FALL RIVER CHIROPRACTIC

DATE:_____

NAME: _____ Mr Mrs Ms Miss Dr Rev
Last name First name Initial (please circle one of the above)

DATE OF BIRTH: Year _____Month_____ Day_____ Ht_____ Wt._____ Shoe Sz._____

HOME ADDRESS: _____
Street City Province Postal Code

PHONE NUMBER: Home: _____ Cell: _____ Work: _____

Email address:_____

OCCUPATION: _____ **EMPLOYER**: _____

MEDICAL DOCTOR: _____ **Health Card#**_____

How did you hear about our office? _____

Who should we contact in case of emergency?_____Phone #_____

What is your major complaint today? _____

How long have you had this condition? _____

Describe the onset of this condition? _____

Is the condition getting: (circle) Worse Same Better Consistent Recurring

How would you describe the pain? (circle) Aching Throbbing Tingling Numbness Burning
Shooting Intermittent Constant

Do you experience Numbness or Tingling to the arms or legs? YES NO

Is there a particular time of day when your complaint is worse? (circle)

Morning Afternoon Evening Night After activities

What activities are you unable to perform due to pain or functional impairment? (ie. golf)

_____

Have you had this condition before? YES NO

Were XRAYS or other imaging performed? YES NO

What aggravates your condition? _____

What relieves your condition? _____

What types of treatment have you had for this condition? _____

Have you had previous chiropractic care? YES NO

If "yes" how long has it been since you were last treated?_____

DO YOU SUFFER –AT PRESENT- FROM ANY OF THE FOLLOWING

( ) Fainting/ Spells/ Dizziness
( ) Difficulty Sleeping
( ) Pain that awakens you at night
( ) General Tiredness/ Fatigue
( ) Fever
( ) Chills
( ) Night sweats
( ) Unexplained or unintentional Weight Loss

Current medications (including birth control)

_____
_____
_____
_____

List any surgeries/hospititalizations you've had & date

_____
_____
_____
_____

Supplements: _____
_____

Have you suffered any fractures/dislocations?

_____

HEALTH HABITS

Smoking: YES NO if "yes" how many years? _____ packs/day_____

Exercise: YES NO **Drinking Alcohol**: YES NO **Caffeine**: YES NO

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

Neuromusculoskeletal
( ) Convulsions
( ) Headaches
( ) Backache
( ) Stiff neck
( ) Pain between shoulders
( ) Spinal curvature
( ) Swollen joints
( ) Weakness
( ) Twitching
( ) Numbness
( ) Tremors

Skin or Allergies
( ) Allergy
( ) Bruise Easily
( ) Dryness
( ) Eczema
( ) Sensitive Skin
( ) Shingles

Cardiovascular
( ) Heart disease
( ) High blood pressure
( ) Low blood pressure
( ) Stroke
( ) Varicose Veins
( ) Irregular heart beat

Gastrointestinal
( ) Poor digestion
( ) Nausea/Vomiting
( ) Belging/Bloating/Gas
( ) Irritable bowel
( ) Hemorrhoids

Ear/Nose/Throat
( ) Earaches
( ) Frequent colds
( ) Sinusitis
( ) Hayfever

Respiratory
( ) Chest Pain
( ) Chronic cough
( ) Difficulty breathing
( ) Wheezing

Genitourinary
( ) Bed wetting
( ) Frequent urination
( ) Painful urination
( ) Prostate trouble
( ) Inability to control urine

Women Only
( ) Pregnant
( ) Cramping /backache

( ) Miscarriage
( ) Irregular Cycle
( ) Hot flashes/menopausal

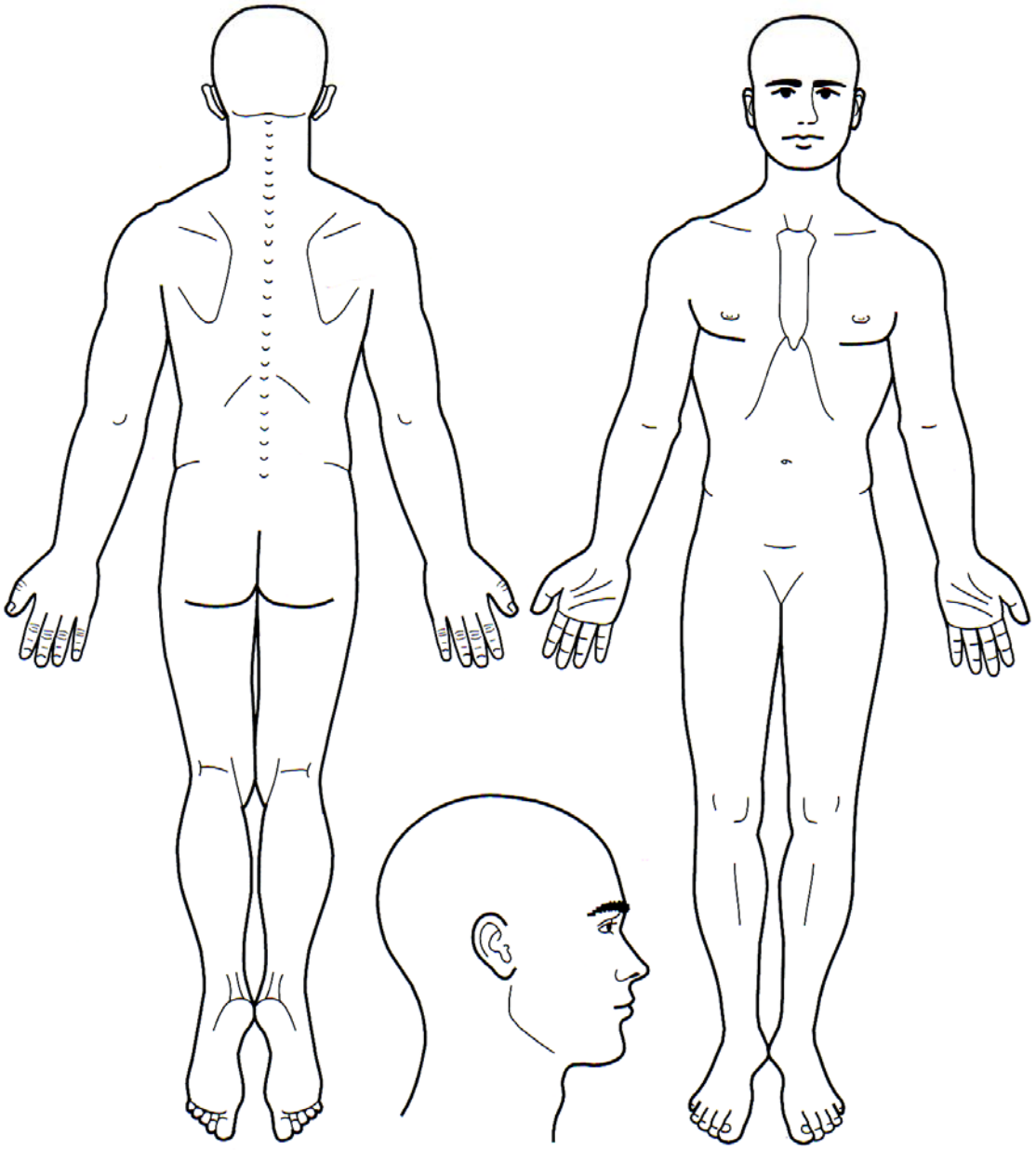
Other
( ) Diabetes
( )Cancer
( ) Depression
( ) Thyroid trouble

( )Alcoholism
( )HIV positive
( )Anxiety

Anything else not listed here?_____

Mark the areas on your body where you feel the following sensations:

Ache	Numbness	Pins & Needles	Burning	Stabbing
^^^	ooo	...	xxx	///
^^^	ooo	...	xxx	///
^^^	ooo	...	xxx	///



NAME _____ DATE _____

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than 1/2 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing
A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from sleeping at all.

SECTION 9--Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms off travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: %_____

FALL RIVER CHIROPRACTIC
FEE SCHEDULE

Chiropractic Services

Adult (18-64)	Initial Consultation	$80.00
	Regular Office Visit	$45.00
	Progress Exam	$45.00
	Gaitscan / Orthotic Exam	$55.00
	Case Re-evaluation	$55.00
Child*/Student*/Senior	Initial Consultation	$80.00
	Regular Office Visit	$42.00
	Progress Exam	$42.00
	Gaitscan / Orthotic Exam	$55.00
	Case Re-evaluation	$55.00

*Children ages 18 and younger
* Students must be enrolled in full-time study to qualify

We direct bill Blue Cross for chiropractic services. All fees are due at the time services are rendered.

Massage Therapy

1 hour Therapeutic Massage	$80.00
½ hour Massage	$50.00
1 ½ hour Massage	$120.00

Patients will be billed in the event of a missed massage therapy appointment if 24 hours notice of cancellation is not given.

Prices are subject to change without notice.