PATIENT MEDICAL RECORD

☐ BRENT SMITH, D.C. INC. ☐ LISA PERLE, D.C. ☐ JOHN GREENE, D.C. ☐ HEATHER CARMONA, D.C. ☐ AUSTIN NIETO, D.C.

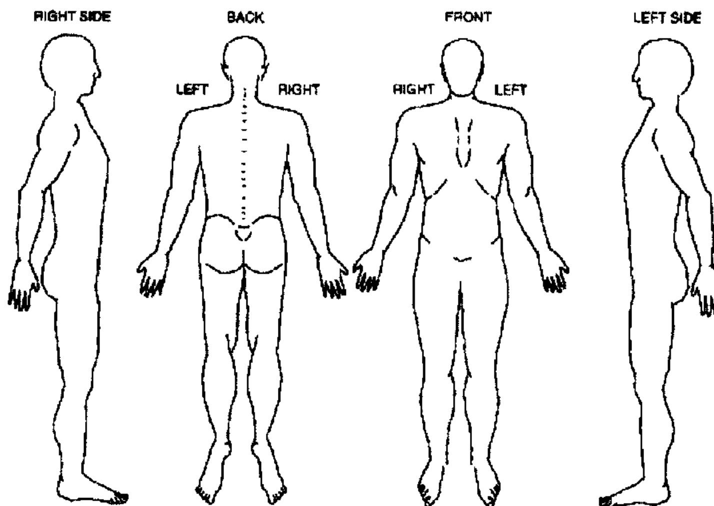
4200 TRABUCO ROAD SUITE 180 IRVINE CALIFORNIA 92620

First name:		Last name			
Height		Weight		Dominant hand	☐ Right ☐ Left
Smoking status:	☐ never smoked	☐ current smoker	☐ former smoker		
Active medication list:	☐ NONE				
Allergies list:	☐ NONE ☐ Lidocaine ☐ Menthol ☐ Latex ☐ Adhesive sports tape ☐ Sulpha ☐ Penicillin ☐ Rubbing alcohol ☐ List other:				
List Surgeries:	☐ NONE				
Family History:	☐ Cancer ☐ Diabetes ☐ Stroke ☐ Heart attack ☐ High blood pressure ☐ Arthritis ☐ Back pain				
Medical History:	☐ Pain or numbness in arms or legs ☐ Recent infection ☐ Pacemaker ☐ Vertigo ☐ Joint replacement ☐ Migraines ☐ Thyroid ☐ Stress ☐ Insomnia ☐ Foot ☐ Shoulder ☐ Knee ☐ Elbow ☐ Wrist ☐ Hip ☐ TMJ				
Primary Physician:		Have you had Chiropractic care before?	☐ YES ☐ NO		
Have you had an X-ray/ MRI/CT	☐ YES ☐ NO	Date:		Are you Pregnant?	☐ YES ☐ NO

CURRENT CONDITION

Describe your current problem:			
Date started:		Cause of pain:	
How frequent are symptoms?	☐ constant 75-100% ☐ frequent 50-75% ☐ occasional 25-50% ☐ Intermittent 0-25%		
Pain at its worse is:	Mild 1 2 3 4 5 6 7 8 9 10 Severe	Pain is currently at:	Mild 1 2 3 4 5 6 7 8 9 10 Severe
How much has pain interfered with daily activities?	☐ None ☐ A little bit ☐ Moderately ☐ Quite a lot ☐ Extremely		
Because of pain I cannot:	☐ Work ☐ Play sports ☐ Sleep ☐ Drive ☐ Sit ☐ Stand ☐ Walk ☐ Stairs ☐ Lift		

PLACE AN X ON ALL PLACES THAT YOU HAVE PAIN OR DISCOMFORT



SIGNATURE OF PATIENT:	DATE:

PATIENT DEMOGRAPHICS

☐ BRENT SMITH, D.C. INC. ☐ LISA PERLE, D.C. ☐ JOHN GREENE, D.C. ☐ HEATHER CARMONA, D.C. ☐ AUSTIN NIETO, D.C.

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First name:		Middle:		Last:	
Date of birth:	Marital status:	Single ☐	Married ☐	Widowed ☐	Divorced ☐
Street address:					
City:		State:		ZIP Code:	
Home:	Cell:	Work:		Email:	
Race:	Asian ☐	African American ☐	Caucasian ☐	Native American ☐	Other please list:
Primary language if not English:			Are you:	Hispanic ☐	Non – Hispanic ☐
Gender:	Male ☐	Female ☐	Referred by:		
Occupation:		Employer:		Work phone:	

EMERGENCY CONTACT/PARENT IF MINOR

Name:		
Address:		Phone:
City:	State:	ZIP Code:
Relationship:		

AUTHORIZATION FOR PATIENT CONTACT

I authorize the doctor and staff to contact me at: ☐ home ☐ cell ☐ work ☐ e-mail INITIALS_____

INSURANCE INFORMATION

IF CARDS WERE PROVIDED YOU DO NOT NEED TO FILL THIS SECTION OUT

INSURED NAME:		DRIVER'S LICENCE#:
INS CO:	POLICY#	GROUP#
INS PHONE #	PRIMARY:	RELATION TO PT:

COPY OF INSURANCE CARD ☐	COPY OF DRIVERS LICENCE ☐

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby authorize my insurance carrier to pay the expense benefits allowable under my current policy. I also authorize the release of my medical information necessary to process all insurance claims. I understand that I am personally financially responsible for all services rendered to me including deductibles and co-pays which I agree to pay on a timely basis. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

INITIALS_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been informed that I may request a copy of Notice of Privacy Practices for my review at any time. INITIALS_____

ATHORIZATION FOR TREATMENT OF MINOR

I authorize the treating doctor and assistants to perform diagnostic tests and administer treatment to my minor son/daughter

SIGNATURE OF PARENT OR GUARDIAN:	DATE:

ATHORIZATION FOR TREATMENT

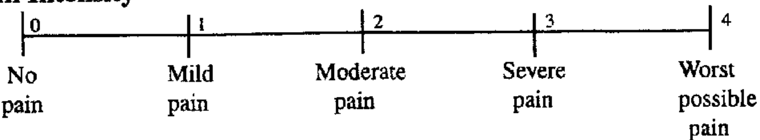
SIGNATURE OF PATIENT:	DATE:

Functional Rating Index

For use with **Neck and/or Back Problems** only.

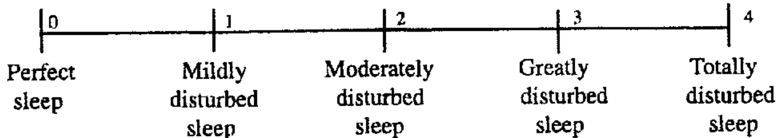
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



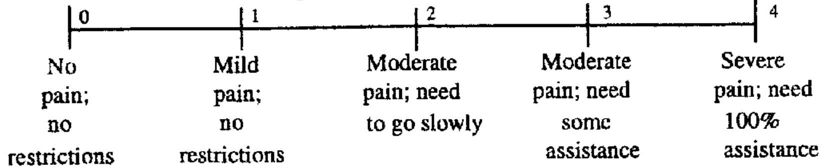
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



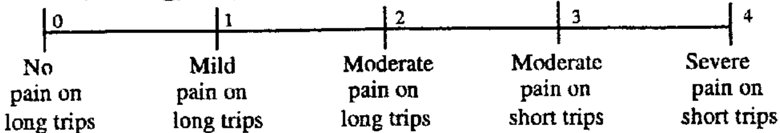
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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



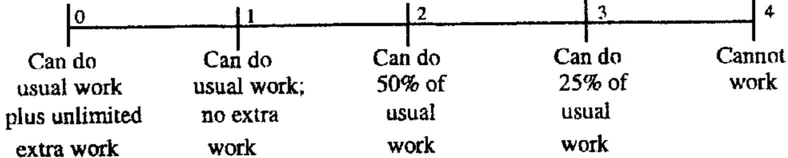
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



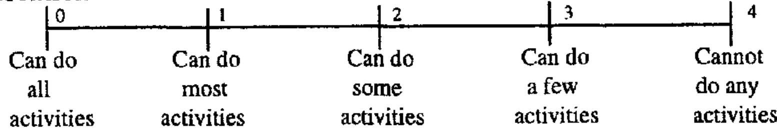
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



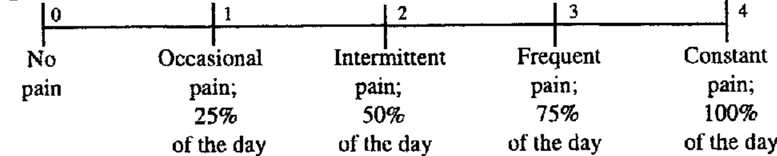
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



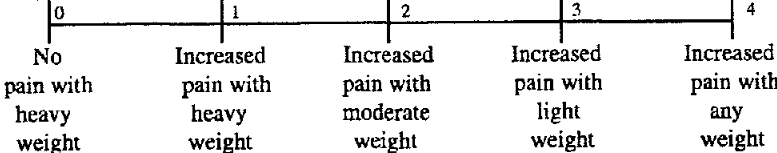
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



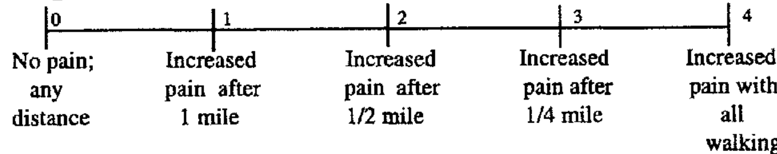
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



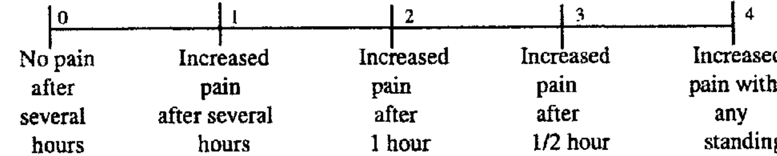
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 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 1/2 hour	Increased pain with any standing

Total Score ________

Name ______________________
PRINTED

____
Signature

____
Date

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