Patient Basic Information

Personal Information:

Last Name:	First Name:	Middle Initial:
Address:	City, State, Zip:	
Home Phone:	Work Phone:	Cell Phone:
Date of Birth:	Date of Injury/Onset:	Email address:
Dominant Hand: ❑Right ❑Left ❑Both		Age of Oldest Living Relative:
Marital Status: M S D W	Sex: □ Male □ Female	Social Security #:
Occupation:		Employer/School:
Employer Address:		City/State/Zip:
Spouse/Parent/Legal Guardian Name:		Cell Ph:
Spouse/Parent/Legal Guard Social Security #:		Date of Birth:
Spouse/Parent/Legal Guardian Employer:		
Employer Address:		City/State/Zip:
Nearest Relative not living with you:		Relationship:
Address:		City/State/Zip:
Home Ph:	Work Ph:	Cell Ph:

How were you referred to our office? ____

1. **Purpose of this visit:** ❑Automobile accident ❑Slip/Fall ❑Other:______________ What State did this occur: _____
2. **What makes the problem worse?** ____
3. **Is there anything you can do to relieve the problem?** □ Yes □ No
   If yes, please describe: ____
   If no, what have you tried to do that has not helped?______________________________
4. **Description of Accident/Injury/Onset** *

   Enter a full description of the accident, injury or onset in the space below.

5. **During and after accident details**
   Enter the details of your condition during and after the accident/onset.

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Description of Symptoms (Describe your symptoms in the sections below, **in the order of severity**, if possible.)

I. Current Symptom: (Please check off the boxes below to describe your symptom. **Describe only ONE symptom per section**).

1. Check only one body location below

Location	L	R	B
❑Headaches	L❑	R❑	B❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑

Other locations:________________

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
____
____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:______________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
______________	❑	❑	❑
______________	❑	❑	❑

II. Current Symptom: (Please check off the boxes below to describe your next symptom. Describe only ONE symptom per section.

1. Check only one body location below

Location	L	R	B
❑Headaches	L❑	R❑	B❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑

Other locations:________________

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
____
____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:______________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
______________	❑	❑	❑
______________	❑	❑	❑

III. Current Symptom: (Please check off the boxes below to describe your next symptom. Describe only ONE symptom per section.

1. Check only one body location below

Location	L	R	B
❑Headaches	L❑	R❑	B❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑

Other locations:________________

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
____
____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:______________

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
______________	❑	❑	❑
______________	❑	❑	❑

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Duties Under Duress of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it all, because of the pain".
Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities

Bathing____ Drying hair____ Brushing teeth____ Putting on shoes____ Preparing meals____ Taking out trash____
Showering____ Combing hair____ Making bed____ Tying shoes____ Eating____ Doing laundry____
Washing hair____Washing face____ Putting on shirt____ Putting on pants____ Cleaning dishes____ Going to toilet____

Difficulties with Physical Activities

Standing____ Walking____ Kneeling ____ Bending back ____ Twisting left____ Leaning back____
Sitting____ Stooping____ Reaching____ Bending left____ Twisting right____ Leaning left____
Reclining____ Squatting____ Bending forward____ Bending right____ Leaning forward____ Leaning right____
Standing for long periods____ Sitting for long periods____ Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities

Carrying small objects____ Lifting weights off floor____ Pushing things while seated____ Exercising upper body____
Carrying large objects____ Lifting weights off table____ Pushing things while standing____ Exercising lower body____
Carrying brief case____ Climbing stairs____ Pulling things while seated____ Exercising arms____
Carrying large purse____ Climbing inclines____ Pulling things while standing____ Exercising legs____

Difficulties with Social and Recreational Activities

Bowling____ Jogging____ Swimming____ Ice Skating____ Competitive Sports____ Dating____
Golfing____ Dancing____ Skiing____ Roller Skating____ Hobbies____ Dining out____

Difficulties with Travelling

Driving a motor vehicle____ Riding as a passenger in a motor vehicle____ Riding as a passenger on a train____
Driving for long periods of time____ Riding as a passenger on an airplane____ Riding as a passenger for long periods____

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Duties Under Duress of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

❑I have NOT had prior symptoms similar to my current complaints.
❑My current complaints DID exist before, but had not been bothering me.
❑My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

❑My history HAS contributed to my current symptoms.
❑My history HAS NOT contributed to my current symptoms.
❑I 'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms **(if applicabl**e) occurred____ ❑months ago / ❑years ago **OR on** Date:_____/_____/_____

Write in below any other Prior Symptom History, not covered above:

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Authorization and Acknowledgement

The above questions have been accurately answered. I authorize Rustici & Associates Chiropractic to release any information, including the diagnosis and records of any treatment or examination rendered to myself or my dependents, during the period of such chiropractic care to my attorney/third-party payor/insurance carrier and/or health practitioners for the payment of claims or for continuity of care. I authorize and request my attorney/third-party payor and/or auto insurance carrier to pay directly to Rustici & Associates Chiropractic benefits otherwise payable to me. I understand that my attorney/third-party payor and/or auto insurance carrier may pay less than the actual bill for services and that **I shall be responsible for the remaining balance within 30 days.**
I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MY DEPENDENTS.

** I ___accept or ___decline a copy of Rustici & Associates Chiropractic HIPAA Information Brochure. **

____ ____________________
Patient Signature / Parent or Legal Guardian of Minor Date

____ ____________________
Parent or Legal Guardian of Minor – Please Print Name Relationship