VAN METRE CHIROPRACTIC
CONFIDENTIAL HEALTH INFORMATION

Dr. Kirk Van Metre D.C. Dr. Amy Cannatta D.C.

***Patient Name** _____ **Date**_____

***Referred by: (if new patient)** _____

***Location of today's pain:** _____neck _____upper-back _____mid-back _____low-back _____shoulder
_____elbow _____wrist _____hip _____knee _____legs/foot

Pain Scale 1-10 (10 being worst)

*** 1 2 3 4 5 6 7 8 9 10**

***Vitals**

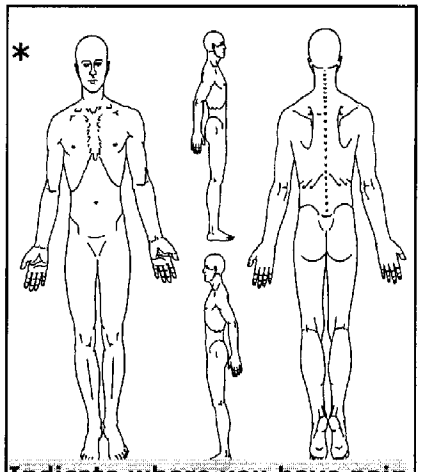
HEIGHT:_____FT_____IN

WEIGHT:_____LBS

AGE:_____

BLOOD PRESSURE:_____/_____
(120/80 considered normal range)

SMOKER: □ Yes □ No
- □ current every day smoker
- □ current some day smoker
- □ former smoker
- □ never smoked



Indicate where you have pain

CERVICAL	NORMAL	PAIN
Flexion	50	
Extension	60	
Left Lat Flex	45	
Right Lat Flex	45	
Left Rotation	80	
Right Rotation	80	
LUMBER	**NORMAL**	**PAIN**
Flexion	60	
Extension	25	
Left Lat Flex	25	
Right Lat Flex	25	
Left Rotation	30	
Right Rotation	30	

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***Is today's problem caused by a recent Auto Accident?** □ **Yes** □ **No**

If yes, when/where: _____

***What is the number one thing that bothers you today?**

_____

***When did your pain begin?** □ _____**day(s) ago** □ _____**week(s) ago** □ _____**month(s) ago**
***Is your condition:** □ **getting better** □ **getting worse**
***Is your condition:** □ **on & off (or)** □ **constant**
***Type of pain:** □ **sharp** □ **stabbing** □ **burning** □ **achy** □ **dull** □ **stiff** □ **sore**
***Radiating: (does the pain travel)** □ **left /right** □ **base of skull** □ **shoulder** □ **arm** □ **hand** □ **hip** □ **leg** □ **knee** □ **foot** □ **ribs** □ **other**
***What makes it better:** □ **ice** □ **heat** □ **rest** □ **movement** □ **stretching**
***What makes it worse:** □ **sitting** □ **standing** □ **walking** □ **lying down** □ **sleep** □ **overuse**

ICD-10
Diagnosis: 1._____ 2._____ 3._____

4._____ 5._____ 6._____

Doctor's Initials:_____ Onset Date_____

13927 W. Grand Ave, Ste.402, Surprise, AZ 85374 Phone (623) 209-2225 FAX (623) 584-2311

OVER →

*** For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Osteoporosis
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		
□	□ Jaw Pain	□	□ Abdominal Pain		
□	□ Joint Pain/Stiffness	□	□ Ulcer	**For Females**	
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Birth Control Pills
□	□ Cancer	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Tumor	□	□ Muscular Incoordination	□	□ Pregnancy
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		

* **Any surgeries to spine or other joints?** □ **Yes** □ **No**

If yes, when and why:_____

* **Have you been hospitalized within the past year?** □ **Yes** □ **No**

If yes, when and why:_____

* **Have you had any spinal x-rays/MRI within the past 2 years?** □ **Yes** □ **No**

If yes, when and where:_____

* **Have you had any massage treatment?** □ **Yes** □ **No**

If yes, when and where was your last massage:_____

* **Do you have a pacemaker or defibulator implanted?** □ **Yes** □ **No**

* **Do you take a blood thinner?** □ **Yes** □ **No**

* **Have you seen anyone else for this condition?** □ **Chiropractor** □ **Medical Doctor**

□ **Physical Therapist** □ **Massage Therapist** □ **Other**_____

*_____

Patient Signature / Responsible Party if minor Relationship Date

FUNCTIONAL RATING INDEX

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 answer** which most closely describes your condition right now. If the category does not apply, please skip.

	0	1	2	3	4
PAIN INTENSITY	No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst possible pain
SLEEPING	Perfect Sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
PERSONAL CARE (washing, dressing, etc)	No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain; need to go slowly	Moderate Pain; need some assistance	Severe Pain; need 100% assistance
TRAVEL (driving, etc)	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
WORK	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
RECREATION	Can do all activities	Can do most activities	Can do some activities	Can do few activities	Cannot do any activities
FREQUENCY OF PAIN	No Pain	Occasional pain 25% of day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day
LIFTING	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
WALKING	No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain any distance
STANDING	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 30 minutes	Increased pain with any standing

Patient Signature _____ Date _____

Doctors Signature _____ Date _____

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Total Score _____

= _____%