

LifeLong Health & Wellness Center
Chiropractic Associates, PC
5540 South St. Ste. 200 Lincoln, NE 68506 402-488-1500

WORKER'S COMPENSATION PATIENT INFORMATION

Patient Last Name: _____ M.I.: _____ First Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell #: _____ Social Security _____

E-Mail Address: _____ Drivers License #: _____

Birth Date: _____ Age: _____ Marital Status S ___ M ___ D ___ W ___ Sep ___

Emergency Contact Not Living With You

Name: _____ Relationship: _____ Phone #: _____

Address: _____ Cell # _____

WORK COMP VERIFICATION

Employer: _____ FT ___ PT ___ Employer Phone: _____

Supervisor/Contact: _____ Date of Accident: _____

Address: _____

City: _____ State: _____ Zip: _____

Did you fill out and accident report? Yes No Did your employer forward it to the work comp carrier? Yes No

Work comp Carrier: _____ Phone number: _____

Address: _____ Adjuster name or person Spoken to: _____

Do they require pre-authorization for visits or therapies? Yes No

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Have you or are you considering applying for Medicaid? Y _____ N _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby confirm that all the information provided by me is accurate. Any false information will result in my responsibility for any costs incurred due to fraudulent information. I authorize release of any medical or other information necessary to process my insurance claim.

Signature _____ Date _____

AUTHORIZATION OF PAYMENT: I realize that any insurance that I have is a contract between myself and that company. I authorize all insurance benefits to the Physician for services performed. I am responsible for providing the insurance information for the submission of claims. I am also responsible for any non-covered services or for services for which no referral was obtained.

Signature _____ Date _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I have had the opportunity to obtain a copy of Chiropractic Associates, P.C./LifeLong Health and Wellness (medical practice) Notice of Privacy Practices for Protected Health Information. I have been informed that I may have a copy of this notice at anytime. I have been informed that the Medical Practice has available to me a copy of the Notice of Privacy Practices for Protected Health Information posted in the waiting room for my use.

Signature _____ Date _____

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Financial Policy

Worker's Compensation

If you have been hurt on the job it is the legal obligation of your employer to restore you to your pre-injury state. The chiropractic, medical, or other care required to achieve pre-injury status will be paid for by your employer provided certain criteria have been met. We will need to call your employer to verify that they are aware and acknowledge you were hurt on the job.

Once we have verification from your employer we will file the insurance with the worker's compensation insurance carrier and complete the necessary paper work in order for your care to be paid for appropriately. We will need the following to accept your case:

- A completed worker's compensation packet
- The name, phone number, and contact person for your employer.

Supplies such as braces, splints, or supports required to treat your condition will most likely be paid for by the insurer. Other supplies such as pillows, vitamins, biofreeze, etc. must be paid for by you at the time they are taken.

Any fees for items not covered by your worker's compensation insurance will be your responsibility. We will do our best to inform you if any service or supply may not be covered in advance.

I _____ understand the Worker's Compensation Financial Policy as it was explained to me and agree to abide by it. If I am aware of any change in the status of my case or coverage I agree to inform LifeLong Health & Wellness Center/Chiropractic Associates, PC at my earliest convenience.

Signed: _____

Date: _____

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Informed Consent

The following examination is comprised of a series of tests designed to measure your strength and/or functional abilities that relate to performing daily activities. Some of the components of the exam will look specifically at your body's ability to provide muscle resistance and your ability to move your extremities and spine. This information will assist in defining and determining the degree of impact your injury is having on your ability to perform daily tasks.

Your participation in this exam request of you to exert maximal motion, force and effort in response to the activities offered to you to the best of your ability without changing your current comfort level. Because you are going to be asked to engage in physical activity, you must be aware that there is the potential for injury or aggravation to your current status. Make sure that you understand all that is asked of you, that you understand fully the instructions and to stop or not engage in any offered activity that you are not comfortable with. If at any point in time you have increase in pain, stop the activity that you are engaging in and report the increased pain. Do not perform any activity that you feel you are unable to perform. At no point in time will you be encouraged to participate in this exam beyond the levels that you feel comfortable with. If you do engage in a given activity, you can terminate your participating at any point in time. Remember the goal of this exam is to determine your best ability without changing your current level of comfort. There is not goal that focuses on what you can do despite a worsening of your condition.

You may be placed in positions to isolate and test specific areas of your body. You may be asked to perform isometric tests, simulated lift tasks, cardiovascular test, work activities, work postures, individual muscle tests, hand strength tests, and/or range of motion tests. You will be asked to give your best effort without causing yourself any pain. You may be asked to repeat these procedures 2 to 4 times to determine your best effort. You will be allowed to rest at least thirty (30) seconds between each repetition.

Your will be exposed to certain risks when performing the aforementioned tests, including temporary pain, a worsening of any existing injury, or a new injury. It is not possible to determine in advance whether or to what extent you will experience any of these complications as a result of doing these tests.

It is your responsibility to inform your evaluator if you have any physical limitations or restrictions prior to beginning the tests. You should gradually exert force or movement until you have reached maximum effort without experiencing any pain. You should not jerk or use any form of ballistic movement. If you feel any pain, you must stop the test, and immediately report to the evaluator what has happened.

I understand the above procedures, risks, and instructions and agree to participate in the examination to the best of my ability.

Patient Signature _____ Date _____

Clinician
Examiner _____ Date _____

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Confidential Patient Health Record

Patient Name : _____

Today's Date: ___/___/___

How did you hear about us? Family _____ Friend _____ Co-Worker _____
 Close to home/work Dr. _____ Yellow pages Drove by Hospital Insurance Plan

Personal Information

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

When did this condition begin? ___/___/___

Has it ever occurred before? Yes No
 When? _____

Is the condition: Auto Related Work Related
 No Injury Other

Explain: _____

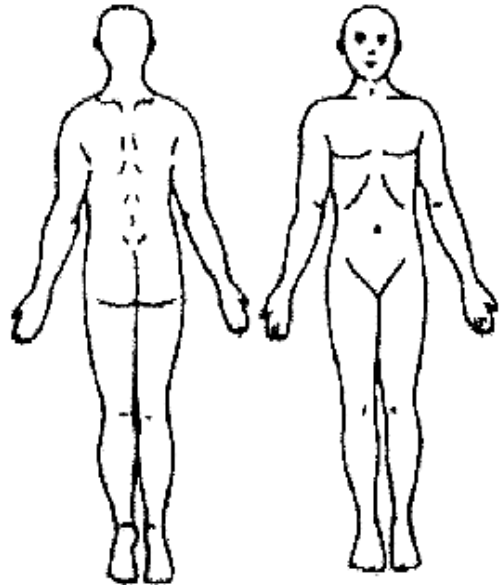
Date of Accident: _____

Time of Accident: _____

Complaint/Pain Onset Date: _____

If Work Related:

Have you filed an injury report with your employer? Yes No
Claim #: _____



Use the letters below to indicate the type and location of your sensations right now:
 A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing O=Other

REVIEW OF SYSTEMS -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Have you had the following symptoms or problems either in the past or now? Please check the appropriate boxes.

General: **I DENY having or have had any of the symptoms or problems listed below.**

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> chills | <input type="checkbox"/> fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> rashes | <input type="checkbox"/> unusual lymph glands or lumps |
| <input type="checkbox"/> daytime drowsiness | <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> risk factors for AIDS | |

Eyes/Vision: **I DENY having any of the symptoms or problems listed below.**

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> blindness | <input type="checkbox"/> change in vision | <input type="checkbox"/> field cuts | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> tearing |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> eye pain | <input type="checkbox"/> itching | <input type="checkbox"/> wear glasses/contacts |

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Ears, Nose and Throat: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> bleeding | <input type="checkbox"/> ear drainage | <input type="checkbox"/> hearing loss | <input type="checkbox"/> nosebleeds | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> dentures | <input type="checkbox"/> ear pain | <input type="checkbox"/> history of head injury | <input type="checkbox"/> postnasal drip | <input type="checkbox"/> nasal congestion |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> fainting | <input type="checkbox"/> hoarseness | <input type="checkbox"/> snoring | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> discharge | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> loss of sense of smell | <input type="checkbox"/> sinus infections | <input type="checkbox"/> headaches |
| <input type="checkbox"/> tinnitus
(ringing in ears) | <input type="checkbox"/> difficulty
swallowing | <input type="checkbox"/> rhinorrhea
(runny nose) | <input type="checkbox"/> bleeding gums | <input type="checkbox"/> migraines |

Respiration: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---------------------------------|--|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> coughing up blood | <input type="checkbox"/> sputum production | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing | <input type="checkbox"/> recurrent pneumonia or bronchitis |

Cardiovascular: I DENY having any of the symptoms or problems listed below.

- | | | |
|---|---|---|
| <input type="checkbox"/> angina (chest pain or discomfort) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> bruise or bleed easily |
| <input type="checkbox"/> claudication (leg-calf pain/ache) | <input type="checkbox"/> swelling of legs | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> palpitations | <input type="checkbox"/> heart failure |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> racing heart | <input type="checkbox"/> blood transfusion |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> orthopnea (difficulty breathing lying down) | <input type="checkbox"/> blood clotting |
| <input type="checkbox"/> shortness of breath
with exertion or exercise | <input type="checkbox"/> paroxysmal nocturnal dyspnea
(waking at night w/ shortness of breath) | |

Gastrointestinal: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea | <input type="checkbox"/> indigestion | <input type="checkbox"/> abnormal stool | <input type="checkbox"/> vomiting blood |
| <input type="checkbox"/> belching | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> jaundice | <input type="checkbox"/> abnormal stool color | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> black - tarry stools | <input type="checkbox"/> heartburn | <input type="checkbox"/> nausea | <input type="checkbox"/> abnormal stool consistency | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> constipation | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | |

Female: I DENY having any of the symptoms/problems and/or using any of the items listed below.

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> hormone therapy | <input type="checkbox"/> vaginal bleeding | <input type="checkbox"/> burning urination | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> breast lumps/pain | <input type="checkbox"/> vaginal discharge | <input type="checkbox"/> urine retention | # of pregnancies: _____ |
| <input type="checkbox"/> discharge from nipple | <input type="checkbox"/> irregular menstruation | <input type="checkbox"/> frequent urination | # of living children: _____ |
| <input type="checkbox"/> cramps | <input type="checkbox"/> Abnormal Pap test | <input type="checkbox"/> birth control | Age of onset of Period: _____ |
| | Last Pap date: _____ | method: _____ | Cycle; _____ days (start to start) |

Male: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> burning urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> prostate problems | <input type="checkbox"/> discharge from penis |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> hesitancy/dribbling | <input type="checkbox"/> urine retention | <input type="checkbox"/> lump in testicles |

Endocrine: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> cold intolerance | <input type="checkbox"/> excessive hunger | <input type="checkbox"/> goiter | <input type="checkbox"/> unusual hair growth |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> hair loss | <input type="checkbox"/> voice changes |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> abnormal frequency of urination | <input type="checkbox"/> heat intolerance | |

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Urinary: I DENY having any of the symptoms or problems listed below.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> kidney stones | <input type="checkbox"/> burning with urination | <input type="checkbox"/> blood in urine | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> slow urine flow | <input type="checkbox"/> venereal disease | |
| <input type="checkbox"/> bladder or kidney infection | <input type="checkbox"/> difficulty starting or controlling urination | | |

Skin: I DENY having any of the symptoms or problems listed below.

- | | | | |
|--|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> changes in nail texture | <input type="checkbox"/> hair loss | <input type="checkbox"/> itching | <input type="checkbox"/> skin lesions / ulcers |
| <input type="checkbox"/> changes in skin color | <input type="checkbox"/> hives | <input type="checkbox"/> paresthesias | <input type="checkbox"/> varicosities |
| <input type="checkbox"/> history of skin disorders | <input type="checkbox"/> hair growth | <input type="checkbox"/> rash | |

Bones/Joints/Muscles: I DENY having any of the symptoms or problems listed below.

- painful or swollen joints persistent back or neck pain muscle cramps osteoporosis

Nervous System: I DENY having any of the symptoms or problems listed below.

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> loss of memory | <input type="checkbox"/> slurred speech | <input type="checkbox"/> tremors |
| <input type="checkbox"/> facial weakness | <input type="checkbox"/> facial numbness | <input type="checkbox"/> seizures/epilepsy | <input type="checkbox"/> stress | <input type="checkbox"/> unsteadiness of gait/
loss of balance |
| <input type="checkbox"/> limb weakness | <input type="checkbox"/> limb numbness | <input type="checkbox"/> sleep disturbance | <input type="checkbox"/> strokes | |
| <input type="checkbox"/> headache | | | | |

Psychologic: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|--|--------------------------------------|--|
| <input type="checkbox"/> crying spells | <input type="checkbox"/> behavioral change | <input type="checkbox"/> convulsions | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> memory problems | <input type="checkbox"/> bi-polar disorder | <input type="checkbox"/> depression | <input type="checkbox"/> mood change |
| <input type="checkbox"/> loss or change in appetite | <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> insomnia | <input type="checkbox"/> job or family
difficulty |
| <input type="checkbox"/> loss of interest in previously
enjoyable things | <input type="checkbox"/> suicide attempts | <input type="checkbox"/> confusion | |

Allergy: I DENY having any of the symptoms or problems listed below.

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> anaphalaxis | <input type="checkbox"/> itching | <input type="checkbox"/> chronic nasal congestion | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> acute nasal congestion | <input type="checkbox"/> rash | |

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

I have not previously seen a doctor for this condition OR Fill in the information BELOW

Have you seen other doctors for THIS CONDITION? Yes No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? Yes No

Explain: _____

Previous Chiropractic Care: I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Were you satisfied with your care? Yes No. Why? _____

Do you wear any of the following? Heel Lifts Innersoles Arch Supports Orthotics Other _____

For how long? _____ Were they prescribed by a doctor? Yes or No.

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Name: _____

Date: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage / Times Daily	For What Condition?	How long have you been taking this?

Medication Allergies: List ANY/ALL medications you are allergic to and the type of reaction. Be Specific.

Medications	Reaction

Current Vitamins, Herbs, etc: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

	Dosage	For What Condition, if any?	How long have you been taking this?

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> angioplasty | <input type="checkbox"/> cosmetic | <input type="checkbox"/> hysterectomy | <input type="checkbox"/> pacemaker insertion |
| <input type="checkbox"/> appendectomy | <input type="checkbox"/> D & C | <input type="checkbox"/> joint reconstruction | <input type="checkbox"/> rotator cuff |
| <input type="checkbox"/> caesarian section | <input type="checkbox"/> dental sugery | <input type="checkbox"/> joint replacement | <input type="checkbox"/> spinal fusion |
| <input type="checkbox"/> cardiac catheterization | <input type="checkbox"/> gall bladder | <input type="checkbox"/> knee repair | <input type="checkbox"/> tonsilectomy |
| <input type="checkbox"/> carpal tunnel repair | <input type="checkbox"/> hemorrhoidectomy | <input type="checkbox"/> laminectomy | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> coronary artery bypass | <input type="checkbox"/> hernia repair | <input type="checkbox"/> mastectomy | _____ |

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|---|--|------------------------------------|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> chicken pox | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> atopic dermatitis (eczema) | <input type="checkbox"/> Crohn's/colitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> allergies/hayfever | <input type="checkbox"/> depression | <input type="checkbox"/> HIV | <input type="checkbox"/> sickle cell anemia |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes | <input type="checkbox"/> measles | <input type="checkbox"/> spina bifida |
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> other: |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> fetal drug exposure | <input type="checkbox"/> psoriasis | |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> food allergies (list below) | <input type="checkbox"/> rash | |

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Name: _____

Date: _____

Do you believe that the Adult Illnesses listed below are contributory to your CURRENT Condition? yes or no.

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD | <input type="checkbox"/> cystic kidney disease | <input type="checkbox"/> hypertension | <input type="checkbox"/> psychiatric problems |
| <input type="checkbox"/> alzheimers | <input type="checkbox"/> depression | <input type="checkbox"/> influenzal pneumonia | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diabetes (insulin dep) | <input type="checkbox"/> liver disease | <input type="checkbox"/> seizures |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes (non insulin) | <input type="checkbox"/> lung disease | <input type="checkbox"/> shingles |
| <input type="checkbox"/> asthma | <input type="checkbox"/> eczema | <input type="checkbox"/> lupus erythema (discoïd) | <input type="checkbox"/> past history of similar symptoms |
| <input type="checkbox"/> cancer | <input type="checkbox"/> emphysema | <input type="checkbox"/> lupus erythema (systemic) | <input type="checkbox"/> STD's (unspecified) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> eye problems | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> suicide attempt(s) |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> parkinson's disease | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> Crohn's/colitis | <input type="checkbox"/> heart disease | <input type="checkbox"/> unspecified pleural effusion | <input type="checkbox"/> vertigo |
| <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> hepatitis | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> HIV | <input type="checkbox"/> psoriasis | _____ |

Females ONLY: Ob/Gyn Mark all that apply below.

If you have been pregnant in the past, please fill in the appropriate information below.

_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____ Number of C-sections	_____ Number of vaginal deliveries
_____ Number of miscarriages	_____ Number of terminated pregnancies
I... <input type="checkbox"/> am currently pregnant	<input type="checkbox"/> am NOT currently pregnant

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- | | | |
|---|---|--|
| <input type="checkbox"/> back injury | <input type="checkbox"/> head injury (loss of consciousness) | <input type="checkbox"/> motor vehicle accident |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> head injury (no loss of consciousness) | <input type="checkbox"/> soft tissue injury (mild) |
| <input type="checkbox"/> disability (ies) | <input type="checkbox"/> industrial accident | <input type="checkbox"/> soft tissue injury (moderate) |
| <input type="checkbox"/> fall (severe) | <input type="checkbox"/> joint injury | <input type="checkbox"/> soft tissue injury (severe) |
| <input type="checkbox"/> fracture | <input type="checkbox"/> laceration (severe) | <input type="checkbox"/> other: _____ |

Immunizations: Please list the date(s) next to the immunization, if known.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> adenovirus | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> pertussis | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> anthrax | <input type="checkbox"/> influenza | <input type="checkbox"/> pneumococcal | <input type="checkbox"/> tularemia |
| <input type="checkbox"/> botulism | <input type="checkbox"/> IPV (polio) | <input type="checkbox"/> pneumovax | <input type="checkbox"/> typhoid |
| <input type="checkbox"/> flu | <input type="checkbox"/> Japanese encephalitis | <input type="checkbox"/> PPD (mantoux test- TB) | <input type="checkbox"/> varivax (chicken pox) |
| <input type="checkbox"/> haemophilus B | <input type="checkbox"/> lyme disease | <input type="checkbox"/> rabies | <input type="checkbox"/> whooping cough (pertussis) |
| <input type="checkbox"/> hepatitis A | <input type="checkbox"/> measles | <input type="checkbox"/> rotavirus | <input type="checkbox"/> yellow fever |
| <input type="checkbox"/> hepatitis B | <input type="checkbox"/> meningococcal | <input type="checkbox"/> rubella | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> MMR | <input type="checkbox"/> smallpox | _____ |
| <input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis) | <input type="checkbox"/> mumps | <input type="checkbox"/> tetanus | _____ |

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Non-Drug Allergies: Mark all that apply below.

- | | | | |
|--|--|------------------------------------|------------------------------------|
| <input type="checkbox"/> adhesive tape | <input type="checkbox"/> eggs | <input type="checkbox"/> newsprint | <input type="checkbox"/> shellfish |
| <input type="checkbox"/> animals | <input type="checkbox"/> feathers | <input type="checkbox"/> nuts | <input type="checkbox"/> smoke |
| <input type="checkbox"/> bee sting | <input type="checkbox"/> food coloring | <input type="checkbox"/> peanuts | <input type="checkbox"/> soap |
| <input type="checkbox"/> chocolate | <input type="checkbox"/> latex | <input type="checkbox"/> perfumes | <input type="checkbox"/> soy |
| <input type="checkbox"/> dairy | <input type="checkbox"/> mold | <input type="checkbox"/> pollen | <input type="checkbox"/> wheat |
| <input type="checkbox"/> other: _____ | | | |

Social History: Mark all that apply below.

Tobacco:	<input type="checkbox"/> None	<input type="checkbox"/> Pipe/Cigar	<input type="checkbox"/> Chew	<input type="checkbox"/> Cigarettes: Amt/day _____	
				How long? _____	<input type="checkbox"/> Quit?
Alcohol:	<input type="checkbox"/> 1/wk-2/day	<input type="checkbox"/> Weekends	<input type="checkbox"/> None	<input type="checkbox"/> Over 2 daily	<input type="checkbox"/> Quit?
Coffee:	<input type="checkbox"/> 0-4 cups daily	<input type="checkbox"/> More: _____		Last Tetanus shot date: _____	
Meals?	<input type="checkbox"/> Reg low-fat	<input type="checkbox"/> Regular	<input type="checkbox"/> Often Skip	<input type="checkbox"/> Fast food	
Exercise:	<input type="checkbox"/> Regular	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Rarely	<input type="checkbox"/> No	
Use of Seat Belts	<input type="checkbox"/> Yes	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No		
Use of Street Drugs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		
Treatment of Alcohol abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		
Treatment of Drug abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details: _____		

Family History: Mark all that apply below.

Family History	Age	Deceased	Alcoholism	Arthritis	Bleeds easily	Cancer	Diabetes	Epilepsy	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Mental Illness	Migraine	Stroke	TB	Thyroid Disease	Other
Father																		
Mother																		
Bro/Sis																		
Bro/Sis																		
Spouse																		
child																		
child																		

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QUADRUPLE VISUAL ANALOGUE SCALE
 (QUAD-VAS)

Patient Name: _____

Date: _____

Please read carefully:

Instructions: Please circle the number and list the area of your complaint that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

No pain _____ *Headache* _____ *Neck* _____ *Low Back* _____ worst possible pain
 pain 0 (1) 2 3 4 (5) 6 7 (8) 9 10

1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

No pain _____ worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

No pain _____ worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

Examiner

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