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/
( ) Anxiety

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
( ) Thyroid trouble
Anything not listed here?_____

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

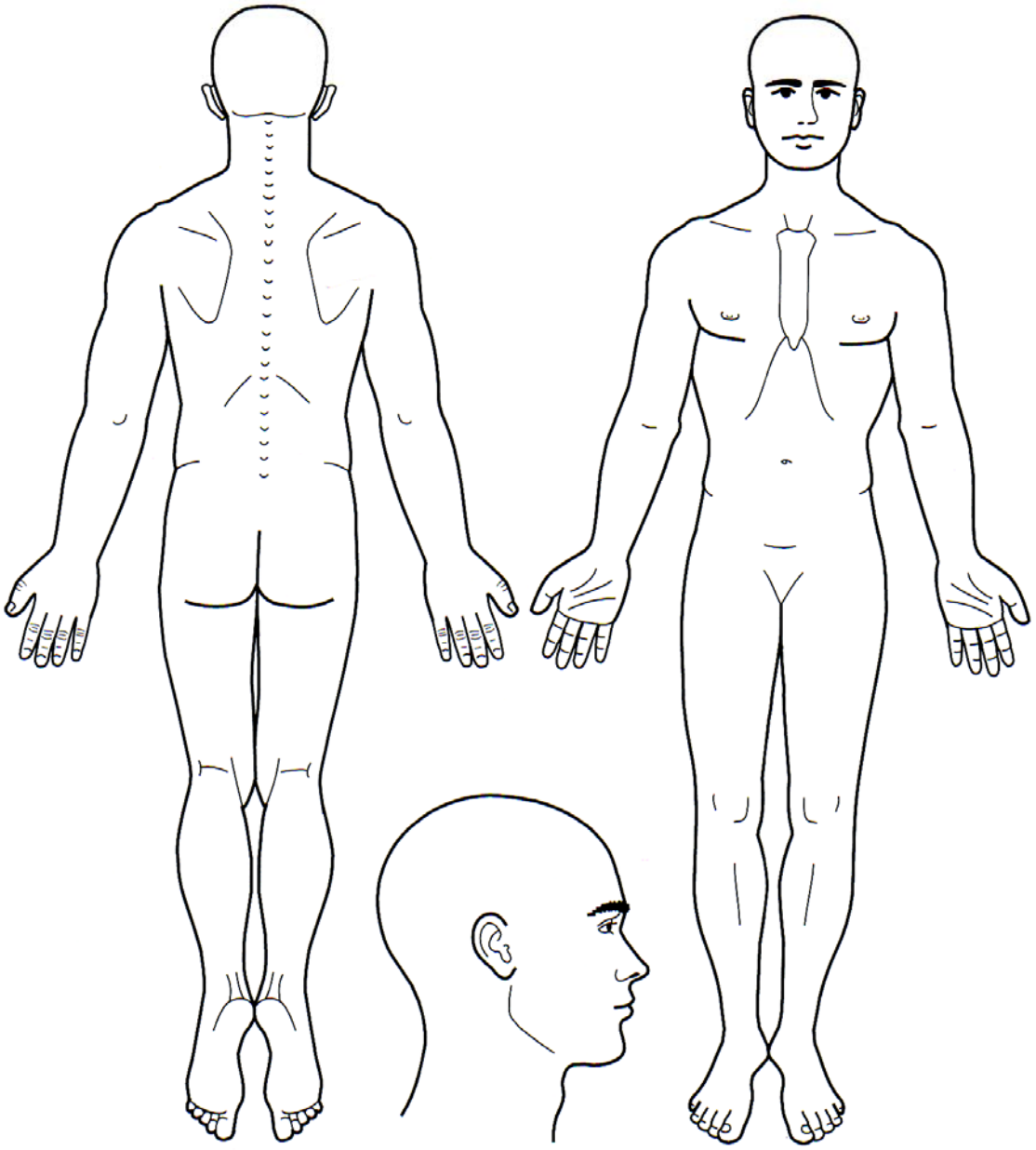
Genitourinary
( ) Bed wetting
( ) Frequent urination
( ) Painful urination
( ) Prostate trouble
( ) Inability to control urine

Women Only
( ) Pregnant
( ) Cramping /backache

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

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 neck pain 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. I have no pain at the moment
B. The pain is mild at the moment.
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 (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

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 but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

SIGNATURE:_____ **DATE:**_____

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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.