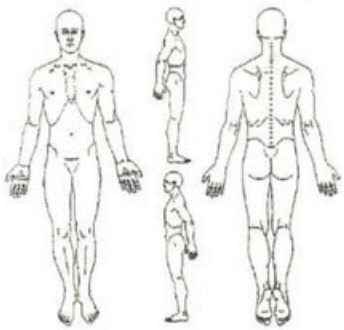
Primary Complaint: _____ **Secondary Complaint:** _____

When did the pain start? _____ **How did it happen?** _____

Frequency of pain: ***Please circle all that apply*** On & Off Constant



Does the pain radiate? ***Please indicate where on the drawing with a P, S, T, or N***

P) Pain

S) Spasm

T) Tender

N) Numbness

Pain Scale: ***Please circle all that apply***

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild	Mild	Mild	Moderate	Moderate	Moderate	Severe	Severee	Severe	Very Severe

What daily activities are being affected by this condition? ***Please circle all that apply***

Working	Homemaking	Golfing	Travel/Driving
Lifting	Personal Care	Sitting	Walking
Sleeping	Social Life	Standing	Other

Quality: ***Please circle all that apply***

Aching	Annoying	Burning	Deep	Tightness
Dull	Heavy	Sharp	Intolerable	Pulling
Shock Like	Stabbing	Stiffness	Throbbing	Tingling

Improves with: ***Please circle all that apply***

Chiropractic Adjustment	Cold Pack	Heat Pack	Exercise	Massages
Physical Therapy	Medication	Rest	Stretching	Nothing

Worsen with: ***Please circle all that apply***

Bending	Carrying	Moving	Climbing Stairs	Coughing or Sneezing
Sleeping	Lifting	Reaching	Running	Sitting
Standing	Stress	Stretching	Twisting	Walking

Women: Are you pregnant: **If Yes,** (due date): _____ **If No,** (last menstrual period: _____

Prescriptions: _____

Illness: (please circle all that apply)

Asthma	Autoimmune Disorder	CVA/TIA (stroke)	Cancer
Blood Clots	Migraine Headaches	Diabetes	Osteoporosis

Injuries: (please circle all that apply)

Back Injury	Broken Bones	Head Injury	Neck Injury

Other: _____

Non-Surgical Hospitalizations with Date: _____

Surgery for Cancer with Dates: _____

_____

Orthopedic Surgeries with Dates(Right/Left): _____

_____

Spinal Surgeries with Dates: _____

_____

Other: _____

Family History: (please mark the box that applies with (M) Male (F) Female _____**Unknown** _____ **None Apply**

Family History	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Child 1	Child 2	Child 3
Deceased (age at death)								
Aneurysms								
CVA (stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other								

Social & Occupational History (please circle all that apply)

Marital Status: Single Married Divorced Other: _____

Children: None 1 2 3 5 6 Other: _____

Student Status: Full-Time Student Part-Time Student Non-Student

Level of Education: High School College Grad Post Grad Other: _____

Employed: No Yes Other: _____

Dominant Hand: Right Left Ambidextrous

Tobacco Use: Every Day Occasionally Former Never Other: _____

Alcohol Use: Every Day Occasionally Never Other: _____

Caffeine Use: Coffee Tea Energy Drinks Soda Never Other: _____

Exercise Frequency: Daily 3-4x week 2-3x week Rarely Never Other: _____

Are you **CURRENTLY** experiencing any of the following symptoms? **Please select all that apply.**

	CONSTITUTIONAL (General)
	Fever
	Fatigue
	Other:
	NONE

	MUSCULOSKETAL
	Joint Pain | Stiffness or Swelling
	Muscle Pain | Stiffness or Spasms
	Broken Bones:
	Other:
	NONE

	NEUROLOGICAL
	Dizziness or Lightheaded
	Convulsions or Seizures
	Tremors
	Other:
	NONE

	PSYCHIATRIC
	Nervousness or Anxiety
	Depression
	Sleep Problems
	Memory Loss or Confusion
	Other:
	NONE

	GENITOURINARY
	Frequent or painful Urination
	Blood in Urine
	Incontinence or Bed Wetting
	Painful or Irregular Periods
	Other:
	NONE

	GASTROINTESTINAL
	Loss of appetite
	Blood in stool or black stool
	Nauseaq or Vomiting
	Abdominal pain
	Frequent diarrhea
	Constipation
	Other:
	NONE

	RESPIIRATORY
	Difficulty Breathing
	Cough
	Other:
	NONE

	EYES & VISION
	Eye Pain
	Blurred or Double Vision
	Sensitive to Light
	Other:
	NONE

	ENDOCINE
	Infertility
	Recent Weight Change
	Eating Disorder
	Other:
	NONE

	HEMATOLOGIC & LYMPHATIC
	Excessive Thirst or Urination
	Cold Extremities
	Swollen Glands
	Other:
	NONE

	ALLERGIC / IMMUNOLOGIC
	Food Allergies
	Enviromental Allergies
	Other:
	NONE

	CARDIOVASCULAR & HEART
	Chest Pain & Tightness
	Rapid or Heartbeat changes
	Swelling Hands, Ankles or Feet
	Other:
	NONE

	INTEGUMENTARY (Skin, Nails & Breast)
	Rash or Itching
	Change in Skin, Hair or Nails
	Non-Healing Sores or Lesions
	Change of appearance of a Mole
	Breast Pain, Lump, or Discharge
	Other:
	NONE

	HEAD, EARS, NOSE, MOUTH & THROAT
	Headaches - Frequent or Recurring
	Ear - Aches, Ringing or Drainage
	Hearring Loss
	Sensitive to Loud Noises
	Sinus Problems
	Sore Throat
	Other:
	NONE

Instructions: This questionnaire has been designed to give us information as to how your pain has affected your ability to manage everyday life. Please answer every question below marking the box which most closely describes your *current condition*.

Pain Scale

0 – No Pain 1 – Some Pain 2 – Mild Pain

3 – Moderate Pain 4 – Severe Pain 5 – Worst Pain Possible

1) Pain Intensity	0	1	2	3	4	5
2) Personal Care (e.g., washing, dressing)	☐	☐	☐	☐	☐	☐
3) Lifting	☐	☐	☐	☐	☐	☐
4) Walking	☐	☐	☐	☐	☐	☐
5) Sitting	☐	☐	☐	☐	☐	☐
6) Standing	☐	☐	☐	☐	☐	☐
7) Sleeping	☐	☐	☐	☐	☐	☐
8) Social Life	☐	☐	☐	☐	☐	☐
9) Traveling	☐	☐	☐	☐	☐	☐
10) Employment/Homemaking	☐	☐	☐	☐	☐	☐

OFFICE USE ONLY

Score _____/50

Transform to percentage score x 1000 = _____ % points

WELLSPRING CHIROPRACTIC & ACUPUNCTURE

Consent to Bill / Collect Insurance

I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, parent/guardian, etc.), to allow Wellspring Chiropractic & Acupuncture (Dr. Pamela Fernandes) to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the office or doctor.

Consent to Examination & Treatment

I give the doctors and staff at Wellspring Chiropractic & Acupuncture permission to perform all examinations, x-rays, and treatments deemed necessary by the doctor. I understand that some of these procedures may be performed by either staff or by the doctor.

Consent to Retrieve Medical Records

I give the doctors and staff at Wellspring Chiropractic & Acupuncture permission to obtain all medical records from other providers, offices, or hospitals which may assist with my care.

HIPAA

A copy of the full Health Information Privacy Policy for our office can be requested at the front desk. In brief, it states that we will not give any information about you except as consented above. The only people we give information to are your parents/guardians if you are a minor or whomever is responsible for your bill (i.e., insurance company, third party, or attorney if you have one).

Clinical Summary Report (CCR)

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. Currently, I am asking Wellspring Chiropractic & Acupuncture to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

Pregnancy Waiver (Women Only)

By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time. Initials: _____

Consent to Social Media

I give the doctors and staff at Wellspring Chiropractic & Acupuncture permission to video record office visits and procedures. I understand that video material will be used only in an educational setting intended for healthcare professionals only. Initials: _____

Patient Signature: _____ Date: _____

Address	
City, State, Zip	

Cell	
Email	
Emergency Contact	

Birthdate			
Sex	Male	Female	Other

Primary Care Physician	
Primary Insurance	
Secondary Insurance	

Employment Status	Student	Employed	Retired	Other
Occupation				

How did you hear about us?	

Is todays visits the result of a work or auto accident?	Yes	No

- *If yes, please provide the front desk with your accident report.*