

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

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

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_ Marital Status: S M D W SSN#: \_\_\_\_\_

Do you have children Y N If yes, what are their ages? \_\_\_\_\_

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

Business Address: \_\_\_\_\_

May we contact you at work? Y N

Emergency Contact: \_\_\_\_\_ Relation \_\_\_\_\_

Phone Number \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Address: \_\_\_\_\_

Claim Number (if NF/WC): \_\_\_\_\_

Adjuster (NF/WC): \_\_\_\_\_

Have you ever received Chiropractic care? Y N With whom? \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason for ending care? \_\_\_\_\_

**Women:** Are you pregnant? Y N Date of last menstrual period: \_\_\_\_\_

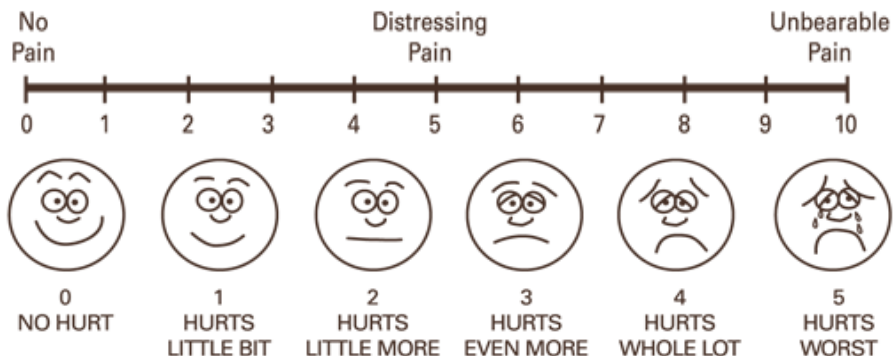
**PATIENT HEALTH ASSESSMENT**

**1. What is your present complaint?** \_\_\_\_\_

**2. How would you describe your pain?**

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

**3. How would you rate the intensity of your pain? (Please circle)**



**4. How often is the pain present?**

- Constant (80 – 100%)
- Frequent (50 – 80%)
- Occasional (25 – 50%)
- Intermittent (25% or less)

**5. When did your problem begin? (Give approximate date if possible)** \_\_\_\_\_

**6. Since your problem began is the pain:**

- Getting worse
- Getting better
- Staying the same

**7. How did your problem begin?**

- Auto accident
- Work related
- Other type of accident
- Gradual
- Sudden
- No specific reason

**8. Describe how the problem began:** \_\_\_\_\_

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**9. What makes your problem better?**

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

**10. What makes your problem worse?**

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

**11. What prior treatments have you received for this present condition?**

- Medical
- Chiropractic
- Physical Therapy
- Acupuncture
- Surgery
- Other \_\_\_\_\_

**Did the treatments help?**  Yes  No

**12. Are you currently taking any medications?**  Yes  No

**13. List any major or minor surgery(s):** \_\_\_\_\_

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**14. What is your physical activity at work?**

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

**15. What general physical activity do you do?**

- No regular exercise
  - Light exercise
  - Strenuous exercise
- Describe \_\_\_\_\_
- 

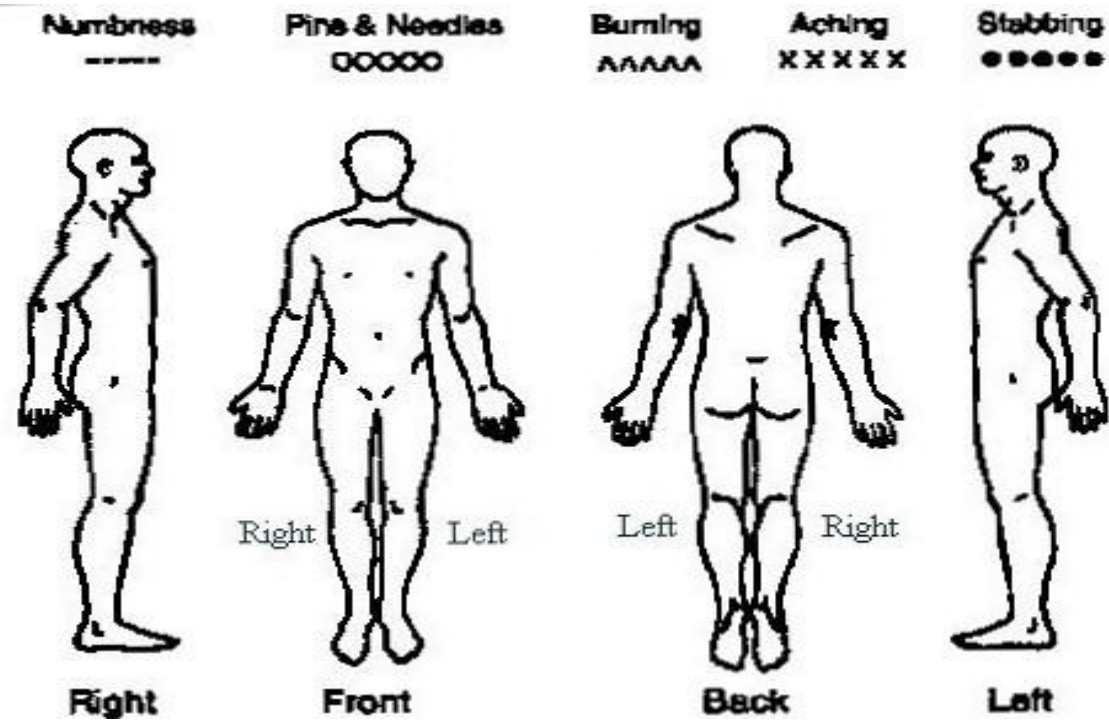
**16. What is your present general stress level?**

- No stress
- Minimal stress
- Moderate stress
- greatly stressed

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

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

Please mark an X on the figures below where you have pain, ache, numbness, or tingling.



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

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**I do hereby authorize Benson Chiropractic to administer such care that is necessary for my particular case. I further agree to pay for services rendered as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand I am personally responsible for payment of any and all services non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.**

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_