

Patient Introduction Card

Patient No: _____ Date: _____

Name: _____
(Last, First, MI)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Email Address: _____ Social Security #: _____

Married _____ Single _____ Other _____ Date of Birth: _____

Occupation: _____ Employer: _____

Name of Ins. Company: _____

Primary Ins. Holder: _____ Primary Holders DOB: _____

Previous Chiropractic Care? Yes No Chiropractors name: _____

Primary Physicians Name and Phone Number: _____

Who may we thank for referring you to the office? _____

Please hand this page, along with your insurance card to the front desk as soon as it is completed. Thank you!

Lindeman Chiropractic PC * 3303 W 144th Ave Ste 200* Broomfield, CO 80023

Patient Name _____ Date: _____

1. Primary reason(s) for seeking chiropractic care:

Primary reason (Chief Complaint): _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint:

Location of Complaint: _____

Complaint began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No Complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible complaint/pain imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery or care you've sought for your complaint:

4. Past Health History:

Previous major illnesses, injury or trauma: _____

Allergies: _____

Medications: _____ Reason for taking: _____

Surgery - Type and Date: _____

Females - Pregnancies/Date of Delivery: _____ Outcome: _____

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Death in immediate family: _____ Age at death: _____

6. Social and Occupational History:

Level of Education: high school some college college graduate post graduate studies

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

Functional Rating Index

Patient Name: _____ Date: _____

For use with neck and/or back problems. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0- No pain 1 - Mild Pain 2 - Moderated Pain 3 - Severe Pain 4 - Worst Possible Pain

2. Sleeping

0- Perfect Sleep 1 -Mildly Disturbed 2 -Moderately Disturbed 3- Greatly Disturbed 4 -Totally Disturbed Sleep

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

0-No Pain No Restrictions 1 -Mild Pain No Restrictions 2 -Moderate Pain Go Slowly 3 -Moderate Pain Some Assistance 4 -Severe Pain 100% Assistance

4. Traveling (driving, etc.)

0 -No Pain on Long Trips 1 -Mild Pain on Long Trips 2 -Moderate Pain on Long Trips 3 -Moderate Pain on Short Trips 4 -Severe Pain on Short Trips

5. Work

0 -Usual Work + Extra 1 -Usual Work - No Extra 2 -50% of Usual Work 3 -25% of Usual Work 4 -Cannot Work

6. Recreation

0 -All Activities 1 -Most Activities 2 -Some Activities 3 -Few Activities 4 -No Activities

7. Frequency of Pain

0 -No Pain 1 -Occasional (25%) 2 -Intermittent (50%) 3 -Frequent (75%) 4 -Constant (100%)

8. Lifting

0 -No Pain with Heavy Weight 1 -Increased Pain with Heavy Weight 2 -Increased Pain with Moderate Weight 3 -Increased Pain with Light Weight 4 -Increased Pain with Any Weight

9. Walking

0 -No Pain with Any Distance 1 -Increased Pain after 1 Mile 2 -Increased Pain after ½ Mile 3 -Increased Pain after ¼ Mile 4 -Increased Pain after Any Distance

10. Standing

0 -No Pain with Any Time 1 -Increased Pain after Several Hours 2 -Increased Pain after 1 Hour 3 -Increased Pain after ½ Hour 4 -Increased Pain after Any Time

Total _____ (/4. X 10) = Functional Rating Score _____ %

Patient or Guardian Signature _____ Date _____

HEALTH ANALYSIS

Date: _____

Patient Name: _____ Pt. #: _____

1. Do you need glasses to read?Yes No
2. Do you need glasses to see things at a distance?Yes No
3. Has your eyesight often blacked out completely?Yes No
4. Do your eyes continually blink or water?Yes No
5. Do you often have bad pains in your eyes?Yes No
6. Are your eyes often red or inflamed?Yes No
7. Are you hard of hearing?Yes No
8. Have you ever had a fluid leaking from your ear?Yes No
9. Do you have constant noises in your ears?.....Yes No
10. Do you have to clear your throat constantly?Yes No
11. Do you often feel a choking lump in your throat?Yes No
12. Are you often troubled with bad spells of sneezing?Yes No
13. Is your nose continually stuffed up?Yes No
14. Do you suffer from a constantly running nose?Yes No
15. Have you at times had bad nose bleeds?Yes No
16. Do you often catch severe colds?Yes No
17. Do you frequently suffer from heavy chest colds?Yes No
18. When you catch a cold, do you always have to go to bed?Yes No
19. Do frequent colds keep you miserable all winter?Yes No
20. Do you get hay fever?Yes No
21. Do you suffer from asthma?Yes No
22. Are you troubled by constant coughing?Yes No
23. Have you ever coughed up blood?Yes No
24. Do you wake up drenched with sweat during the middle of the night?Yes No
25. Have you ever had a chronic chest condition?Yes No
26. Have you ever had T.B. (tuberculosis)?Yes No
27. Did you ever live with anyone who had T.B.?.....Yes No
28. Has a doctor ever said your blood pressure was too high?Yes No
29. Has a doctor ever said your blood pressure was too low?Yes No
30. Do you have pains in the heart or chest?Yes No
31. Are you often bothered by thumping of the heart?Yes No
32. Does your heart often race like mad?Yes No
33. Do you often have difficulty in breathing?Yes No
34. Do you get out of breath before anyone else?Yes No
35. Do you sometimes get out of breath just sitting still?Yes No
36. Are your ankles often badly swollen?Yes No
37. Do cold hands or feet trouble you, even in hot weather?Yes No
38. Do you suffer from frequent cramps in your legs?Yes No
39. Has a doctor ever said you had heart trouble?Yes No
40. Does heart trouble run in your family?.....Yes No
41. Have you lost more than half your teeth?Yes No
42. Are you troubled by bleeding gums?Yes No

Patient Name: _____ Date: _____

- 43. Have you often had sever tooth aches? Yes No
- 44. Is your tongue usually badly coated? Yes No
- 45. Is your appetite always poor? Yes No
- 46. Do you usually eat sweets or other foods between meals? Yes No
- 47. Do you always gulp your food hurriedly? Yes No
- 48. Do you often suffer from an upset stomach? Yes No
- 49. Do you usually feel bloated after eating? Yes No
- 50. Do you usually belch a lot after eating? Yes No
- 51. Are you often sick at your stomach? Yes No
- 52. Do you suffer from sever indigestion? Yes No
- 53. Do severe pains in the stomach often cause you to double up? Yes No
- 54. Do you suffer from constant stomach trouble? Yes No
- 55. Does stomach trouble run in your family? Yes No
- 56. Has a doctor ever said you had stomach ulcers? Yes No
- 57. Do you suffer from frequent loose bowel movements? Yes No
- 58. Have you ever had severe bloody diarrhea? Yes No
- 59. Were you ever troubled with Intestinal worms? Yes No
- 60. Do you constantly suffer from bad constipation? Yes No
- 61. Have you ever had piles (rectal hemorrhoids)? Yes No
- 62. Have you ever had jaundice (yellow eyes and skin)? Yes No
- 63. Have you ever had serious liver or gall bladder trouble? Yes No
- 64. Are your joints often painfully swollen? Yes No
- 65. Do your muscles and joints constantly feel stiff? Yes No
- 66. Do you usually have severe pains in the arms or legs? Yes No
- 67. Are you crippled with severe arthritis? Yes No
- 68. Does arthritis run in your family? Yes No
- 69. Do weak or painful feet make your life miserable? Yes No
- 70. Do pains in the back make it hard for you to keep up with your work? Yes No
- 71. Are you troubled with a serious bodily disability or deformity?..... Yes No
- 72. Do you have sensitive skin? Yes No
- 73. Does it take a long time for a cut to heal? Yes No
- 74. Does your face often get badly flushed? Yes No
- 75. Do you sweat a great deal, even in cold weather? Yes No
- 76. Are you often bothered by severe itching? Yes No
- 77. Does your skin often break out in a rash? Yes No
- 78. Are you often troubled with boils?..... Yes No
- 79. Do you suffer from frequent severe headaches? Yes No
- 80. Does pressure or pain in the head often make life miserable? Yes No
- 81. Are headaches common in your family? Yes No
- 82. Do you have hot or cold spells? Yes No
- 83. Do you often have spells of severe dizziness? Yes No
- 84. Do you frequently feel faint? Yes No
- 85. Have you fainted more than twice in your life? Yes No
- 86. Do you have constant numbness or tingling in any part of your body? Yes No
- 87. Was any part of your body paralyzed? Yes No
- 88. Were you ever knocked unconscious? Yes No
- 89. Have you at times had a twitching of the head, face or shoulders? Yes No
- 90. Did you ever have a seizure or convulsions (epilepsy)? Yes No
- 91. Has anyone in your family ever had seizures or convulsions (epilepsy)? Yes No
- 92. Do you bite your nails? Yes No
- 93. Are you troubled by stuttering or stammering? Yes No
- 94. Are you a sleep walker? Yes No
- 95. Are you a bed wetter? Yes No
- 96. Were you a bed wetter between the ages of 8 to 14? Yes No

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Patient Name: _____ Date: _____

Women Only... Are you Pregnant? Yes No

- 97. W. Have your menstrual periods usually been painful? Yes No
- 98. W. Have you often felt weak or sick with your periods? Yes No
- 99. W. Have you often had to lie down when your periods came on? Yes No
- 100.W. Have you usually been tense or jumpy with your periods? Yes No
- 101.W. Have you ever had severe hot flashes or sweats? Yes No
- 102.W. Have you ever been troubled with a vaginal discharge?..... Yes No

Men only...

- 97. M. Have you ever had anything wrong with your genitals? Yes No
- 98.M. Are your genitals often painful or sore? Yes No
- 99.M. Have you ever had treatment for your genitals? Yes No
- 100.M. Has a doctor ever said you had a hernia (rupture)? Yes No
- 101.M. Have you ever passed blood while urinating? Yes No
- 102.M. Do you have trouble starting your stream when urinating?..... Yes No

Everyone...

- 103. Do you have to get up every night and urinate? Yes No
- 104. During the day, do you usually have to urinate frequently? Yes No
- 105. Do you have severe burning when you urinate? Yes No
- 106. Do you sometimes lose control of your bladder? Yes No
- 107. Has a doctor ever said you had kidney or bladder disease?..... Yes No
- 108. Are you often exhausted or fatigued? Yes No
- 109. Does working tire you out completely? Yes No
- 110. Do you usually get up tired or exhausted in the morning? Yes No
- 111. Does every little effort wear you out? Yes No
- 112. Are you constantly too tired and exhausted even to eat? Yes No
- 113. Do you suffer from severe nervous exhaustion? Yes No
- 114. Does nervous exhaustion run in your family?..... Yes No
- 115. Are you frequently ill? Yes No
- 116. Are you frequently confined to bed by illness? Yes No
- 117. Are you always in poor health? Yes No
- 118. Are you considered a sickly person? Yes No
- 119. Do you come from a sickly family? Yes No
- 120. Do severe pains and aches make it impossible for you to do your work? Yes No
- 121. Do you wear yourself out worrying about work? Yes No
- 122. Are you always ill and unhappy? Yes No
- 123. Are you constantly made miserable by poor health?..... Yes No
- 124. Did you ever have scarlet fever? Yes No
- 125. As a child, did you have rheumatic fever, growing pains, or twitching of the limbs? Yes No
- 126. Did you ever have malaria? Yes No
- 127. Were you ever treated for severe anemia? Yes No
- 128. Were you ever treated for venereal disease? Yes No
- 129. Do you have diabetes? Yes No
- 130. Did a doctor ever say you had a goiter in your neck? Yes No
- 131. Did a doctor ever treat you for a tumor or cancer? Yes No
- 132. Do you suffer from any chronic disease? Yes No
- 133. Are you definitely underweight? Yes No
- 134. Are you definitely overweight? Yes No
- 135. Did a doctor ever say you had varicose veins (swollen veins) in your legs? Yes No
- 136. Did you ever have a serious operation? Yes No
- 137. Did you ever have a serious injury? Yes No
- 138. Do you often have small accidents or injuries?..... Yes No
- 139. Do you usually have difficulty falling asleep or staying asleep? Yes No
- 140. Do you find it impossible to take a regular rest period each day? Yes No
- 141. Do you find it difficult to exercise daily? Yes No

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Patient Name: _____

- 142. Do you smoke more than 20 cigarettes a day? Yes No
- 143. Do you drink more than six cups of coffee or tea a day? Yes No
- 144. Do you usually take two or more alcoholic drinks a day? Yes No
- 145. Do you sweat or tremble a lot during examinations or questioning? Yes No
- 146. Do you get nervous and shaky when approached by a superior? Yes No
- 147. Does your work fall to pieces when the boss or a superior is watching you? Yes No
- 148. Does your thinking get completely mixed up when you have to do things quickly? Yes No
- 149. Must you do things slowly to do them without mistakes? Yes No
- 150. Do you always get directions and orders wrong? Yes No
- 151. Are you anxious around unfamiliar people or places? Yes No
- 152. Are you scared to be alone when there are no friends around you? Yes No
- 153. Is it difficult for you to make up your mind? Yes No
- 154. Do you always wish you had someone at your side to advise you? Yes No
- 155. Are you considered a clumsy person? Yes No
- 156. Does it bother you to eat anywhere except in your home?..... Yes No
- 157. Do you feel alone and sad at a party? Yes No
- 158. Do you usually feel unhappy and depressed? Yes No
- 159. Do you often cry? Yes No
- 160. Are you always miserable and blue? Yes No
- 161. Does life look entirely hopeless? Yes No
- 162. Do you often wish you were dead and away from it all? Yes No
- 163. Does worrying continually get you down? Yes No
- 164. Does worrying run in your family? Yes No
- 165. Does every little thing get on your nerves and wear you out? Yes No
- 166. Are you considered a nervous person? Yes No
- 167. Does nervousness run in your family? Yes No
- 168. Did you ever have a nervous breakdown? Yes No
- 169. Did anyone in your family ever have a nervous breakdown? Yes No
- 170. Were you ever a patient in a mental hospital? Yes No
- 171. Was anyone in your family ever in a mental hospital?..... Yes No
- 172. Are you extremely shy or sensitive? Yes No
- 173. Do you have a shy or sensitive family? Yes No
- 174. Are your feelings easily hurt? Yes No
- 175. Does criticism always hurt you? Yes No
- 176. Are you considered a touchy person? Yes No
- 177. Do people usually misunderstand you?..... Yes No
- 178. Is your guard up, even around friends? Yes No
- 179. Do you always do things on sudden impulse? Yes No
- 180. Are you easily upset or irritated? Yes No
- 181. Do you go to pieces if you don't constantly control yourself? Yes No
- 182. Do little annoyances get on your nerves and get you angry? Yes No
- 183. Does it make you angry to have anyone tell you what to do? Yes No
- 184. Do people often annoy and irritate you? Yes No
- 185. Do you often flare up in anger if you can't have what you want right away?..... Yes No
- 186. Do you often get in a violent rage?..... Yes No
- 187. Do you often shake or tremble? Yes No
- 188. Are you constantly keyed up or jittery? Yes No
- 189. Do sudden noises make you jump or shake? Yes No
- 190. Do you tremble or feel weak whenever someone shouts at you? Yes No
- 191. Do you become scared at sudden movements or noises at night? Yes No
- 192. Are you awakened out of your sleep by frightening dreams? .. Yes No
- 193. Do frightening thoughts keep coming back in your mind? Yes No
- 194. Do you often become frightened for no apparent reason? Yes No