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, sharp)_____

What makes your pain worse?_____

What makes your pain feel better?_____

How often are your symptoms present? **Daily** **Weekly** **Monthly** **Yearly**

☐ ☐ ☐ ☐

(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

In the past week, how intense has your pain been at its worse on a scale of 1-10 (10 being the worst and 1 being minimal)?

Normal 0 1 2 3 4 5 6 7 8 9 10 Unbearable

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:** _____