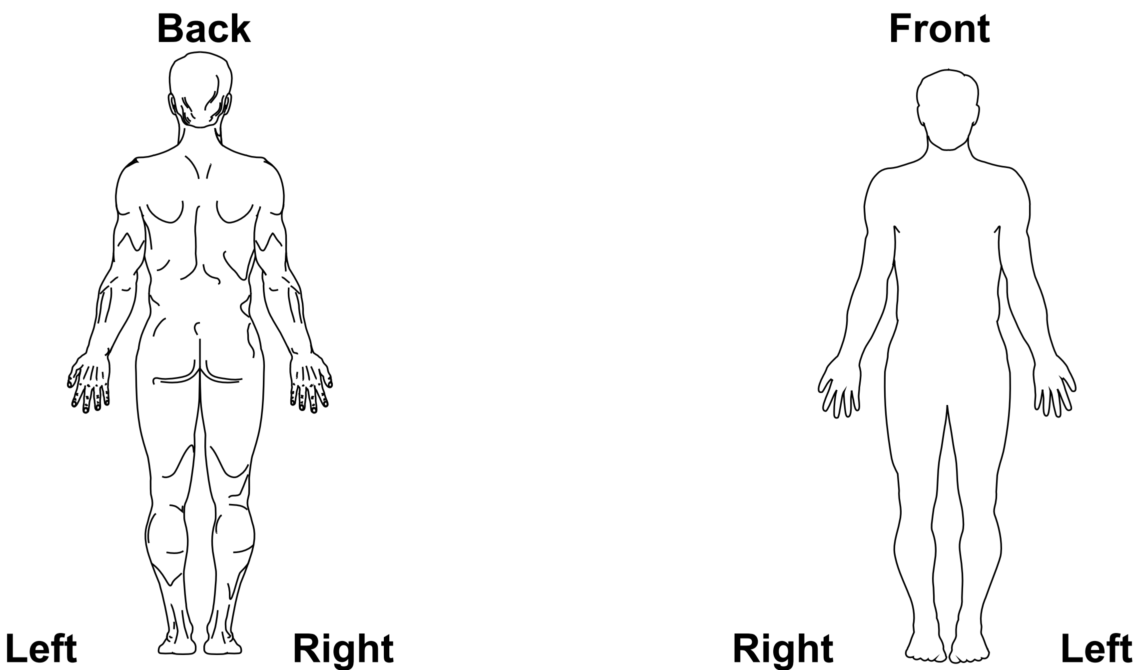
Date Signature of Parent, Spouse or Guardian Authorizing care

Information recorded by____

Pain Drawing

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^^^^ ^^^^^^	===== =====	⊙⊙⊙⊙ ⊙⊙⊙⊙	. . . .	//////////// ////////////	XXXX XXXX

Draw the location of your pain on the body outlines:



Pain Scale: **0 = No pain** **10 = worst possible pain**

Head	1	2	3	4	5	6	7	8	9	10	constant	intermittent
Shoulder	1	2	3	4	5	6	7	8	9	10	constant	intermittent
Upper back	1	2	3	4	5	6	7	8	9	10	constant	intermittent
Mid back	1	2	3	4	5	6	7	8	9	10	constant	intermittent
Low back	1	2	3	4	5	6	7	8	9	10	constant	intermittent
Arms	1	2	3	4	5	6	7	8	9	10	constant	intermittent
Legs	1	2	3	4	5	6	7	8	9	10	constant	intermittent

How long have you been having pain?

❍ 1 week or less
❍ 1 - 6 weeks
❍ 3 months - 1 year
❍ Over 1 year

How many times have you had this problem in the past?

❍ Never
❍ 1 - 3 episodes
❍ 4 or more episodes

When did you first have these or similar symptoms?

❍ Never
❍ Less than 6 months ago
❍ 6 months - 1 year ago
❍ More than 1 year ago

How would you describe your chief complaint at this time?

____

____

____

When did it start? Date____

(Include at least month and year, day if known)

What is your history with this injury?

❍ Sudden trauma ❍ Reoccurrence ❍ Repetitive Trauma

What makes the pain worse?

____

What makes the pain better?

____

How would you describe your pain?

____

Where is your pain located?

____

At what time of the day or week is your pain the worst?

____

Motor Vehicle Accident?	**Job Injury?**	**Personal Injury?**
YES NO	YES NO	YES NO

Have you been to a chiropractor before? YES NO

Dr's Name____ When seen______________________________

What results did you receive? (relief, moderate relief, no relief, etc.)____

Have you been treated for today's condition by a M.D. or D.O.? YES NO

Dr's Name____When seen________________________________

Diagnosis ___________________________________ Results____

Are you taking any medication? YES NO What kind?____

How long?____

Childhood diseases? (circle) Measles Mumps Chicken Pox Whooping Cough Rheumatic/Scarlet Fever Polio Other_____________________

Are you taking any self medications (aspirin, vitamins, herb remedies, etc)? Y N

If yes, list preparations used, amount used and for what purpose____
____

Are you pregnant? Y N If "Yes", when are you due? ______________________________________

Health Habits

Do you drink alcohol? Y N If Yes, please indicate the following:

Hard Liquor:	Y	N	○ 1 oz	○ Daily
			○ 2 oz	○ Weekly
			○ 3 oz	○ Monthly
Beer:	Y	N	○ 1 - 2 beverages	○ Daily
			○ 3 - 4 beverages	○ Weekly
			○ 5 - 6 beverages	○ Monthly
			○ 7 + beverages	
Wine:	Y	N	○ 1 - 2 beverages	○ Daily
			○ 3 - 4 beverages	○ Weekly
			○ 5 - 6 beverages	○ Monthly
			○ 7 + beverages	

Do you drink coffee: Y N ____________ cups per day ○ caffeinated ○ decaffeinated

Do you use recreational drugs? Y N If yes, please indicate the following:

Marijuana?	Y	N	If yes, how often?	○ Daily	○ Weekly	○ Monthly
Cocaine?	Y	N	If yes, how often?	○ Daily	○ Weekly	○ Monthly
IV drugs?	Y	N	If yes, how often?	○ Daily	○ Weekly	○ Monthly

Do you drink soda? Y N If yes, how much? ______________ ○ Daily ○ Weekly ○ Monthly

Do you use tobacco? Y N If yes, please indicate the following:

○ cigarettes ○ cigars ○ pipe tobacco ○ smokeless tobacco

Number of pack per day: ____________ Number of years: ___________

Have you stopped using tobacco? Y N If yes, when? ___________________________________

Travel: Have you visited outside the U.S. in the last six months? Y N

If yes, where? ____

Have you visited any farms recently? Y N If yes, please indicate the following:

What kind of farm? _______________________ When? ___________________________

Work History

Briefly describe your job:____

Are you able to work? YES NO

Are you primarily (circle appropriate answers): Lifting Bending Twisting Turning Carrying Walking Arms Overhead

Work strain (physical): Light Moderate Heavy Strenuous

Work strain (mental): Light Moderate Heavy Strenuous

Family History	Father	Mother	Sibling	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Still Alive							
Alcoholism							
Allergies/Asthma							
Anemia							
Arthritis							
Back Issues							
Bladder Infection							
Bleeding Problems							
Birth defects							
Cancer							
Depression							
Diabetes							
Emphysema							
Epilepsy or seizures							
Gallstones							
Glaucoma							
Heart trouble							
High blood pressure							
Kidney disease							
Mental Illness							
Migraine headaches							
Osteoporosis							

Family History	Father	Mother	Sibling	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Stroke							
Thyroid disease							
Tuberculosis							
Ulcers							
Venereal disease (STD)							

Activities of daily living	Can do without difficulty	Can do with some difficulty	Can do with great difficulty	Can't do at all
Bathing				
Dressing				
Driving a car				
Going up or down stairs				
House and/or yard work				
Jogging and/or running				
Kneeling				
Lifting and/or carrying				
Lying down				
Overhead reaching				
Rising from seated position				
Sitting				
Sleeping				
Standing				
Walking				

Are you exercising at home? Y N

If yes, what type?____

Past Health History

Please indicate the conditions that have been diagnosed, the year of the diagnosis and by whom. If you have doctors' addresses, please include them.		
Condition	Year	By Whom

Surgeries / Hospitalizations

Please indicate past surgeries or hospitalizations, the year of the surgery and/or hospitalization, and the name of the facility in which you were hospitalized.		
Surgery	Year	Facility

Health History

Please indicate current conditions by checking the corresponding box of the condition below:

General:

☐ fainting
☐ sweats
☐ nervousness
☐ dizziness
☐ fever
☐ low energy
☐ weight gain > 10 lbs
☐ appetite loss
☐ fatigue
☐ numbness
☐ weight loss > 10 lbs
☐ sleep loss
☐ chills
☐ headaches
☐ forgetfulness

Eyes:

☐ blurred vision
☐ cataracts
☐ excessive dryness
☐ spots
☐ watery eyes
☐ eye pain
☐ eye injury
☐ itching
☐ crusting/draining on eyelids
☐ loss of vision
☐ glaucoma
☐ lack of tears
☐ double vision

ENT:

☐ bleeding gums
☐ persistent cough
☐ ringing in ears
☐ ear discharge
☐ hay fever
☐ mouth sores
☐ sore throat
☐ hearing loss
☐ difficulty swallowing
☐ sinus problems
☐ face pain
☐ hoarseness
☐ nasal drainage
☐ nose bleeding
☐ earache
☐ sleep apnea
☐ frequent colds
☐ loud snoring
☐ post nasal drip

Urinary:

☐ bladder infection
☐ blood in urine
☐ kidney stones
☐ pus discharge
☐ kidney infection
☐ urination at night
☐ painful urination
☐ frequent urination
☐ bed wetting
☐ urinary discharge
☐ hesitancy with urination
☐ lack of bladder control

Heart:	☐ abnormal cholesterol	☐ chest pain	☐ heart attack
	☐ heart disease	☐ pacemaker	☐ high blood pressure
	☐ poor circulation	☐ shortness of breath	☐ abnormally slow heartbeat
	☐ abnormally rapid heartbeat	☐ blackouts or “woozy” feeling	☐ blood clots in legs
	☐ chest pressure when walking	☐ congenital heart defect	☐ fluid retention
	☐ heart murmur	☐ skipped or extra heartbeats	☐ swelling of the ankles
	☐ history of rheumatic fever	☐ irregular heartbeat	☐ leg pain when at rest
	☐ leg pain when walking	☐ low blood pressure	☐ painful breathing
	☐ palpations	☐ phlebitis	☐ varicose veins
Lungs:	☐ asthma	☐ shortness of breath	☐ chronic cough
	☐ emphysema	☐ pneumonia	☐ chronic bronchitis
	☐ cough up sputum	☐ wheezing	☐ exposure to tuberculosis
	☐ frequent cough	☐ hoarseness	
Abdomen:	☐ abdominal pain	☐ acid reflux disease	☐ bowel changes
	☐ indigestion	☐ nausea	☐ vomiting
	☐ poor appetite	☐ black or bloody stool	☐ bloating
	☐ constipation	☐ cramping	☐ diarrhea
	☐ excessive hunger	☐ excessive thirst	☐ gas
	☐ heartburn	☐ hemorrhoids	☐ irritable bowel syndrome
	☐ jaundice	☐ lack of bowel control	☐ loose stools
	☐ rectal bleeding	☐ regurgitation	☐ stomach pain
	☐ trouble swallowing	☐ unusual stool color	☐ vomiting blood
Skin:	☐ eczema	☐ history of cancer	☐ itching
	☐ psoriasis	☐ bruise easily	☐ boils
	☐ change in moles	☐ hair problems	☐ hives
	☐ nail problems	☐ scars	☐ rash
	☐ sores that won’t heal		
Endocrine:	☐ excessive thirst	☐ unexpected weight gain	☐ excessive hunger
	☐ neck swelling	☐ unexpected weight loss	☐ flushing
	☐ glandular or hormonal problems	☐ dry skin	☐ goiter
	☐ tremor		
Neurological:	☐ dizziness	☐ headaches	☐ balance problems
	☐ insomnia		
Muscular/ Skeletal:	☐ back pain	☐ fractures	☐ joint swelling or stiffness
	☐ joint pain	☐ leg cramps	☐ locking
	☐ neck stiffness	☐ muscle pain	☐ sciatica
	☐ buckling	☐ catching	☐ tick bites
Male conditions:	☐ hernia	☐ prostate problems	☐ urinary difficulties
	☐ breast lump(s)	☐ herpes	☐ discharge from penis
	☐ erection difficulties	☐ history of STD	☐ lump(s) in testicles
	☐ painful testicles		
Female conditions:	☐ breast lump(s)	☐ extreme menstrual pain	☐ hot flashes
	☐ history of STD	☐ nipple discharge	☐ vaginal discharge
	☐ abnormal pap smear	☐ bleeding between periods	☐ painful intercourse
Social/ Emotional:	☐ hard to concentrate or remember	☐ unable to sleep	☐ feeling lonely or depressed
	☐ cry frequently	☐ worry a lot	☐ feel that you have a hopeless outlook
	☐ ever considered committing suicide	☐ considered or sought psychiatric help	☐ anxiety
	☐ compulsive behavior	☐ depression	☐ difficulty concentrating
	☐ loss of sexual interest	☐ panic attacks	☐ poor sleep
	☐ recreational drugs	☐ short fuse or anger	☐ suicidal ideas
Blood (Hematology):	☐ abnormal blood count	☐ anemia	☐ bleeding tendency
	☐ blood transfusion	☐ cold fingers or toes	☐ enlarged or tender glands
	☐ frequent infections	☐ severe bruising	

HEALTH QUESTIONNAIRE

1. In general, would you say your health is:

   ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

2. Compared to one (1) year ago, how would you rate your health in general now?

   ○ Much better now than one (1) year ago
   ○ Somewhat better now than one (1) year ago
   ○ About the same
   ○ Somewhat worse now than one (1) year ago
   ○ Much worse now than one (1) year ago

The following items are about activities you might do during a typical day:

		Limited A Lot	Limited A Little	Not Limited At All
3.	Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
4.	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	☐	☐	☐
5.	Lifting or carrying groceries	☐	☐	☐
6.	Climbing several flights of stairs	☐	☐	☐
7.	Climbing one flight of stairs	☐	☐	☐
8.	Bending, kneeling or stooping	☐	☐	☐
9.	Walking more than a mile	☐	☐	☐
10.	Walking several blocks	☐	☐	☐
11.	Walking one block	☐	☐	☐
12.	Bathing or dressing yourself	☐	☐	☐

During the past four (4) weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

		YES	NO
13.	Cut down the amount of time you spend on work or other activities?	☐	☐
14.	Accomplished less than you would like?	☐	☐
15.	Were limited in the kind of work or other activities?	☐	☐

		YES	NO
16.	Had difficulty performing the work or other activities (i.e. it took extra effort)?	☐	☐

During the past four (4) weeks, have you had any of the following problems with your work or other daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

		YES	NO
17.	Cut down the amount of time you spend on work	☐	☐
18.	Accomplished less than you would like	☐	☐
19.	Didn't do work or other activities as carefully as usual	☐	☐

20. During the past four (4) weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

○ Not at all ○ Slightly ○ Moderately ○ Quite a bit ○ Extremely

21. How much bodily pain have you had in the past four (4) weeks?

○ None ○ Very mild ○ Mild ○ Moderate ○ Severe ○ Very severe

22. During the past four (4) weeks, how much did pain interfere with your normal work (including work outside the house and housework)?

○ Not at all ○ Slightly ○ Moderately ○ Quite a bit ○ Extremely

These questions are about how you feel and how things have been with your during the last four (4) weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

		All the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23.	Did you feel full of pep?	○	○	○	○	○	○
24.	Have you been a very nervous person?	○	○	○	○	○	○
25.	Have you felt so down-in-the-dumps that nothing could cheer you up?	○	○	○	○	○	○
26.	Have you felt calm and peaceful?	○	○	○	○	○	○
27.	Did you have a lot of energy?	○	○	○	○	○	○

		All the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
28.	Did you feel worn out?	○	○	○	○	○	○
29.	Have you been a happy person?	○	○	○	○	○	○
30.	Did you feel tired?	○	○	○	○	○	○
31.	During the past four (4) weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?	○	○	○	○	○	○

How true or false is each of the following statements for you?

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33.	I seem to get sick a lot easier than other people	○	○	○	○	○
34.	I am as healthy as anybody I know	○	○	○	○	○
35.	I expect my health to get worse	○	○	○	○	○
36.	My health is excellent	○	○	○	○	○