

Nesnick Family and Sports Chiropractic

Patient Information

Thank you for choosing Nesnick Family and Sports Chiropractic for your chiropractic needs. Please completely fill in the following information to the best of your ability. This will assist us in helping you. If you have any questions or concerns, please do not hesitate to ask.

(Please Print Clearly)

Name _____ Date _____ S/S# _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work/Cell Phone _____ Sex M F D.O.B. _____ Age _____
E-Mail Address: _____
Are you: Minor Single Married Divorced Widowed Separated
Your Employer _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Spouse's or Parents Name _____ Work Place _____ Work Phone _____
Names and ages of children _____ Referred to this office by _____
Person to contact in case of emergency _____ Relation _____ Phone # _____

Insurance Information

(Please present your insurance card upon completion of this form)

Who will be responsible for this account? You Spouse Health Ins Auto Ins Other
Name of Insured _____ Relationship to Patient _____
Insured D.O.B. _____ Insured S/S # _____ Effective Date _____
Name of Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone # (____)
Policy Number _____ Group # _____
Primary Care Physician (MD) _____ MD's phone # _____

Current Health Condition

Health Condition That You Are Here For _____
Other Doctors Seen for This Condition _____
Type of Treatment _____ Results _____
When Did This Treatment Begin? _____ Has This Occurred Before? Yes No
Is Condition: Job Related Auto Accident Home Injury Fall Other _____
Are You Currently Taking Any Medications? _____

Past Health History

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia
Back Surgery Broken Bones Other _____
Major Accidents or Falls _____
Hospitalization _____

(Please Complete Other Side)

Check Any Of The Following You Have Had In The Past 6 Months:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urination

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- General Stiffness
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Colitis

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/ Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain
- Breast Pain/Lumps
- Prostate Dysfunction
- Sexual Dysfunction
- Other Problems

FEMALES ONLY

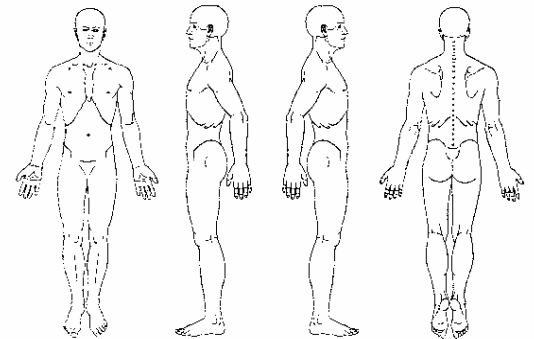
When was your last period? _____

Is there ANY possibility that you may be pregnant?
 Yes No Not Sure

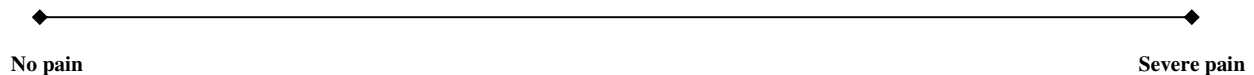
DESCRIPTION & LOCATION OF PAIN

Please mark the location of pain with the following descriptions:

R – Radiating **T** – Tingling **N** - Numbness



Place a mark, at a place somewhere on the line corresponding to the level of pain for your chief complaint.



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Doctor's Office will prepare any necessary reports or forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to Nesnick Family & Sports Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered, if not covered by my insurance policy, are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my conditions as he or she deems appropriate. It is understood and agreed that the amount paid to Nesnick Family and Sports Chiropractic is for examination and consult only. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____
 Consent to Treat a Minor _____
 Guardian Signature _____
 Of Authorizing Care _____

Date _____
 Date _____
 Date _____

HEALTH STATUS QUESTIONNAIRE – RAND 36

Patient Name _____

Date _____

1. In general, would you say your health is:
(circle one number)

Excellent	1
Very Good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago, how would you rate your health in general now?
(circle one number)

Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	(circle one number on each line)		
	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	1	2	3
5. Lifting or carrying groceries.	1	2	3
6. Climbing several flights of stairs.	1	2	3
7. Climbing one flight of stairs.	1	2	3
8. Bending, kneeling or stooping.	1	2	3
9. Walking more than a mile.	1	2	3
10. Walking several blocks	1	2	3
11. Walking one block	1	2	3
12. Bathing or dressing yourself	1	2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
(circle one number on each line)

	Yes	No
13. Cut down the amount of time you spent on work or other activities.	1	2
14. Accomplished less than you would like.	1	2
15. Were limited in the kind of work or other activities.	1	2
16. Had difficulty performing the work or other activities. (for example, it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
(circle one number on each line)

	Yes	No
17. Cut down the amount of time you spent on work or other activities.	1	2
18. Accomplished less than you would like.	1	2
19. Didn't do work or other activities as carefully as usual.	1	2

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
(circle one number)

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

21. How much bodily pain have you had during the past 4 weeks?
(circle one number)

None	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very Severe	6

22. During the past 4 weeks how much did pain interfere with your normal work (including both work outside the home and housework)?
(circle one number)

None at all	1
A little bit	2
Moderately	3
Quite a bit	4
Extremely	5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .

(circle one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6
32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities? (like visiting with friends, relatives, etc.)						

(circle one number)

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	1	2	3	4	5
34. I am as healthy as anybody I know.	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is excellent.	1	2	3	4	5