INSTRUCTIONS: *This is a digital form. Upon completion, please print or email the form(s) to the office. Your responses are entered on the blank spaces next to fields or by checking the boxes.*

PERSONAL INFORMATION:

Last Name: First Name: Email:

Date of Birth: Gender: ☐ Male ☐ Female May we use email to communicate with you? ☐ Yes ☐ No

Home Address: Apt #:

City: State: Zip:

Home Phone #: Cell Phone #: Work Phone #:

Employer Name: Occupation:

How did you hear about this office?

Height (inches): Weight (lbs): Marriage Status: ☐ Single ☐ Married ☐ Other

Current Medications:

Allergies:

Smoking history: ☐ Never ☐ Current ☐ Former Smoking frequency:

SPOUSE or GUARDIAN:

Last Name: First Name:

Date of Birth: Phone #:

PRIMARY INSURED INFO: ***(**Required, even if the primary insured is not a patient of this office**)***

Last Name: First Name: Date of Birth:

Primary Insurance: HMO: ☐ Yes ☐ No

Policy #:

Secondary Insurance: HMO: ☐ Yes ☐ No

Policy #:

RESPONSIBLE PARTY: *(Complete this section if you are not the patient but are responsible for any payments.)*

☐ Self (if yes, skip this section)

Responsible Party: Relationship to Patient:

Home Address: Apt #:

City: State: Zip:

Home Phone #: Cell Phone #:

PREFERRED PAYMENT METHOD: ☐ Cash ☐ Check ☐ Visa ☐ MasterCard

SIGNATURE: *(The above information is true and accurate to the best of my knowledge.)*

☐ **Check this box to indicate your signature** (Patient, Parent, Legal Guardian or Responsible Party)

Patient Name: _____ ***Date:*** _____

1. List your primary symptom(s): _____

a. How long have you had symptoms? _____

b. How did your symptom(s) begin? ☐ Sudden onset ☐ Slow onset ☐ Lifting injury ☐ Auto Accident ☐ Work injury ☐ Other: _____

2. *How often do you experience your symptom(s)?*

☐ Constantly (76-100% of day) ☐ Frequently (51-75% of day) ☐ Occasionally (26-50% of day) ☐ Intermittently (0-25% of day)

3. *What describes the nature of your symptom(s)?*

☐ Sharp ☐ Shooting ☐ Dull ache ☐ Burning ☐ Tingling ☐ Numb

4. *How are your symptom(s) changing?* ☐ Getting better ☐ Not changing ☐ Getting worse

5. *During the <u>past 4 weeks:</u>*

a. Indicate the average intensity of your symptom(s) **Pain-free** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Unbearable**

b. How much pain interfered with your normal work (including both work outside the home, and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. *During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?*

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

7. *In general, would you say your overall health right now is:* ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. *Who have you seen for your symptom(s)?* ☐ No One ☐ Medical Doctor ☐ Physical Therapist ☐ Other Chiropractor ☐ Other: _____

a. What treatment did you receive and when? _____

b. What tests have you had for your symptom(s) and when were they performed? ☐ X-rays (date) _____ ☐ MRI (date) _____

9. *Have you had similar symptom(s) in the past?* ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptom(s), who did you see? ☐ This Office ☐ Medical Doctor ☐ Other Chiropractor ☐ Physical Therapist

☐ **<u>Check this box to indicate your signature</u>**

CESCA FAMILY CHIROPRACTIC

1290 Baltimore Pike Suite 106
Chadds Ford, PA 19317

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment:** The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
- **Health:** The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
- **Vertebral subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

☐ **Check this box to indicate your signature** _____
(Signature) (Date)

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of

_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. ☐ **Check this box to indicate your signature**

Functional Rating Index

Print Name: _____ Date: _____

In order to properly assess your condition, we must understand how much your problem(s) have affected your ability to manage everyday activities. For each item below, please check the number which most closely describes your condition right now.

1. Intensity of problem

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible

2. Sleeping

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Perfect sleep	Mildly affected sleep	Moderately affected sleep	Greatly affected sleep	Totally affected sleep

3. Personal Care (washing, dressing, etc…)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No pain; No restrictions	Mild pain; No restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc…)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

☐ Check this box to indicate your signature **Total Score:** _____