

Plainfield Chiropractic And Rehabilitation

Health Status

Patient name: _____

Date: _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck pain Mid-back pain Low back pain
 Other: _____

Is this? Work related Auto related N/A

Date problem began: _____

How problem began: _____

How would you describe your pain? (ie: achy, burning) _____

What makes your pain worse? _____

What makes your pain feel better? _____

How often are your symptoms present? Daily Weekly Occasional Monthly Sporadic Frequent Irregular

(Occasional) 0-25% 26-50% 51-75% 76-100% (Constant)

In the past week, how much has your pain when its at its worse interfered with your daily activities (e.g. work, social activities, etc.)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Have you missed work or school due to your pain?

Yes No

In general, how would you describe your overall health right now?

Excellent Very good Good Fair Poor

Have seen another physician(s) for this condition? (If so please list names and dates)

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered, and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient signature: _____

Date: _____