HS HealthSource® Chiropractic & Progressive Rehab™

NAME: **DATE:** / / **Account#:**

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

What caused the onset? _____

_____

Date of onset? / /

TIMING AND DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent _____Occasional

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? _____Inflexibility _____Stiffness _____Spasms _____Cramps

Other: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____Deadness	_____Prickly	_____Numb	_____Crawling	_____Tingling
_____Stabbing	_____Hurting	_____Pulsating	_____Pins & Needles	_____Pounding
_____Burning	_____Shooting	_____Throbbing	_____Stinging	
_____Dull	_____Sharp	_____Aching	_____Excruciating	

ADDITIONAL ASSOCIATED SIGNS AND SYMPTOMS

If this pain radiates or travels, please identify where to: _____

_____

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Flashing lights	_____Sneezing	_____Lifting	_____Exercising	_____Looking up/down
_____Coughing	_____Sitting	_____Stooping	_____Looking side/side	_____Anger
_____Standing	_____Depression	_____Stress	_____Driving	_____Walking
_____Getting out of bed	_____Pushing	_____Emotional upset	_____Pulling	_____Repetitive movement
_____Carrying	_____Straining at BM	_____Climbing stairs	_____Walking uphill	_____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting	_____Sleeping	_____Lifting	_____Exercising	_____Looking up/down
_____Shower	_____Advil	_____Stooping	_____Looking side/side	_____Anger
_____Mineral Ice	_____**Other**: _____			

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Have you seen anyone for this condition? _____YES _____NO WHOM?_____

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO

Do you think you may be pregnant? _____YES _____NO

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE:** / / **Account#:**

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? _____Inflexibility _____Stiffness _____Spasms _____Cramps

Other: _____

How would you best describe the sensation of the pain/symptom:

_____Deadness _____Prickly _____Numb _____Crawling _____Tingling
_____Stabbing _____Hurting _____Pulsating _____Pins & Needles _____Pounding
_____Burning _____Shooting _____Throbbing _____Stinging
_____Dull _____Sharp _____Aching _____Excruciating

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? _____Inflexibility _____Stiffness _____Spasms _____Cramps

Other: _____

How would you best describe the sensation of the pain/symptom:

_____Deadness _____Prickly _____Numb _____Crawling _____Tingling
_____Stabbing _____Hurting _____Pulsating _____Pins & Needles _____Pounding
_____Burning _____Shooting _____Throbbing _____Stinging
_____Dull _____Sharp _____Aching _____Excruciating

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

FOURTH COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? _____Inflexibility _____Stiffness _____Spasms _____Cramps

Other: _____

How would you best describe the sensation of the pain/symptom:

_____Deadness _____Prickly _____Numb _____Crawling _____Tingling
_____Stabbing _____Hurting _____Pulsating _____Pins & Needles _____Pounding
_____Burning _____Shooting _____Throbbing _____Stinging
_____Dull _____Sharp _____Aching _____Excruciating

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE:** / / **Account#:**

P = Present • **N** = Not Present • **PN** = If it has ever been present in the past

P	N		PN
		Weakness	
		Fatigue	
		Fever	
		Chills	
		Night Sweats	
		Fainting	
		Nervousness	
		Concentration Loss	
		Dizzy Spells	
		Irritability	
		Depression	
		Memory Loss	
		Loss of Sleep	
		Headache	
		Apprehension	

P	N		PN
		Muscle Pain	
		Muscle Weakness	
		Muscle Cramps	
		Joint Stiffness	
		Joint Tenderness	
		Spinal Curvature	
		Back Pain	
		Hot Joints	
		Joint Swelling	
		Stiff Neck	
		Soreness	
		Lumps	
		Masses	

P	N		PN
		Seizures	
		Vertigo	
		Dizziness	
		Tremors	
		Loss of Sensation	
		Loss of Coordination	
		Weak Grip	
		Paralysis	
		Difficulty of Speech	
		Tingling	
		Numbness	

P	N		PN
		Animal Dander	
		Latex	
		Food Allergies	
		Penicillin	
		Pollen	
		Second Hand Smoke	
		Grasses	
		Sulfa Drugs	
		Dairy Products	
		Perfumes	
		Hay	

FOR DOCTOR'S USE ONLY – PLEASE PROCEED TO PAGE 4

Check additional form for additional Review of Systems
OPTION FOR ESTABLISHED E & M SERVICES OR SHARED COMMON FILE

_____Previous Review of Systems reviewed. Date of previous Review of Systems was: _____/_____/_____

System Reviewed

_____Constitutional _____Musculoskeletal _____Neurological ____Allergic

_____Other, please note: _____

_____No change in systems review

_____Previous Past History reviewed and updated. Date of Past History update: _____/_____/_____

_____No change in Past History _____See old Past History for changes

_____Previous Social History reviewed and updated. Date of Social History updated: _____/_____/_____

_____No change in Social History _____See old Social History for changes

_____Previous Family History reviewed and updated. Date of Family History updated: _____/_____/_____

_____No change in Family History _____See old Family History for changes

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE:** / / **Account#:**

P	N	Past Problem	When and Explanation of Condition
		Cancer	
		Balance Problems	
		Stroke	
		Thyroid Problems	
		Asthma	
		Heart Attack	
		HIV	
		Angina/Chest Pain	
		Diabetes	
		Gout	
		Broken Bones	
		Arthritis	
		Serious Depression	
		Other	

SURGERY	YES	NO	YEAR
Tonsils			
Colon			
Hernia			
Appendix			
Gall Bladder			
Stomach			
Heart			
Kidney			
Other			

SURGERY	YES	NO	YEAR
WOMEN			
Breast			
Uterus			
Ovaries			
MEN			
Prostate			
Other			

What other major injuries have you had? Date

What medications are you currently taking? Date

Have you ever taken:	YES	NO	YEAR
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

Hospitalizations:

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE:** / / **Account#:**

Marital Status _____Married _____Divorced _____Single _____Separated _____Widowed

Number of Children: _____

Frequency of Exercise _____Never _____Rarely _____Occasionally _____Moderately _____Regularly

Intensity of Exercise _____Low Level _____Medium Level _____High Level _____Competition Level

Sufficient Rest _____Never _____Rarely _____Occasionally _____Moderately

Hours of Sleep _____ _____10 or more hours

Well balanced diet _____Never _____Rarely _____Occasionally _____Moderately

Do you smoke? _____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 packs/day

Do you drink caffeinated beverages?
_____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 drinks/day

Do you drink alcoholic beverages?
_____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 drinks/day

Have you ever used street drugs? _____Yes _____No

Hobbies: _____

_____

_____

How did you hear about us? _____

If from advertisement:

1) Newspaper Insert?_____ Which Newspaper?_____
2) Free Report? _____
3) Infomercial? _____
4) Decompression? _____
5) Other _____

Billboard? _____
Yellow Pages? _____
Website? _____
Family or Friend? _____
Monthly Newsletter? _____

Doctor Signature: _____

Patient Signature: _____