Welcome!

About You

Name (Last)__________________________(First)_____________________Sex M F Date________________

What you prefer to be called _________________________________

Birthdate______/______/______ Age____________

Address_______________________________________City____________________State__________Zip__________

H. Phone(_________)_______________________M. Phone(__________)_______________________

Insurance Account Info (If changed)

Subscribers Name: ____ DOB:___________________

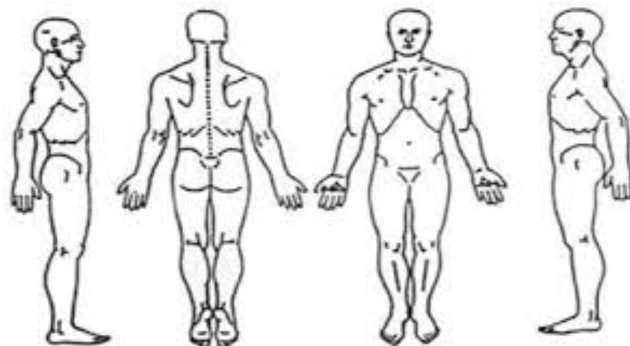
Relation (if not self insured): _______________________________________

Billing Address: _______________________________________

(City)________________________(State)__________(Zip)__________

Reason for visit

Circle all effected areas below:



Primary reasons for seeking chiropractic care:

Emergency [ ] New Injury [ ] Old Injury [ ]
Chronic Pain [ ] Wellness [ ]

Primary Complaint: ________________________________

Complaint began when and how?:_____________________

____

Pain intensity: 0 (No Pain) 1 2 3 4 5 6 7 8 9 10

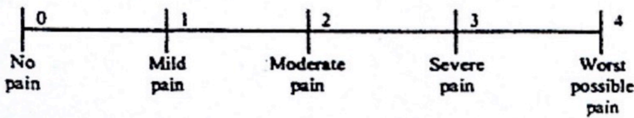
Patient or Guardian Signature:____ **Date:**_________________

Functional Rating Index

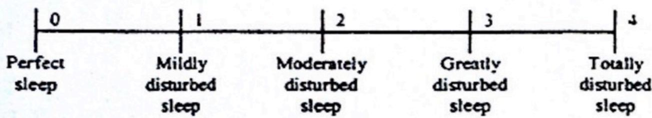
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

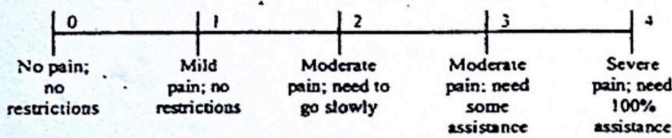
1. Pain Intensity



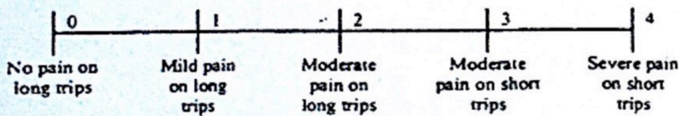
2. Sleeping



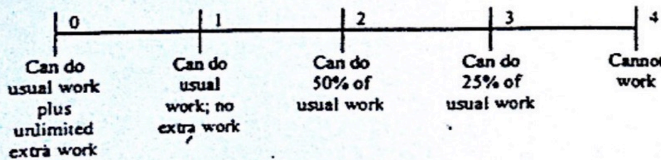
3. Personal Care (washing, dressing, etc.)



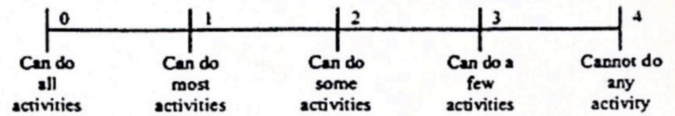
4. Travelling (driving, etc.)



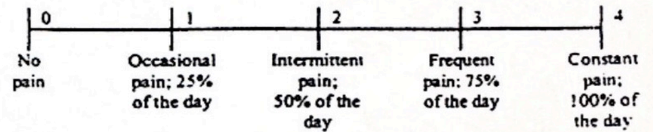
5. Work



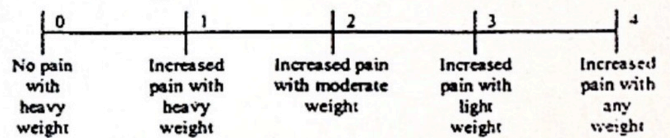
6. Recreation



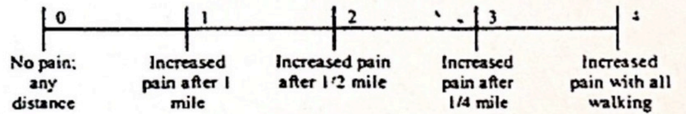
7. Frequency of Pain



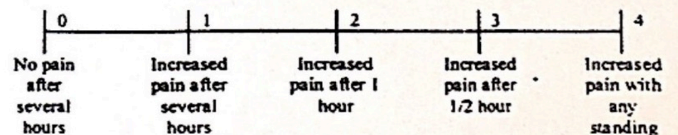
8. Lifting



9. Walking



10. Standing



______________________________ **Patient's Signature**

______________________________ **Date**

For Office Use Only:

Practitioner ID#: ______________________________

Total Score ______________ / 40

Clinical Diagnosis Codes:

Patient ID#: ______________________________

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