

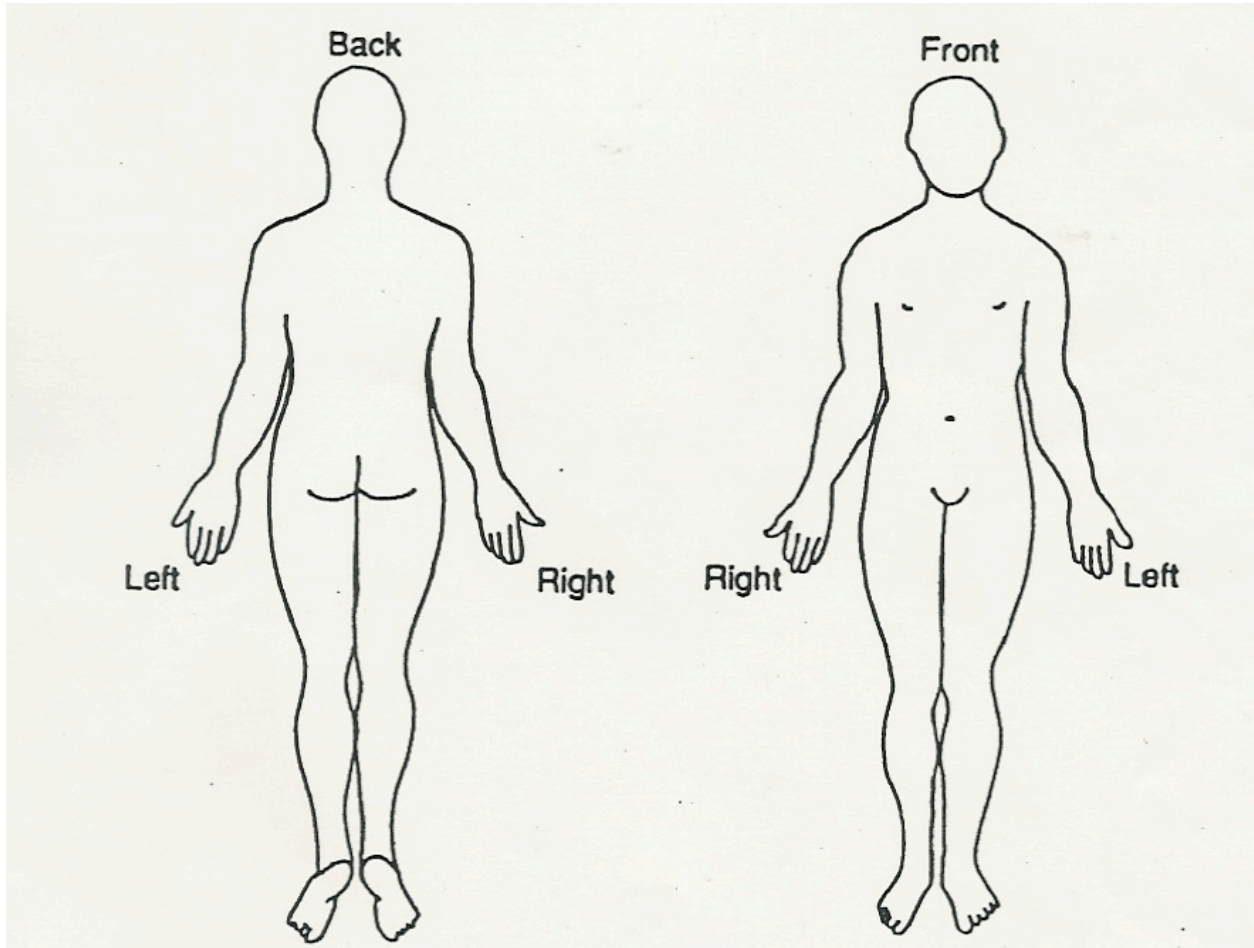
# PAIN DIAGRAM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.**

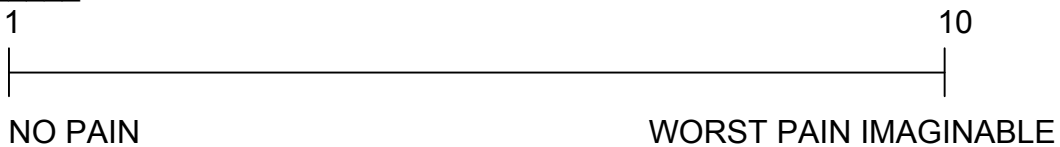
Ache-A  
Burning-B  
Numbness-N

Pins and Needles-P  
Stabbing-S  
Other-O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling **at this time**.

Date: \_\_\_\_\_



## PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Email: \_\_\_\_\_ Referred by: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work (daytime) Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Gender: Male Female Social Security #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Date of Last Exam: \_\_\_\_\_ Dr: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Employer: \_\_\_\_\_

### In case of emergency, whom shall we contact?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell: \_\_\_\_\_ Relationship: \_\_\_\_\_

## FINANCIAL POLICY

As a courtesy to our patients, we offer the following billing options. Please initial the one that applies to you and sign at the bottom of the page.

### PRIVATE PAY

\_\_\_\_ I will pay for all services, as they are rendered and submit my own insurance claims

### PPO & Group / Health

\_\_\_\_ This office is a unique practice offering chiropractic, physical therapy, and laboratory services. I understand that the office will submit my insurance companies, and take the necessary steps to work with the insurance companies to insure payment. The office does not guarantee payment by any insurance company. I am responsible for payment of deductible, co-payments, and non-covered services. **If for any reason my insurance has not paid within 90 days, I will pay the entire balance and collect funds from the insurance company on my own.** I assign my benefits to this office.

### Auto Accident / Personal Injury

\_\_\_\_ I understand this office does not accept 3<sup>rd</sup> party reimbursement. This office will bill my health insurance or my auto insurance and I am responsible for any deductible, co-payments, or non-covered services. I will pay any outstanding balance 45 days after submission. I assign my benefits to this office.

### Medicare

\_\_\_\_ This office does accept assignment and will bill Medicare as described in my Medicare benefits.

\_\_\_\_\_  
Signature of Insured / Guardian

\_\_\_\_\_  
Date

# FirstLineTherapy<sup>®</sup> Health Profile

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for:  Past 30 days  Past 48 hours

<b>Point Scale</b>	0	Never or almost never have the symptom	3	Frequently have it, effect is not severe
	1	Occasionally have it, effect is not severe	4	Frequently have it, effect is severe
	2	Occasionally have it, effect is severe		

**HEAD**

\_\_\_\_\_ Headaches

\_\_\_\_\_ Faintness

\_\_\_\_\_ Dizziness

\_\_\_\_\_ Insomnia

\_\_\_\_\_ TOTAL

**DIGESTIVE TRACT**

\_\_\_\_\_ Nausea, vomiting

\_\_\_\_\_ Diarrhea

\_\_\_\_\_ Constipation

\_\_\_\_\_ Bloating feeling

\_\_\_\_\_ Belching, passing gas

\_\_\_\_\_ Heartburn

\_\_\_\_\_ Intestinal/stomach pain

\_\_\_\_\_ TOTAL

**EYES**

\_\_\_\_\_ Watery or itchy eyes

\_\_\_\_\_ Swollen, reddened or sticky eyelids

\_\_\_\_\_ Bags or dark circles under eyes

\_\_\_\_\_ Blurred or tunnel vision (does not include near- or far-sightedness)

\_\_\_\_\_ TOTAL

**JOINTS / MUSCLE**

\_\_\_\_\_ Pain or aches in joints

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Stiffness or limitation of movement

\_\_\_\_\_ Pain or aches in muscles

\_\_\_\_\_ Feeling of weakness or tiredness

\_\_\_\_\_ TOTAL

**EARS**

\_\_\_\_\_ Itchy ears

\_\_\_\_\_ Earaches, ear infections

\_\_\_\_\_ Drainage from ear

\_\_\_\_\_ Ringing in ears, hearing loss

\_\_\_\_\_ TOTAL

**WEIGHT**

\_\_\_\_\_ Binge eating/drinking

\_\_\_\_\_ Craving certain foods

\_\_\_\_\_ Excessive weight

\_\_\_\_\_ Compulsive eating

\_\_\_\_\_ Water retention

\_\_\_\_\_ Underweight

\_\_\_\_\_ TOTAL

**NOSE**

\_\_\_\_\_ Stuffy nose

\_\_\_\_\_ Sinus problems

\_\_\_\_\_ Hay fever

\_\_\_\_\_ Sneezing attacks

\_\_\_\_\_ Excessive mucus formation

\_\_\_\_\_ TOTAL

**ENERGY / ACTIVITY**

\_\_\_\_\_ Fatigue, sluggishness

\_\_\_\_\_ Apathy, lethargy

\_\_\_\_\_ Hyperactivity

\_\_\_\_\_ Restlessness

\_\_\_\_\_ TOTAL

**MOUTH / THROAT**

\_\_\_\_\_ Chronic coughing

\_\_\_\_\_ Gagging, frequent need to clear throat

\_\_\_\_\_ Sore throat, hoarseness, loss of voice

\_\_\_\_\_ Swollen or discolored tongue, gums or lips

\_\_\_\_\_ Canker sores

\_\_\_\_\_ TOTAL

**MIND**

\_\_\_\_\_ Poor memory

\_\_\_\_\_ Confusion, poor comprehension

\_\_\_\_\_ Poor concentration

\_\_\_\_\_ Poor physical coordination

\_\_\_\_\_ Difficulty in making decisions

\_\_\_\_\_ Stuttering or stammering

\_\_\_\_\_ Slurred speech

\_\_\_\_\_ Learning disabilities

\_\_\_\_\_ TOTAL

**SKIN**

\_\_\_\_\_ Acne

\_\_\_\_\_ Hives, rashes, dry skin

\_\_\_\_\_ Hair loss

\_\_\_\_\_ Flushing, hot flashes

\_\_\_\_\_ Excessive sweating

\_\_\_\_\_ TOTAL

**EMOTIONS**

\_\_\_\_\_ Mood swings

\_\_\_\_\_ Anxiety, fear, nervousness

\_\_\_\_\_ Anger, irritability, aggressiveness

\_\_\_\_\_ Depression

\_\_\_\_\_ TOTAL

**HEART**

\_\_\_\_\_ Irregular or skipped heartbeat

\_\_\_\_\_ Rapid or pounding heartbeat

\_\_\_\_\_ Chest pain

\_\_\_\_\_ TOTAL

**OTHER**

\_\_\_\_\_ Frequent illness

\_\_\_\_\_ Frequent or urgent urination

\_\_\_\_\_ Genital itch or discharge

\_\_\_\_\_ TOTAL

**LUNGS**

\_\_\_\_\_ Chest congestion

\_\_\_\_\_ Asthma, bronchitis

\_\_\_\_\_ Shortness of breath

\_\_\_\_\_ Difficulty breathing

\_\_\_\_\_ TOTAL

**GRAND TOTAL** \_\_\_\_\_

**HEALTH HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Marital Status:     Single         Partner         Married         Separated         Divorced         Widow(er)

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit: \_\_\_\_\_ Date began: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What types of therapies have you tried for these problem(s) or to improve your health over-all:

- diet modification     fasting     vitamins/minerals     herbs     homeopathy     chiropractic     acupuncture     conventional drugs
- other \_\_\_\_\_

Do you experience any of these general symptoms EVERY DAY?

- Debilitating fatigue         Shortness of breath         Insomnia                       Constipation                       Chronic pain/inflammation
- Depression                       Panic attacks                       Nausea                       Fecal incontinence                       Bleeding
- Disinterest in sex                       Headaches                       Vomiting                       Urinary incontinence                       Discharge
- Disinterest in eating                       Dizziness                       Diarrhea                       Low grade fever                       Itching/rash

Current medications (prescription or over-the-counter): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):    1    2    3    4    5    6    7    8    9    10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): \_\_\_\_\_

Do you consider yourself:     underweight         overweight         just right        Your weight today \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? \_\_\_\_\_  
\_\_\_\_\_

What are your current health goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History**

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

**Medical (Men)**

- Benign prostatic hyperplasia
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

**Medical (Women)**

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Date of last GYN exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date - last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_
- Surgical menopause
- Menopause

**Family Health History (Parents and Siblings)**

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

**Health Habits**

- Tobacco:
- Cigarettes: #/day \_\_\_\_\_
- Cigars: #/day \_\_\_\_\_
- Alcohol:
- Wine: #glasses/d or wk \_\_\_\_\_
- Liquor: #ounces/d or wk \_\_\_\_\_
- Beer: #glasses/d or wk \_\_\_\_\_
- Caffeine:
- Coffee: #6 oz cups/d \_\_\_\_\_
- Tea: #6 oz cups/d \_\_\_\_\_
- Soda w/caffeine: #cans/d \_\_\_\_\_
- Other sources \_\_\_\_\_
- Water: #glasses/d \_\_\_\_\_

**Exercise**

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk - #days/wk \_\_\_\_\_
- Run, jog, other aerobic - #days/wk \_\_\_\_\_

**Weight lift - #days/wk \_\_\_\_\_****Stretch - #days/wk \_\_\_\_\_****Other \_\_\_\_\_****Nutrition & Diet**

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy  wheat  eggs
- soy  corn  all gluten
- Other \_\_\_\_\_

**Food Frequency**

- Number of servings per day: \_\_\_\_\_
- Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

**Eating Habits**

- Skip meals - which ones \_\_\_\_\_
- \_\_\_\_\_
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

**Current Supplements**

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Others \_\_\_\_\_

**I Would Like To:**ENERGY - VITALITY

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

BODY COMPOSITION

- Loose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

STRESS, MENTAL, EMOTIONAL

- Learn how to reduce stress
- Think more clearly and be more-focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

LIFE ENRICHMENT

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle