

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

If yes, what is the date of injury? ____/____/____

Do you have an attorney representing you for this auto injury? Yes No if yes, who is your attorney? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions? 1) _____ 2) _____

If due to an auto accident, what is the name of your auto insurance company? _____

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 _____

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