Klass Chiropractic, P.C.

70-8 Fairfield Way
Commack, New York, 11725

Demographic Information

Name _____ Date _____

Street Address _____

City _____ State/Province _____ Zip/Postal Code _____

Sex Female Date of Birth _____

Privacy policy

Your privacy is of utmost importance to us. Please identify the ways that you approve our communications with you including email, voicemail, and fax.

Approved telephone #: _____ Can we leave a voice message? ☐ Yes ☐ No

Approved fax #: _____

Approved email: _____

Any specific instructions for absolutely not communicating with you:
Methods: (ex. Do not speak to...; Do not leave a message on or with...etc.)

Comprehensive Health History

Please fill out the following comprehensive Health History in as much detail as possible. The information given here along with your imaging studies will be the primary source for determining whether or not you are a good candidate for MUA. If additional space is needed for any of your answers, please use the text box at the end of the document.

Chief Complaints

☐ Neck (Cervical spine) pain
☐ Headaches
☐ Middle Back (Thoracic spine) pain
☐ Lower back (Lumbar spine) pain
☐ Pelvis/Sacroiliac pain

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Detailed explanation of each of your chief complaints

Please use the following format to describe your main complaint or complaints including initial onset, reoccurrences and how often?

P_1 - Palliative (What makes your pain better?)

P_2 – Provocative (What makes your pain worse?)

Q – Quality (Aching, Sharp, Burning, Numbness, Weakness)

R – Radiation (Location, Where does the pain go?)

S – Severity Rate your pain on a scale of 1-2-3-4-5-6-7-8-9-10 with 1 being the best and 10 being the worst or Mild, Moderate, Severe

T – Temporal – when (Day/Night, rare 10%, Occasional 25%, Intermittent 50%, Frequent 75%, Constant 100%)

History of care: Please describe diagnoses and treatments that you've had and response to those treatments including Chiropractic, Physical Therapy, Massage, Acupuncture, Pain medications, Injections, Surgery.

Do you have imaging studies (X-ray, CT, MRI, Date taken, Impression/Diagnosis)?

Complaint #1

P_1	
P_2	
Q	
R	
S	
T	

History of care

Imaging studies

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Complaint #2

P_1	
P_2	
Q	
R	
S	
T	

History of care

Imaging studies

Complaint #3

P_1	
P_2	
Q	
R	
S	
T	

History of care

Imaging studies

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Complaint #4

P_1	
P_2	
Q	
R	
S	
T	

History of care

Imaging studies

Complaint #5

P_1	
P_2	
Q	
R	
S	
T	

History of care

Imaging studies

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Activities of daily living assessment

Can you:

1. Take care of yourself i.e. eat, dress, bathe, use toilet?	☐ Yes	☐ No
2. Do you get a restful night's sleep?	☐ Yes	☐ No
3. Walk indoors such as your house?	☐ Yes	☐ No
4. Walk a block or 2 on level ground?	☐ Yes	☐ No
5. Climb a flight of stairs or walk up hill?	☐ Yes	☐ No
6. Run a short distance?	☐ Yes	☐ No
7. Do light work around the house like dusting or washing dishes?	☐ Yes	☐ No
8. Do moderate work around the house like vacuuming, sweeping floors, or carrying groceries?	☐ Yes	☐ No
9. Do heavy work around the house like scrubbing floors, lifting, or moving heavy furniture?	☐ Yes	☐ No
10. Do yard work like raking leaves, weeding or pushing a power mower?	☐ Yes	☐ No
11. Have sexual relations?	☐ Yes	☐ No
12. Participate in light recreational activities like going to the movies or restaurant or museum?	☐ Yes	☐ No
13. Participate in moderate recreational activities like golf, bowling, dancing, doubles tennis or throwing a baseball or football?	☐ Yes	☐ No
14. Participate in strenuous sports like swimming, singles tennis, football, basketball or skiing?	☐ Yes	☐ No

15. Check any of the following that your condition affects:

- ☐ Lifting
- ☐ Walking
- ☐ Stair climbing
- ☐ Squatting
- ☐ Sitting
- ☐ Using hands
- ☐ Bending
- ☐ Kneeling
- ☐ Depression
- ☐ Standing
- ☐ Completing tasks
- ☐ Reaching
- ☐ other (explain) _____

16. Do you use any of the?

- ☐ Crutches
- ☐ Canes
- ☐ Walker
- ☐ Brace/splint
- ☐ Wheelchair
- ☐ Artificial limb
- ☐ Other (explain)

Past medical history and current medical history

Please check any conditions below, doctors currently are or have followed you for in the past

General / Constitutional

☐ Fever ☐ Sweats ☐ Fatigue ☐ Weakness ☐ Chronic pain

Cardio Pulmonary

Never	Previously	Presently	
☐	☐	☐	Chest pain or pressure
☐	☐	☐	Angina
☐	☐	☐	Coronary Heart Disease
☐	☐	☐	Myocardial infarction
☐	☐	☐	Arrhythmia
☐	☐	☐	Hypertension? Controlled?
☐	☐	☐	Congestive heart failure
☐	☐	☐	Murmur
☐	☐	☐	Shortness of breath after walking
☐	☐	☐	Ankle swelling
☐	☐	☐	Take antibiotics before dental work
☐	☐	☐	Fainted recently
☐	☐	☐	Have you been hoarse for more than month
☐	☐	☐	Do you snore
☐	☐	☐	Have you ever had pneumonia
☐	☐	☐	Asthma

☐	☐	☐	Chronic obstructive pulmonary disease
☐	☐	☐	History of airway surgery
☐	☐	☐	Upper or lower airway tumor
☐	☐	☐	History of respiratory distress
☐	☐	☐	Runny nose
☐	☐	☐	Sinusitis
☐	☐	☐	Apnea

Genitourinary

Never	Previously	Presently	
☐	☐	☐	Urinary frequency
☐	☐	☐	Blood in urine
☐	☐	☐	Problems urinating - Awaken at night to urinate?
☐	☐	☐	Problems with sex
☐	☐	☐	Urinary incontinence
☐	☐	☐	Endocrine
☐	☐	☐	Increased urination
☐	☐	☐	Frequent urination
☐	☐	☐	Diabetes
☐	☐	☐	Fatigue
☐	☐	☐	Heat intolerance
☐	☐	☐	Cold Intolerance
☐	☐	☐	Weight loss
☐	☐	☐	Weight gain

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Gastrointestinal

Never	Previously	Presently	
☐	☐	☐	Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Constipation
☐	☐	☐	Abdominal pain
☐	☐	☐	Diarrhea
☐	☐	☐	Blood in stool
☐	☐	☐	GI disorders
☐	☐	☐	Colostomy
☐	☐	☐	Abdominal distension
☐	☐	☐	Jaundice
☐	☐	☐	Hepatitis

Hematologic / Oncology / Lymphatic

Never	Previously	Presently	
☐	☐	☐	Easy bruising
☐	☐	☐	Easy bleeding
☐	☐	☐	Hard to stop bleeding
☐	☐	☐	Edema
☐	☐	☐	Anemia
☐	☐	☐	Transfusions
☐	☐	☐	Fevers/ Chills/Sweats
☐	☐	☐	Lymphadenopathy

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Ear / Nose / Throat

Never	Previously	Presently	
☐	☐	☐	Hearing loss
☐	☐	☐	Tinnitus (ringing in ears)
☐	☐	☐	Ear pain
☐	☐	☐	Postnasal drip
☐	☐	☐	Frequent respiratory infections
☐	☐	☐	Hay fever
☐	☐	☐	Sinus pain
☐	☐	☐	Bleeding from nose
☐	☐	☐	Stuffy nose
☐	☐	☐	Dental pain
☐	☐	☐	Dentures/Partial plates/Bridges

Allergy/ Immunological

Never	Previously	Presently	
☐	☐	☐	Seasonal
☐	☐	☐	Sneezing
☐	☐	☐	Itchy eyes
☐	☐	☐	Runny nose
☐	☐	☐	Latex
☐	☐	☐	Food allergies
☐	☐	☐	Egg
☐	☐	☐	Soybean
☐	☐	☐	Medications (please list)

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Musculoskeletal

Never	Previously	Presently	
☐	☐	☐	Joint swelling
☐	☐	☐	Joint pain
☐	☐	☐	Muscle pain
☐	☐	☐	Degenerative arthritis
☐	☐	☐	Other arthritis ex. Rheumatoid
☐	☐	☐	Gout
☐	☐	☐	Lower extremity pain
☐	☐	☐	Upper extremity pain
☐	☐	☐	Amputations
☐	☐	☐	Inflammation

Neurologic

Never	Previously	Presently	
☐	☐	☐	Numbness
☐	☐	☐	Tingling
☐	☐	☐	Headaches
☐	☐	☐	Weakness
☐	☐	☐	Dizziness
☐	☐	☐	Paralysis
☐	☐	☐	Fainting
☐	☐	☐	Seizures
☐	☐	☐	Known disease

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Mental Health

Never	Previously	Presently	
☐	☐	☐	Mental disorders
☐	☐	☐	Alcohol abuse
☐	☐	☐	Substance abuse
☐	☐	☐	Anxiety
☐	☐	☐	Insomnia
☐	☐	☐	Depression
☐	☐	☐	Suicidal
☐	☐	☐	Memory loss

Skin

Never	Previously	Presently	
☐	☐	☐	Rash
☐	☐	☐	Itching
☐	☐	☐	Growths
☐	☐	☐	Non-healing sore

Nutrition

Are you on a special diet? ☐ Yes ☐ No

If yes, Please describe

Do you take Vitamins, Herbs or nutritional supplements? ☐ Yes ☐ No

If yes, please list and describe what they are used for

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Medications

Please list and describe all medications that you take and what they are prescribed for

Known drug allergies

Please list and describe

Past hospitalizations including all surgeries and implanted medical devices

Please list and describe

Family History

Have any of the following Mother, Father, Grandparents, Brother, or Sister had:

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart surgery
- ☐ Stroke
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Thyroid problems
- ☐ Mental illness
- ☐ Diabetes

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children

Have you ever used tobacco products? ☐ Yes ☐ No

If yes, What kind?

How much?

Quit? ☐ Yes ☐ No

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Do you drink alcohol? ☐ Yes ☐ No

If yes, How many drinks per week? _____

Do you use recreational drugs? ☐ Yes ☐ No

If yes, What type? _____

How often? _____

Do you exercise outside of your job? ☐ Yes ☐ No

If yes ☐ Occasionally ☐ often

Please describe

Are you gainfully employed? ☐ Yes ☐ No

If yes, Please describe your work:

If not, do you want to return to work? ☐ Yes ☐ No

Is your home life satisfactory? ☐ Yes ☐ No

If not, does it contribute to your chronic pain? ☐ Yes ☐ No

Please explain:

Do you feel depressed? ☐ Yes ☐ No

If yes, Please explain:

Are you or might you become pregnant? ☐ Yes ☐ No

Anesthesia

Do you or a family member have a history of prior anesthesia experiences or complications including Thrombic, Hemorrhagic or Hyperthermia (fever) ☐ Yes ☐ No

If yes, please explain

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Please use this space for additional information

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative Authority

Description of Personal Representative