Chiropractic
A NATURAL WAY TO BETTER HEALTH

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 _____ CELL PHONE CO. _____

BIRTHDATE _____ EMAIL ADDRESS _____ AGE _____

MARITAL STATUS: **S M D W** 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? **Explain:** _____

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

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

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**

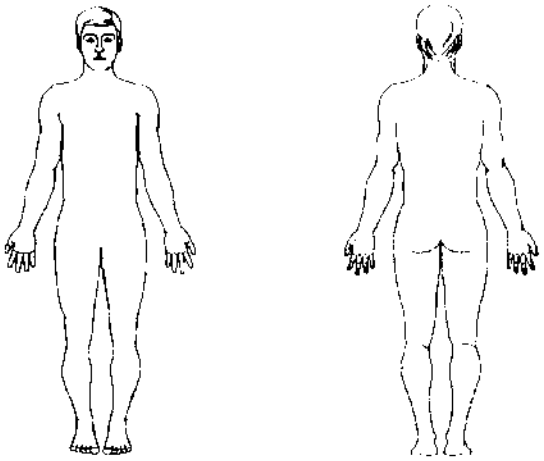
Please list. _____

_____

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