PEAK PERFORMANCE
CHIROPRACTIC | NUTRITION | REHABILITATION

Health History: All Information Is Confidential

Full Legal Name: ______________________________ Name You Prefer: ________________________

Mailing Address: ____

City: ____________________________ State: ____________ Zip Code: ______________________

E-mail: ____________________________________ Cell Phone: ___________________________

Age: ________ Date of Birth: _______________ Gender: Female ☐ Male ☐ Trans ☐ Prefer not to respond ☐

Occupation: ______________________________ Employer: ________________________________

Emergency Contact: ____________________________ Cell Phone: ___________________________

Referred by: ☐ Existing Patient: ___________________ ☐ Internet ☐ Social Media ☐ Other

☐ Insurance Provider Manual ☐ Another Doctor/Professional: __________________________

Past Chiropractic Care? Yes ☐ No ☐ If yes, who? ______________________________________

Who is your primary care doctor? ____________________________ Date of Last Physical: ____________

What medications/supplements are you taking? ____

List any allergies: ____

Have you ever had any of the following:

Surgery: Yes ☐ No ☐ If yes, please describe: ____________________________________

Fractures: Yes ☐ No ☐ If yes, please describe: ____________________________________

Car Accidents: Yes ☐ No ☐ If yes, please describe: ____________________________________

Family history of: Heart disease ☐ Cancer ☐ (type_____________) Diabetes ☐ Other ☐:_______________

Do you smoke/have you ever smoked? Yes ☐ No ☐ If yes, how many years? __________________
Do you consume alcohol? Yes ☐ No ☐ If yes, how many drinks per week? ____________________
Do you use recreational drugs? Yes ☐ No ☐ If yes, what type and how often? __________________
Do you exercise? Yes ☐ No ☐ If yes, please list type and frequency: ______________________

Females only: Are you possibly pregnant? Y ☐ N ☐ Date of last menstrual period ___________ # of children: ________

History of Present Complaint(s)

What is the main reason for your visit today? ____

Date symptoms began? ______________________ Have you had this issue before? Yes ☐ No ☐

How did symptoms first begin? ____

Is the pain: Constant ☐ Intermittent ☐ Is it getting worse? Yes ☐ No ☐

What aggravates the symptoms? ____

What lessens the symptoms? ____

Is the condition worse during certain times of the day? __________________________________

Is the condition interfering with: Sleep? Yes ☐ No ☐ Routine? Yes ☐ No ☐ Work/School? Yes ☐ No ☐

List home remedies tried: ____________________

Other doctors seen for this condition: ____________________

Question	Yes	No
Have you been prescribed an opioid for your primary problem?	Yes ☐	No ☐
Have you had a previous surgery for your primary problem?	Yes ☐	No ☐
Are you considering surgery for your primary problem?	Yes ☐	No ☐
Have you had a previous steroid injection for your primary problem?	Yes ☐	No ☐
Are you considering a steroid injection for your primary problem?	Yes ☐	No ☐

Are you experiencing any of the following?

Constitutional
- ☐ Unexplained weight loss
- ☐ Fatigue or weakness
- ☐ Fever
- ☐ Loss of appetite

Eyes/Nose/Ears/Throat
- ☐ Blurred or double vision
- ☐ Buzzing or ringing in the ears
- ☐ Sore throat
- ☐ Loss of smell
- ☐ Sinus trouble
- ☐ Difficulty swallowing
- ☐ Loss of taste
- ☐ Mouth sores

Skin
- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Lumps or masses

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Blood clotting problem
- ☐ Easy bruising

Respiratory
- ☐ Cough
- ☐ Recurrent infections
- ☐ Wheezing
- ☐ Shortness of breath

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea

Genitourinary
- ☐ Painful urination
- ☐ Loss of urinary control
- ☐ Burning/frequent urination
- ☐ Blood in urine

Neurological
- ☐ Headaches
- ☐ Memory loss
- ☐ Tremors
- ☐ Numbness
- ☐ Loss of strength
- ☐ Seizures
- ☐ Dizziness

Mental Status
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Difficulty sleeping
- ☐ Spectrum disorder

Endocrine
- ☐ Loss of hair
- ☐ Diabetes
- ☐ Changes in appetite
- ☐ Heat/cold intolerance

Cardiovascular
- ☐ Chest pain
- ☐ Swelling of feet, ankles or legs
- ☐ Racing/irregular heartbeat
- ☐ Palpitations
- ☐ Varicose veins

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Sports injuries
- ☐ Pain with walking

Check if you have had any of the following symptoms in the past 30 days:

Pain worse at night ☐	Constant pain unrelated to motion ☐	Unexplained weight loss ☐	Fever or chills ☐
Surgery ☐	Loss of bowel or bladder control ☐	Bacterial infection ☐	COVID infection ☐

Check if you have ever had any of the following:

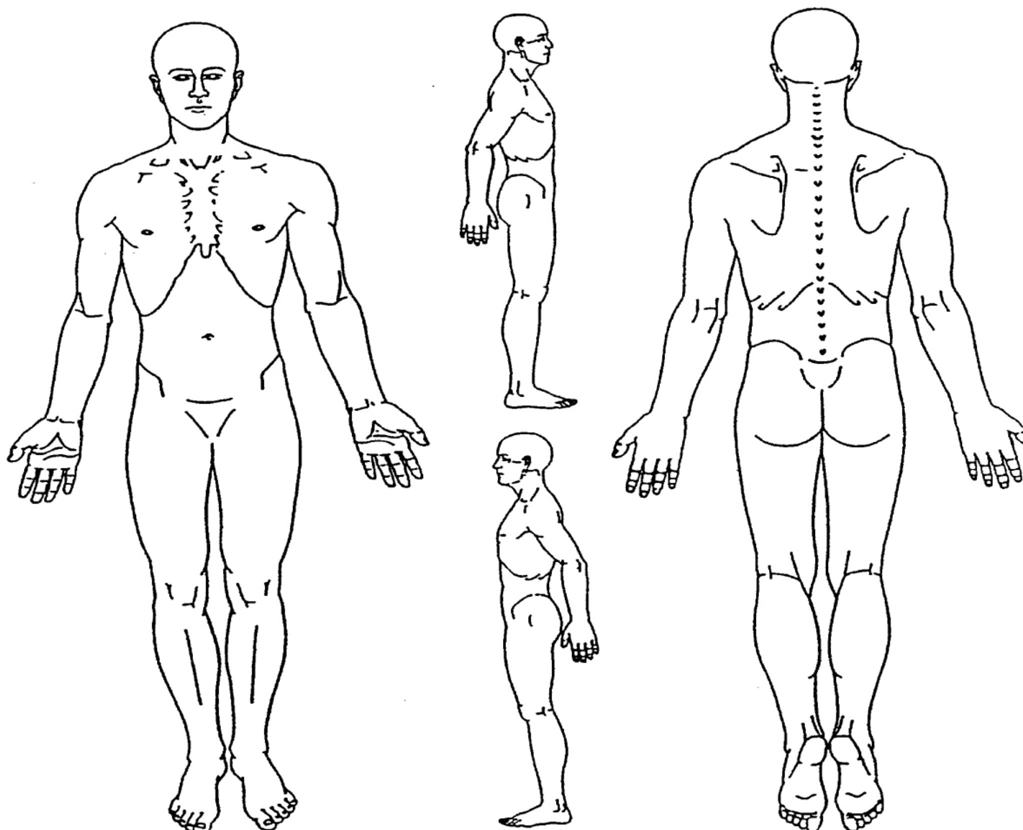
History of cancer ☐ History of HIV/AIDS ☐ Use of anabolic steroids ☐ Use of intravenous drugs ☐ Blood transfusions ☐

* NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

Signature: ____________________ Date: ____________________

Where is your pain now? Mark the areas where you feel sensations using the appropriate symbols. Please mark an X on the area where the pain is now worst.

Aching	Numbness	Pins and Needles	Burning	Sharp/stabbing	Stiff/tight
yyyyy	= = =	oooo	zzzz	/////	***



How bad is your pain? On the scale below circle your pain.

Right now............ <u>No pain</u> 0 1 2 3 4 5 6 7 8 9 10 <u>Worst possible pain</u>
On average........... <u>No pain</u> 0 1 2 3 4 5 6 7 8 9 10 <u>Worst possible pain</u>
At its very worst... <u>No pain</u> 0 1 2 3 4 5 6 7 8 9 10 <u>Worst possible pain</u>

Overall, is your pain generally: improving ❑ same ❑ worsening ❑

Name ___________________________________ Date_______________

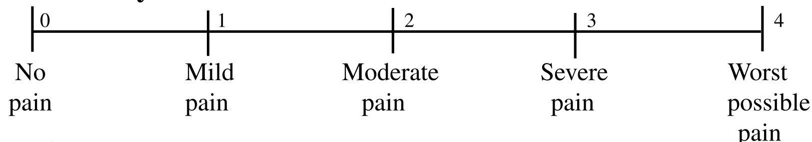
form 102

Functional Rating Index

For use with **Neck and/or Back Problems** only.

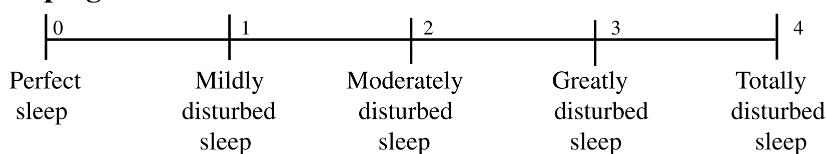
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



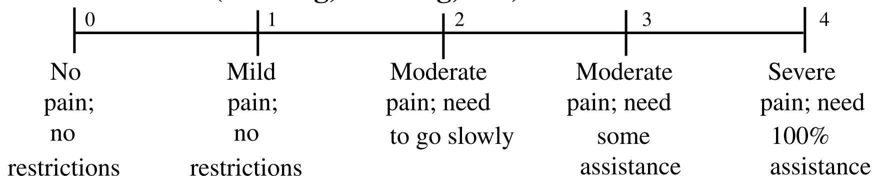
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



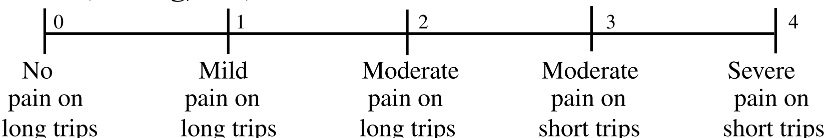
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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



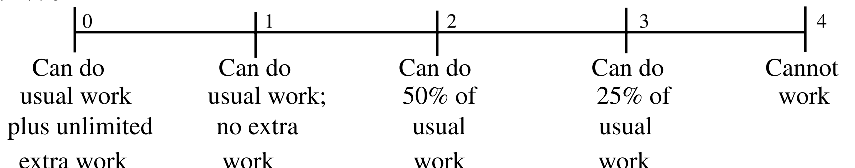
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



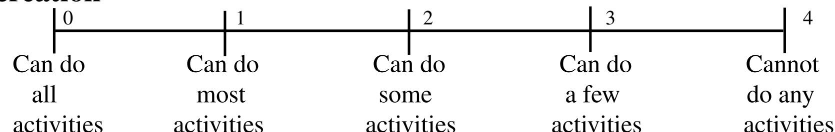
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



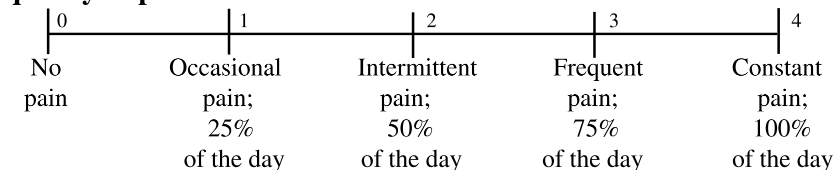
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



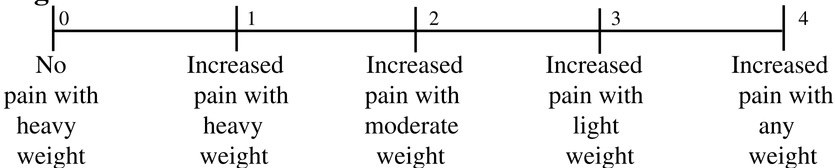
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



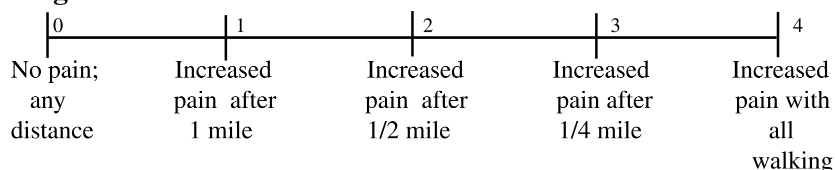
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



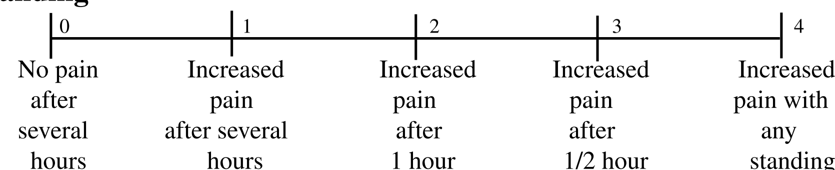
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 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 1/2 hour	Increased pain with any standing

Name ______________________________
PRINTED

Total Score ________

____
Signature

____
Date

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Cancellation and Missed Appointment Policy

Our goal is to provide quality, individualized chiropractic care in a timely manner. Missed appointments and late cancellations inconvenience those individuals who need access to care. Our office policy regarding missed appointments enables us to better utilize available appointments for the needs of our patients.

Cancellation of an appointment: In order to be respectful of the needs of other patients, please be courteous and call us promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, **we ask that you call, email or text the office at least 24 hours in advance**. Appointments are in high demand and your early cancellation will give another patient the opportunity to be treated. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee.

Late cancellations, within the 24 hour period, will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances.

Missed appointment/no-show policy: A no-show is someone who misses an appointment without notifying the office in advance to cancel. No-shows inconvenience those individuals who need access to care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". **The first time there is a no-show there will be no charge to the patient. Any additional no-shows will result in a fee of $70.**

Late arrival policy: A grace period of **up to 10 minutes** will be permitted for unforeseen delays a patient may encounter while traveling to the office for their scheduled appointment. If a patient arrives more than 10 minutes late for their appointment, the patient will be given the option of either being seen in the remaining allotted appointment time, or rescheduled for a later date. If the appointment is rescheduled, it will be considered a missed appointment and there will be a fee.

I acknowledge that I have read and understand the above policy statement regarding the fees for missed/no-show appointments.

____

Patient Signature (or responsible financial party)

____

Signature Date

____

Printed Patient Name