



Dr. Arthur W. Travis

1911 Foulk Rd. • Wilmington, DE 19810 • (302) 475-1267 • (610) 485-9800

Dear Patient:

Date _____

Welcome to our office. Please complete this personal information & the attached questionnaire.

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BIRTHDATE _____

EMAIL ADDRESS _____ AGE _____ MARITAL STATUS: M S W D

INSURANCE COMPANY _____ INSURANCE I.D. # _____

REFERRED BY _____

INSURANCE ASSIGNMENT ACKNOWLEDEMENT:

Patient is responsible for payments of insurance deductibles, co-pays and non-covered services.

Name of person responsible for payment of services provided _____

Signature of person responsible for payment of services provided _____

Patient Name _____ Date: _____

PLEASE FILL OUT TO THIS LINE ONLY. THANK YOU.

CHIRO COV? Y N AMOUNT OF DEDUCT. \$ _____ MET \$ _____

IS A REFERRAL NEEDED? _____

SPECIAL NOTES:

PATIENT # _____



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Patient Health Assessment

Please PRINT or WRITE Clearly

General Information

Patient Name: _____ Date: _____

Provider Name: Arthur W. Travis, D.C.

Primary Care Physician's Name: _____

Patient Sex: M _____ F _____ Date of Birth: _____

Complaint History

1. Describe your current complaint and how the problem began: _____

How long have you had this condition? _____ Date of onset: _____

2. How would you describe pain?

- Sharp, Soreness, Throbbing, Tingling, Dull, Stiffness, Spasm, Burning, Ache, Weakness, Numbness, Shooting

3. How would you rate the intensity of your pain? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10
(no pain) (moderate pain) (terrible/unbearable pain)

4. How often is the pain present?

- Constant (81-100%), Frequent (51-80%), Occasional (26-50%), Intermittent (25% or less)

5. Since your problem began is the pain:

- Getting worse, Getting better, Staying the same

6. How did your problem begin?

- An auto accident, Work related accident, Other type of accident, Gradual, Sudden, No specific reason

Explain: _____

7. What makes your problem better?

- Nothing, Walking, Standing, Sitting, Moving around/exercise, Lying down, Inactivity

8. What makes your problem worse?

- Nothing, Walking, Standing, Sitting, Moving around/exercise, Lying down, Inactivity

9. Are you currently taking any medications?

- Yes, No

If yes, please describe _____

10. Were you previously treated for an earlier occurrence of this same condition? Yes No

If yes, by whom? MD, Chiropractor, Physical therapist, Other

What were the approximate dates, type of treatment and the results? _____

11. What is your physical activity at work?

- Mostly sitting, Light manual labor, Moderate manual labor, Heavy manual labor

Patient Health Assessment (cont.)

12. Do you exercise?

- No regular exercise
 1-2 times a week
 3-4 times a week
 5-7 times a week
 Cardiovascular
 Stretching
 Weight Machine
 Free Weights
 Sports _____
Type

13. What is your present general stress level:

- No stress
 Minimal stress
 Moderate stress
 Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

- No effect
 Have some limited physical restrictions, but can function
 Need some assistance with daily activities
 Cannot work
 Cannot function without assistance
 Totally disabled

Past Or Present Symptoms, Conditions Or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Arm/elbow pain	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>
Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder problem	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
Pain in upper leg or hip	<input type="checkbox"/>	<input type="checkbox"/>	Breast soreness/lump	<input type="checkbox"/>	<input type="checkbox"/>
Pain in lower leg or knee	<input type="checkbox"/>	<input type="checkbox"/>	Sinus conditions	<input type="checkbox"/>	<input type="checkbox"/>
Pain in ankle or foot	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/stiffness of joints	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Excessive weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Skin condition	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
General prolonged fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Prostate condition	<input type="checkbox"/>	<input type="checkbox"/>
Condition of uterus/ovaries	<input type="checkbox"/>	<input type="checkbox"/>			

Tobacco use:

- Past
 Present
 Occasional
 Moderate
 Heavy

Alcohol use:

- Past
 Present
 Occasional
 Moderate
 Heavy

Caffeine use: *(Coffee, tea, soft drinks)*

- Past
 Present
 Occasional
 Moderate
 Heavy

Pregnancy: Past Present

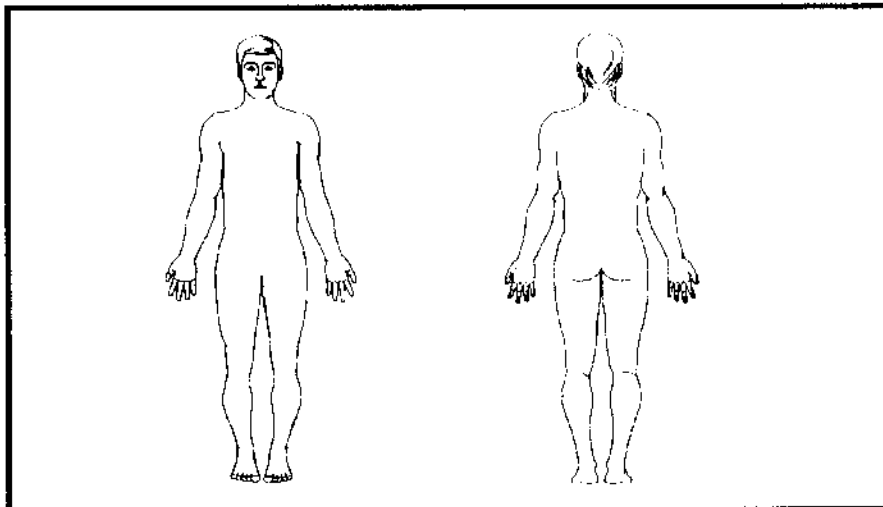
Surgical Procedure:

- Past
 Present

Please list: _____

Comments: _____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

 Patient Name

 Provider Initials

 Date