Panzica Family Chiropractic Center **Patient Health Assessment**

Please PRINT or WRITE Clearly

General Information

Patient Name: _____ Date:_____

Provider Name: Dr. Anthony J. Panzica _____ Primary Care Physician:_____

Soc. Sec. #: _____ Referred for Treatment by_____

Patient Address:_____ City:_____ State:_____ Zip:_____

Patient Sex: M_____F_____ Date of Birth:__/__/__ Marital Status: (*circle 1*) S M W D # children:_____

Home Phone:_____ Work Phone: _____

Cell Phone:_____ Email Address:_____

Patient Employer: _____ Patient Occupation: _____

Subscriber Name:_____ Subscriber Social Security #: _____

Health Insurance Plan: _____ ID#: _____ Group #: _____

Have you had previous chiropractic care? Yes____ No____ When & where?_____

How were you referred to this office? _____

Complaint History

1. Describe your current complaint and how the problem began: _____

_____

_____

How long have you had this condition? _____ **Date of Onset:** _____

Have you ever been in a car accident? _____ **When?** _____ **Describe any injuries** _____

2. How would you describe the pain?

☐Sharp ☐Soreness ☐Throbbing ☐Tingling ☐Dull ☐Stiffness
☐Spasm ☐Burning ☐Ache ☐Weakness ☐Numbness ☐Shooting

3. How would you rate the intensity of your pain? *(Circle the appropriate number)*

☺ **0 1 2 3 4 5 6 7 8 9 10** ☹
(no pain) *(moderate pain)* *(terrible/unbearable pain)*

4. How often is the pain present?

☺☐ Intermittent (25% or less) ☐ Occasional (26-50%) ☐ Frequent (51-80%) ☹☐Constant (81-100%)

5. Since your problem began, is the pain:

☐Getting worse ☐getting better ☐Staying the same

6. How did your problem begin? **Explain:** _____

☐An auto accident ☐Work related accident ☐Other type of accident
☐Gradual ☐Sudden ☐No specific reason

7. What makes your problem better?

☐Nothing ☐Walking ☐Standing ☐Sitting ☐Moving around/exercise ☐Lying down ☐Inactivity

8. What makes your problem worse?

☐Nothing ☐Walking ☐Standing ☐Sitting ☐Moving around/exercise ☐Lying down ☐Inactivity

9. Are you currently taking any medications? ☐Yes ☐No
If yes, please describe _____

10. Were you previously treated for an earlier occurrence of this *same* condition? ☐Yes ☐No
If yes, by whom? ☐MD ☐Chiropractor ☐Physical Therapist ☐Other _____

What were the approximate dates, type of treatment and the results? _____

11. What is your physical activity at work? ☐Mostly sitting ☐Light manual labor ☐Moderate manual labor ☐Heavy manual labor

12. Do you exercise?

☐No regular exercise ☐1-2 times per week ☐3-4 times per week ☐5-7 times per week
☐Cardiovascular ☐Stretching ☐Weight Machine ☐Free Weights ☐Sports _____
Type

13. What is your present stress level?

☐No stress ☐Minimal stress ☐Moderate stress ☐Greatly stressed

14. Is your problem affecting your ability to work or to do other routine daily activities?

☐No effect ☐Have some limited physical restrictions, but can function
☐Need some assistance with daily activities ☐Cannot work
☐Cannot function without assistance ☐Totally disabled

Past Or Present Symptoms, Conditions Or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck Pain	☐	☐	High blood pressure	☐	☐
Shoulder pain	☐	☐	Heart condition	☐	☐
Arm/Elbow pain	☐	☐	Respiratory condition	☐	☐
Hand pain	☐	☐	Digestive problems	☐	☐
Upper back pain	☐	☐	Kidney/bladder problems	☐	☐
Lower back pain	☐	☐	Menstrual problems	☐	☐
Pain in upper leg or hip	☐	☐	Breast soreness/lump	☐	☐
Pain in lower leg or knee	☐	☐	Sinus conditions	☐	☐
Pain in ankle or foot	☐	☐	Allergies/Asthma	☐	☐
Jaw pain	☐	☐	Cancer	☐	☐
Swelling of joints	☐	☐	Stroke	☐	☐
Stiffness of joints	☐	☐	Excessive weight loss/gain	☐	☐
Headaches	☐	☐	Skin condition	☐	☐
Dizziness	☐	☐	Arthritis	☐	☐
Fainting Spells	☐	☐	Diabetes	☐	☐
Convulsions	☐	☐	Prostate Condition	☐	☐
General prolonged fatigue	☐	☐	Condition of uterus/ovaries	☐	☐

Tobacco Use:
☐Past ☐Present
☐Occasional ☐Moderate ☐Heavy

Alcohol Use:
☐Past ☐Present
☐Occasional ☐Moderate ☐Heavy

Caffeine Use: *(Coffee, tea, soft drinks)*
☐Past ☐Present
☐Occasional ☐Moderate ☐Heavy

Pregnancy: ☐Past ☐Present

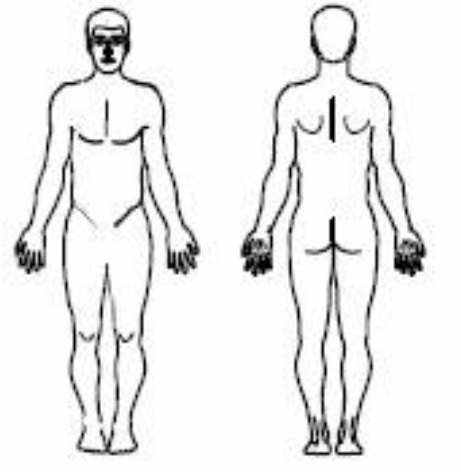
Surgical Procedure:
☐Past ☐Present

Please List: _____
_____

Comments: _____

_____

Please shade in the figures below where you have pain or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date