SpineFit

Dane Kohl, DC
4550 E. Bell Rd. Bldg 6 Ste 152 Phoenix, AZ 85032

Name_____Address_____
City_____State_____Zip_____ Home ph# (_____) _____--_____
Cell # (For confirming apt): (_____)_____--_____E-mail Address:_____
SSN _____/_____/_____ Date of Birth ____/____/____ Age _____ Height ____ft_____ in Weight _____lbs
Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ # of children _____ Spouse's name_____
Employer_____Address_____
City _____State ____ Zip _____ Work ph# (____) _____-_____Occupation _____

What is the name of your family Physician?_____ What city are they located in_____
Have you ever had Chiropractic care before_____ if yes, doctor name: _____Date of last visit_____
If you are experiencing any pain (neck pain, low back pain, etc.), health problems, symptoms, and/or complaints.
please list in order of severity
1._____For how long? _____
2._____For how long? _____
3._____For how long? _____
4._____For how long? _____
Has this problem been getting worse □ staying the same □ ? Currently or in the past have you ever experienced any of the complaints while working? _____ If yes please describe what activities at work may be causing you these complaints:
_____
Are there any other activities, incidents, or events outside of work that may have caused these complaints? Yes □ No □
If yes, please explain: _____
Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of injury? ____/____/____
Do you have an attorney representing you for this work injury? Yes □ No □ If yes, who is your attorney? _____
Have you been involved in an auto accident in the last 12 months? Yes □ No □

Have you ever had any surgeries or hospitalizations? _____ If yes, please list:_____
Please list any current or past injuries and illnesses not listed above: _____
Please check all medications (over the counter and/or prescribed) you are currently taking: NSAID/Aspirin/Tylenol □
Pain killers □ Insulin □ Muscle Relaxer □ Birth Control Pills □ Sleeping Pills □ Anti-depressants □
Others _____

Health Insurance Co. Name_____ Policyholder_____
Name of Spouse's health insurance (if applicable) _____ Policyholder_____
Spouse's Health Insurance Claims address _____Policy number _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). I n other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. **Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.**

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.
0 means no disability at all and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — **Totally unable to function**

RATE:

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands favors for other family members, driving children to school, etc) _____

2. REREATION: hobbies, sports, and other similar leisure time activities. _____

3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____

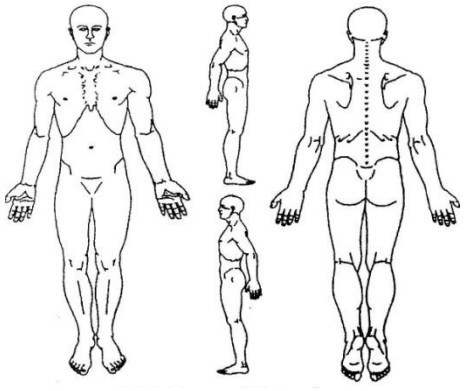
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please **mark the exact location of your pain on the diagram below**. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: ☐CASH ☐CHECK ☐CREDIT CARD ☐_____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE, IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. If x-rays are needed, patient will be sent out to an imaging center for procedure.

Patient's Signature _____ Date _____/_____/_____

CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

_____ _____ _____

Patient's Name **DOB** **ACCOUNT**

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please explain in detail how your accident happened. _____
_____
_____
_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____
_____
_____

Did you require post accident hospitalization? Yes/ No

Check symptoms you have noticed since the accident:

_____Headache	_____Dizziness	_____Depression	_____Fatigue
_____Light Bothers Eyes	_____Buzzing in Ears	_____Diarrhea	_____Neck Pain
_____Head Seems too Heavy	_____Memory Loss	_____Feet Cold	_____Neck Stiff
_____Pins and Needles in Arms	_____Ears Ring	_____Hands Cold	_____Fainting
_____Sleeping Problems	_____Back Pain	_____Face Flushed	_____Loss of Balance
_____Pins and Needles in Legs	_____Constipation	_____Tension	_____Nervousness
_____Numbness in Fingers	_____Loss of Smell	_____Fever	_____Irritability
_____Numbness in Toes	_____Loss of Taste	_____Chest Pain	_____Cold Sweats
_____Shortness of Breath	_____Stomach Upset		

Symptoms other than above: _____
_____

Where were you taken after the accident? _____

Hospitalized? Yes/ No If yes, admitted? _____How long? _____

Name of Hospital_____

Name of Doctors _____

What treatment was given? _____

Was any other doctor consulted after your accident? Yes/ No

Patient's Name **DOB** **ACCOUNT**

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given?_____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes/ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? Yes/ No

Are your work activities restricted as a result of this accident? Yes/ No

Since this injury are your symptoms, Improving? Getting worse? Same?

Drive of other vehicle (if any)

Name_____Insurance Company_____ Policy No. _____

Driver of vehicle in which you were injured (if applicable)

Name_____ Insurance Company_____Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? Yes/ No

If so, his/her name and address_____

You were heading North/ East/ South/ West on _____(street or highway)

Other vehicle was heading North/ East/ South/ West on _____(street or highway)

Were police notified? Yes/ No

Were you knocked unconscious? Yes/ No If so, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side_____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts_____

_____ _____
Patient's Name DOB

_____ _____
Patient signature DATE

_____ _____
Doctor signature DATE

SpineFit

Patient Name_____ Date _____/_____/_____

PATIENT SYMPTOM(S) FORM

Symptom 1 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually** ? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually** ? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually** ? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually** ? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 5 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually**? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day

Symptom 6 _____

On a scale from 0-10 with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____

Did the symptom begin **suddenly** or **gradually**? (circle one)

How did the symptom begin? _____

What makes the symptom worst? (circle all that apply):

Bending neck forward, bending neck backward, tilting head to the left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, other (please describe):

_____

What makes the symptom better? (circle all that apply):

Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, other (please describe): _____

Describe the quality of the symptom (circle all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging

Other (please describe): _____

Does the symptom radiate to another part of your body? (circle one) YES No

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (circle one)

Morning Afternoon Evening Night Unaffected by time of day