proactive spine care™

expert spine & sports care
from pain relief to peak performance

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Welcome to ProActive Spine Care Center™. Thank you for choosing us to help improve your health and well-being. Our goal is to provide you the best care and an outstanding experience as we help you with leading-edge, conservative avenues for better health and an active, pain-free lifestyle. **Please complete the following information to help us get to know you and provide our best help to you.**

NEW PATIENT INFORMATION

Confidential health history & information for your clinic file.

Today's Date: ___________________ 20_____

BASIC INFORMATION:

Name (*First/Middle/Last*): ____ Name you prefer to be called: ____________________

Full name of parent/legal guardian (if patient is a minor): ____

Address: ____ Apt#: _______ City: _________________ St: _____ Zip___________

Birth date: ______________________ Current Age: _______ Soc Sec #: __________-_______-_____________ ☐ Male ☐Female

Marital Status (check one): ☐Single ☐Married ☐Divorced ☐Widowed ☐ Separate Children: ☐No ☐Yes - Ages:____________

CONTACT INFORMATION:

Home Ph # : (________)________________________________ Work #: (________)________________)___________Ext_____________

Personal Email: ____ Mobile: ______________________________________

Emergency Contact Name: ____ Phone #:____________________________

WORK/OCCUPATIONAL INFORMATION:

Are you currently employed? ☐No ☐Yes -- What is your occupation? ____________________________________

Employer: ____ Contact Name:__________________________________

Address: ____ Suite #: _____ City: _________________ St: _____Zip: __________

Main Work Ph # : (______)__________________________ Ext________ Work Email:__________________________________

Please provide a brief description of your typical/normal work duties: ____

____

____

How many years that this job? ___________ Briefly list previous work: ____

INSURANCE INFORMATION – Health / Injury Coverage:

Do you have insurance or other coverage that will be helping you with payment (eg, health, auto injury, work injury, Medicare)?
☐No ☐Don't Know ☐ Yes Would you like us to help you check and verify possible insurance coverage? ☐No ☐Yes

Possible Coverage (check all that apply): ☐Health Ins. ☐Car Accident Ins. ☐Work Injury Coverage ☐Medicare ☐Other_________
Would you like us to help you check for possible insurance coverage you may have available? ☐No ☐Yes

CURRENT PROBLEM / COMPLAINT DETAILS:

Are you here today for a specific problem (s)? ☐No, general spinal or health exam. ☐Yes – Please describe: ____________

When did your symptoms start? ____________
Was there a specific cause? ☐No ☐ Yes- describe: ____________
☐Work injury ☐Car accident injury ☐Other injury ☐No known injury

Please indicate where you are feeling pain or symptoms on the body drawing below – *show all areas including radiating patterns:*

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF SYMTPOMS:

A = ACHE
N = NUMBING
B = BURNING
P = PINS & NEEDLES
O = OTHER
C = STABBING

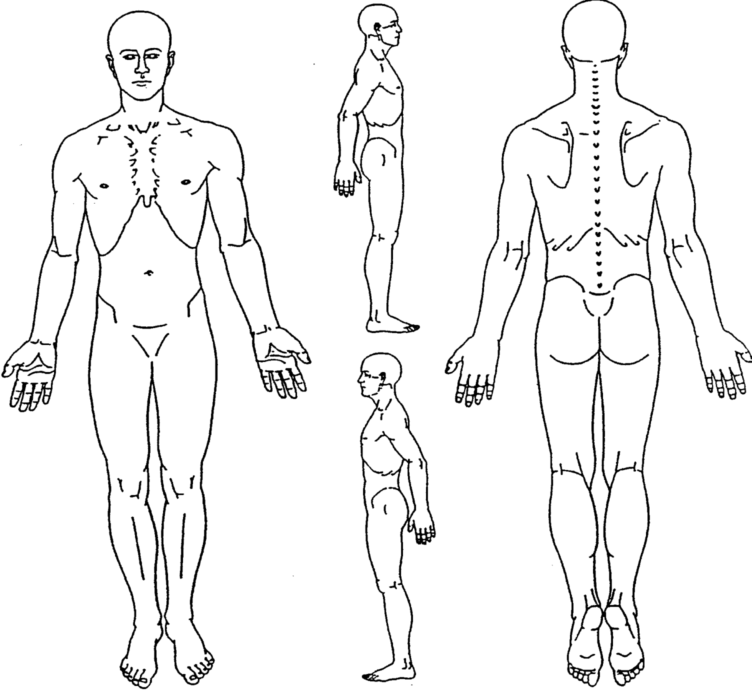
How severe are symptoms?

Use the scale below to rate the worst your pain/symptoms have been in the past week.

0= No pain
10= Worst imaginable pain

0 1 2 3 4 5 6 7 8 9 10

(CIRCLE LEVEL OF SEVERITY)



Since they started, symptoms are: ☐ Getting worse ☐Staying the same ☐Getting better ☐Episodic recurrences

At present symptoms are: ☐ Constant every day ☐ Daily, but come & go ☐ > once per week ☐ < once per week

What makes symptoms better?____________ Worse?____________

Are symptoms interfering with: ☐Sitting ☐Standing/walking ☐Driving ☐Sleeping ☐Bending/lifting ☐Work ☐Recreation

Are you using medication for this problem? ☐No ☐Yes - List ____________
Is this problem preventing you from working? ☐No ☐Yes What and how often? ____________

How has this problem affected your work? ☐Not able to work ☐Working with modifications ☐ Normal work with difficulty ☐ No affect

Have you had any treatment for your current problem/symptoms ☐No ☐Yes -- Where and what type?____________

List your previous care providers for this problem? ____________
Any testing done (Xrays, CAT scan, MRI)?____________
What treatment helped the most , if any? ____________
Have you ever had symptoms/problems like this before? ☐No ☐Yes -- when____________

Are you currently having : ☐ Pain worse at night ☐Pain with coughing/sneezing/straining ☐ Loss of sexual function ☐ Urination changes ☐ Bowel changes ☐Loss of bowel or bladder control ☐Fever/chills

Have you had: ☐Recent weight loss ☐Recent illness ☐ History of cancer? ☐ History of HIV or other immune disorder?

PAST MEDICAL HISTORY:

Who is your Primary/Family MD? ______________________________

1. SURGERIES: List any surgeries (with dates):______________________________

____

Any spinal surgery? ☐No ☐Yes: ______________________________

List hospitalizations:______________________________

2. ILLNESSES: List any illnesses/condition you have ***now or in the past*** (eg, cancer, diabetes, stroke, osteoporosis, high blood pressure, etc):

____

3. INJURIES: List all major injuries you have had (falls, accidents, major joint/bone injuries, etc). Include dates: ______________________________

____

____

Any previous back or neck injuries? ☐No ☐Yes: ______________________________

CURRENT MEDICATION: List all medication you take:

Medication	Frequency	Problem medication is used for:

ALLERGIES: List your allergies (ie, medication, wheat, shellfish, etc) ______________________________

FAMILY HISTORY: List all major medical illnesses or conditions that you know run in your family: ______________________________

____

HABITS: Please indicate any of your personal habits that may impact your health:

Current tobacco use?	☐No ☐Yes:	_____ packs/day. ________years used.
Past tobacco use?	☐No ☐Yes:	_____packs/day. ________years used. ______ years stopped.
Alcohol use?	☐No ☐Yes:	_____drinks/day _____ drinks/week _____drinks/month
Do you exercise regularly?	☐No ☐Yes:	_____days/week aerobic _____days/week strength
Are you active in other exercise?	☐No ☐Yes:	Describe:
Do you take vitamins/supplements?	☐No ☐Yes:	Describe
Do you specifically exercise your back/neck?	☐No ☐Yes:	Describe:

PAST SPINE CARE:

Have you had any past care for your neck or back? ☐No ☐Yes: ______________________________

Have you ever been instructed on proper home back care? ☐No ☐Yes______________________________

Do you know how to properly exercise your back/neck? ☐No ☐Yes

REVIEW OF BODY SYSTEMS: Please indicate if you have any of the following problems related to general body systems:

Fever or chills	☐No ☐Yes	Coughing or wheezing	☐No ☐Yes
Fatigue or loss of energy	☐No ☐Yes	Painful breathing	☐No ☐Yes
Insomnia or problems sleeping	☐No ☐Yes	Nausea of vomiting	☐No ☐Yes
Difficulty swallowing	☐No ☐Yes	Abdominal pain	☐No ☐Yes
Visual or hearing disturbance	☐No ☐Yes	Blood in stool or with bowel movements	☐No ☐Yes
Loss of taste or smell	☐No ☐Yes	Urinary problems (frequency, pain, difficulty)	☐No ☐Yes
Fainting or loss of consciousness	☐No ☐Yes	Skin rashes	☐No ☐Yes
Confusion or memory disturbance	☐No ☐Yes	Painful or enlarged nodes/glands	☐No ☐Yes
Headache	☐No ☐Yes	Muscle or joint pain/swelling	☐No ☐Yes
Numbness, tingling or weakness	☐No ☐Yes	Bruising easily	☐No ☐Yes
Difficulty talking	☐No ☐Yes	Depression or psychiatric illness	☐No ☐Yes
Problems with walking or balance	☐No ☐Yes	**WOMEN:** Last Menstrual Cycle :	
Chest pain	☐No ☐Yes	Possibility you are pregnant?	☐No ☐Yes
Ankle swelling	☐No ☐Yes	Reproductive tract issues (cysts, fibroids, etc)	☐No ☐Yes
Heart palpitation or rhythm problems	☐No ☐Yes		
Shortness of breath	☐No ☐Yes		
Dizziness or lightheadedness	☐No ☐Yes		

FOR WORK INJURIES:

Has a claim been opened? ☐No ☐Yes: Claim No:_________________________________ Date of Injury: _____/_____/______

If a claim has been filed, do you have a copy of the Initial Accident Report? ☐No ☐Yes: (if yes, please provide)

If a claim has been filed, is the claim still open? ☐No ☐Yes ☐Don't know

FOR CAR ACCIDENT INJURIES:

Has a claim been opened? ☐No ☐Yes: Claim No:_______________________________ Date of Accident: _____/_____/______

Have you opened a PIP claim with your own insurance company? ☐No ☐Yes: (if yes, please provide contact info)

FOR PRIVATE HEALTH INSURANCE:

Have you used insurance covered chiropractic, massage therapy, or physical therapy benefits elsewhere this coverage year?? ☐No ☐Yes:

NOTICE TO ALL NEW PATIENTS:

Please try to obtain any X-rays, MRI or CT scans, or any other testing that may have already been done for your condition and bring them to you new patient appointment if possible.

USE THIS SECTION TO PROVIDE ANY OTHER RELEVANT HEALTH INFORMATION OR CONCERNS:

I affirm that have provided accurate information related to my health history and current status to the best of my knowledge, and that areas of the intake left blank are because there is nothing to disclose related to these areas.

Patient Name: ____ Responsible Party Name:____________________________________

PATIENT/GUARDIAN SIGNATURE:____**Date**________________________