Wenger Chiropractic Group Patient Information

Patient ID# (office use): _____ Today's Date: _____

First name _____ M.I. ____ Last Name _____ Nick Name _____

Address _____ City _____ State ____ Zip Code _____

Social Security # _____ Gender: Male/Female Primary Language _____ Date of Birth _____

Email: _____

Marital Status: [ ]Single[ ]Married[ ]Widowed[ ]Divorced[ ]Legally Separated Spouse Name: _____

Race: (Choose most appropriate)
[ ] White [ ] African American or Black [ ] Asian [ ] Hawaiian or Pacific Islander
[ ] American Indian or Alaska native [ ] Decline to specify

Ethnicity: (Choose most Appropriate)
[ ] Not Hispanic or Latino [ ] Hispanic or Latino [ ] Decline to Specify

Contact preference for appointment reminders:

[ ] **Text Message Preferred** _____ [ ] Phone Call _____
CELL PHONE Cell / Home /Work Phone

[ ] Do Not Contact for Appointment Reminders

Emergency Contact Name _____ Phone Number _____ Family Doctor Name _____ Family Doctor Office _____

Primary Insurance _____ Member ID _____ Group Number _____

Primary Insured Name _____ Employer Name _____ HSA / HRA / Neither

Who Referred You To Us? [ ] Physician [ ] Internet [ ] Office Sign [ ] Patient _____

I authorize the following person(s) to have access to my personal health information:

Name: _____ Phone Number: _____

WENGER CHIROPRACTIC GROUP

Today's Date:_____

MEDICAL HISTORY

Patient ID #:_____

Name:_____ Date of Birth:_____ Height:_____ Weight:_____

What is the primary reason/problem/condition you have come in for chiropractic treatment?

_____

_____

Have you had similar problems before? ☐No ☐Yes If yes, When?_____

Have you had Chiropractic care in the past? ☐No ☐Yes

Are there any other issues/problems you wish the doctor to know about: _____

_____

Have you had any recent falls, traumas or other accidents? ☐No ☐Yes Describe:_____

_____

What is the initial date of injury or onset of this condition? _____ Are you off from work? ☐No ☐Yes

Rate your restriction of performing activities of daily living on a scale from 0 to 10

(no restriction) 0 1 2 3 4 5 6 7 8 9 10 (severe restriction)

Over the past 2 weeks what is your average level of pain on a scale from 0 to 10?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain) What level is your pain today? ____/10

Is your pain or discomfort? (Mark with a ✓) ☐continuous ☐off and on ☐getting worse ☐ sharp or stabbing

List symptoms you have had recently: ☐Headache ☐Numbness or tingling in arms/hand or legs/feet ☐Fever

Do you perform moderately intense exercise 3 time per week? ☐No ☐Yes

Is your MD currently co-treating your condition? ☐No ☐Yes If yes, who: _____

What recent diagnostic studies (x-ray, MRI, CT, blood work) have you had? _____

Taken where? _____

[ ] Difficulty sleeping Other:_____

List your Current Primary Medications:_____

Medication Allergies:_____

List your Allergies: ☐None ☐Seasonal/Pollen ☐Food ☐Animals ☐X-Ray Dye ☐ Other:_____

List any Surgeries: ☐None ☐Neck ☐Back ☐Hip ☐Knee ☐Shoulder ☐Brain ☐Other:_____

_____

List your Medical Conditions: ☐None ☐High Blood Pressure ☐Diabetes ☐Stroke ☐Cancer

☐Other:_____

Do you smoke or use tobacco products? ☐No ☐Yes Former Smoker? ☐No ☐Yes

Do you have currently have significant problems with depression or anxiety? ☐No ☐Yes

Do you drink alcohol? ☐No ☐Yes – How many per day? _____

Do you drink caffeine? ☐No ☐Yes – How many per day? _____

Do you exercise? ☐No ☐Yes: What forms and how often?_____

Patient Signature:_____ Date:_____

Functional Rating Index

For use with Neck and/or Back Problems only

In order to properly assess your condition, we must understand how much your **neck and/or back problem** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Traveling (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work and/or household chores

0	1	2	3	4
Can do usual work; unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain;100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

FRI Score:_____

Patient Specific Functional Scale (PSFS)

Please list up to three (3) things you cannot do or are having difficulty doing because of your problem. Then rate them 0 (unable to perform) to 10 (able to perform activity at same level as before injury or problem).

One Word	Unable (circle) Able
1. _____	0 1 2 3 4 5 6 7 8 9 10
2. _____	0 1 2 3 4 5 6 7 8 9 10
3. _____	0 1 2 3 4 5 6 7 8 9 10

Pain/Discomfort Level

Please circle a number on the 0-10 scale indicating your pain/discomfort as of today

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unimaginable pain)

_____ **Patient Name (printed)** _____ **Patient Signature** _____ **Date** _____ computer #