Required for Your Case History File: All Information Is Confidential

Full Legal Name_____ Name you prefer_____

Mailing Address_____

City_____ State_____ Zip Code_____

Telephone (Home) _____ Telephone (Work) _____

Email _____ Referred by_____

Occupation_____ Employer_____

Name of Spouse_____Number of Children_____

Emergency Contact _____Telephone_____

Age_____ Date of Birth _____ Sex _____ Years of Education_____

Circle one: Married Single Widowed Divorced Separated

Past chiropractic care? Yes ❑ No ❑ If yes, who? _____

Who is your primary care physician? _____
Date of Last Physical Examination_____

Have you been treated for any health condition by a physician in the last year? Yes ❑ No ❑

What medications/vitamins/herbs are you taking?_____
_____
_____Are you allergic to any medications? Yes ❑ No ❑

Previous serious illness/ hospitalization: (Please date & describe) _____
_____

Have ever had: Surgery Yes ❑ No ❑ Fractures Yes ❑ No ❑ Car Accidents Yes ❑ No ❑
Falls Yes ❑ No ❑ On-Job Injury Yes ❑ No ❑

Family history of: Heart disease Yes ❑ No ❑ Cancer Yes ❑ No ❑ Diabetes Yes ❑ No ❑

If you are female, are you possibly pregnant? Yes ❑ No ❑ Date of last menstrual period ____

Primary Symptom/Problem for this visit _____
_____

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 ❒

Date symptoms first began _____

How did your symptoms first begin? _____

Other Symptoms _____

Pains is: Constant ❑ Intermittent ❑ Is your condition getting? Worse ❑ Better ❑ Same ❑

What activities aggravate your condition?_____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day?_____

Is this condition interfering with work? Yes ❑ No ❑ sleep? Yes ❑ No ❑ routine? Yes ❑ No ❑

Other doctors seen for this condition _____

List home remedies tried _____

Do you have any of the following?

Constitutional
___ Unexplained Weight Loss
___ Fatigue or Weakness
___Fever

Eyes
___Glaucoma
___Cataracts
___Double Vision

Ears, Nose, Throat
___ Difficulty Hearing
___Buzzing or Ringing in Ears
___Dizziness
___ Loss of Smell
___Sinus Trouble
___ Difficulty Swallowing
___Loss of Taste

Skin
___Rashes
___Hives
___Itching

Allergic/Immunologic
___Hives/Hay Fever

Respiratory
___Cold/Flu/Cough
___Coughing Blood
___Wheezing

Gastrointestinal
___Nausea or Vomiting
___Constipation
___Diarrhea
___Digestive Problems

Genitourinary
___Blood in Urine
___Bladder Leakage
___Burning/Frequent Urination

Musculoskeletal
___Spinal Pain
___Joint Swelling
___Joint Stiffness

Cardiovascular
___Chest Pain
___Shortness of Breath
___Racing Heartbeat
___Fainting Spells

Neurological
___Headaches
___Memory Loss
___Tremors
___Numbness
___Loss of Strength
___Seizures

Mental Status
___Anxiety/Depression
___Mood Swings
___Difficult Sleeping
___Stress

Endocrine
___Loss of Hair
___Heat/Cold Intolerance
___Diabetes
___Excessive Sweating
___Change in Appetite

Hematologic/Lymphatic
___Ease of bruising
___Gums Bleed Easily
___Enlarged Glands

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

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

Check if you have ever had any of the following:

History of Cancer ❑ History of HIV ❑ Use of Steroids ❑ Use of IV Drugs ❑ Blood Transfusions ❑

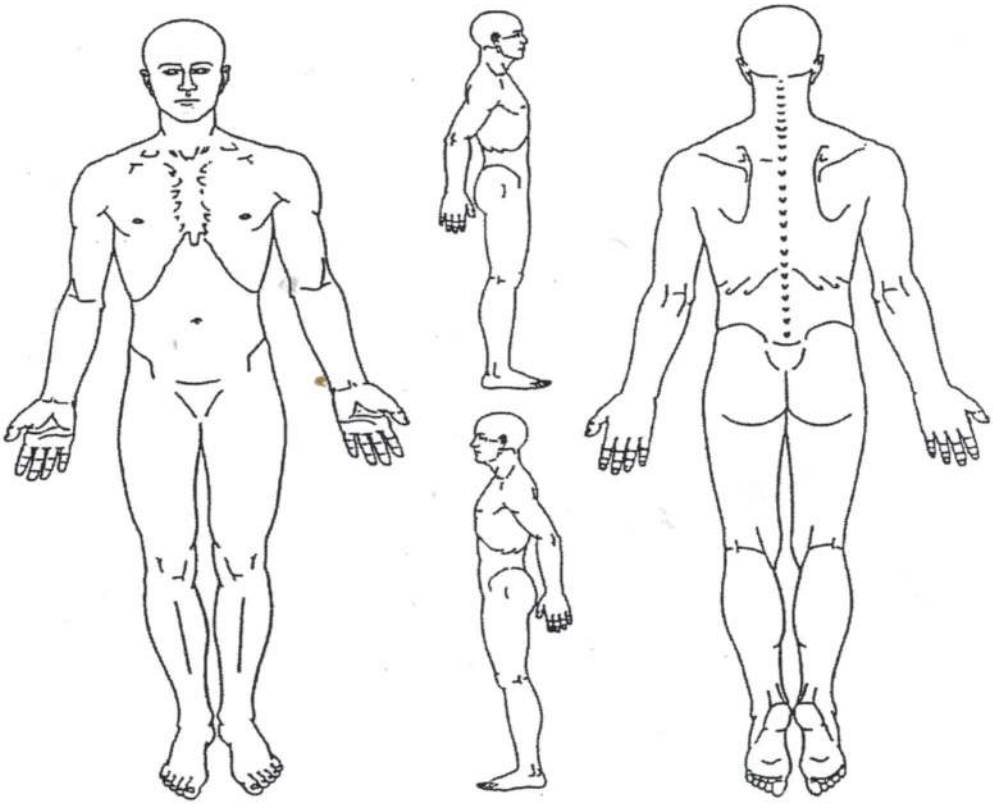
*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information you deem appropriate to any insurance company.

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..... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
On average..... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
At its very worst... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

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

_____
Signature

_____
Date

Total Score _____

PEAK PERFORMANCE

CHIROPRACTIC | NUTRITION | REHABILITATION

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.

Late cancellations will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee.

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 medical 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 $40**.

I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments. Additional information is available in the Notice of Privacy Practices which is available at the front desk and online at www.peakperformancencr.com.

_____

Patient Signature (or responsible financial party)

_____

Signature Date

_____

Printed Patient Name