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: _____

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

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

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

( )Alcoholism
( )HIV positive
( )Anxiety

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

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

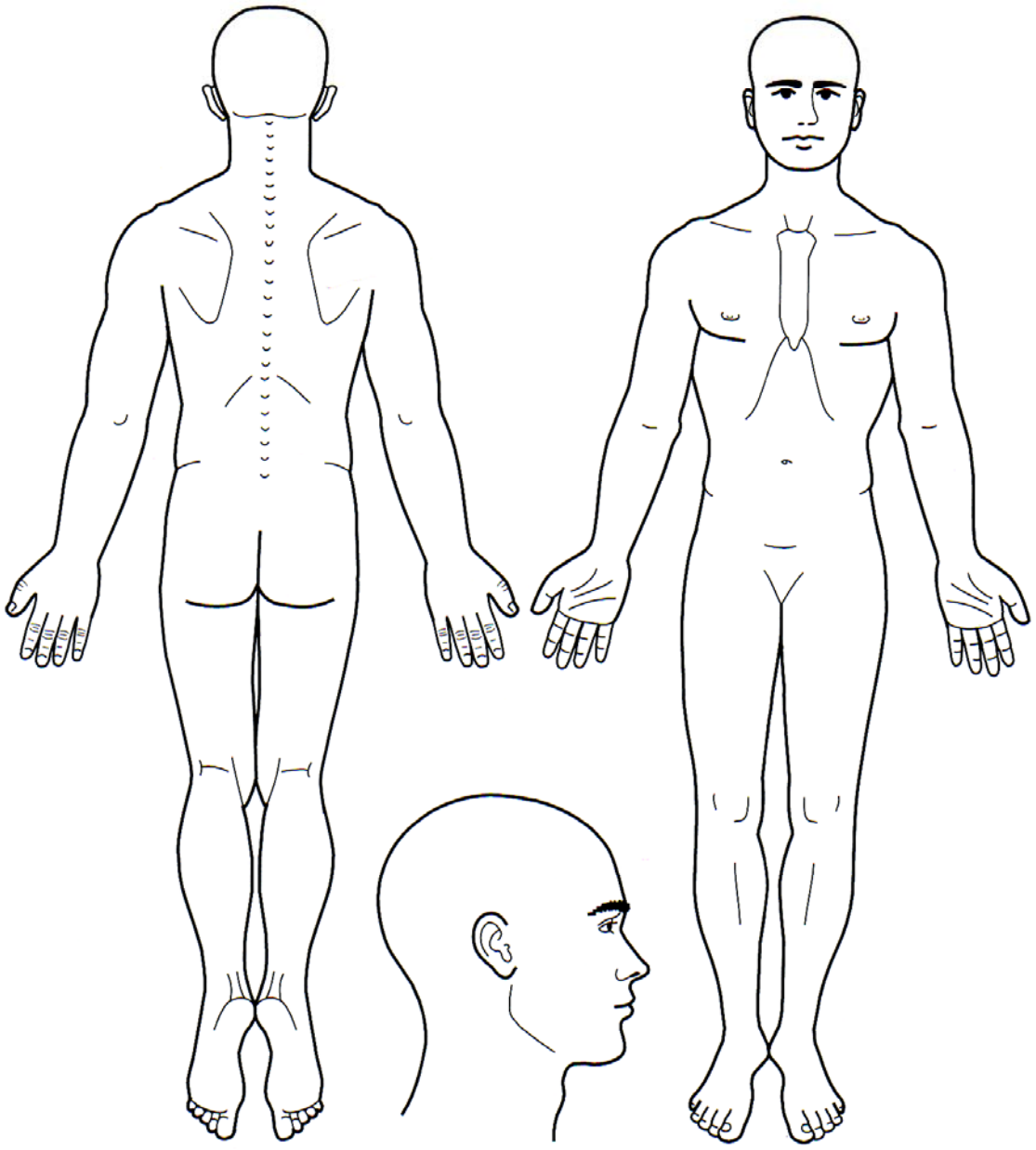
Women Only
( ) Pregnant
( ) Cramping /backache

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

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 _____

LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention.
Please check (✓) an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities					
Your usual hobbies, recreational or sporting activities					
Getting into or out of the bath					
Walking between rooms					
Putting on your shoes or socks					
Squatting					
Lifting an object, like a bag of groceries from the floor					
Performing light activities around your home					
Performing heavy activities around your home					
Getting into or out of a car					
Walking 2 blocks					
Walking a mile					
Going up or down 10 stairs (approximately 1 flight of stairs)					
Standing for 1 hour					
Sitting for 1 hour					
Running on even ground					
Running on uneven ground					
Making sharp turns while running fast					
Hopping					
Rolling over in bed					

Patient name _____ Patient signature _____ Date _____
Score _____/80 MDC (minimum detectable change) = 9 points Error +/– 5 scale points

Form 8 (16)

Lower Extremity Functional Scale reprinted with permission from Binkley JM, Stratford POW, Lott SA, Riddle DL. The lower extremity functional scale (LEFS): Scale development, measurement properties, and clinical application. Phys Ther 1999;79:371–383.

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.