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: _____

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 <u>30 days:</u>

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:

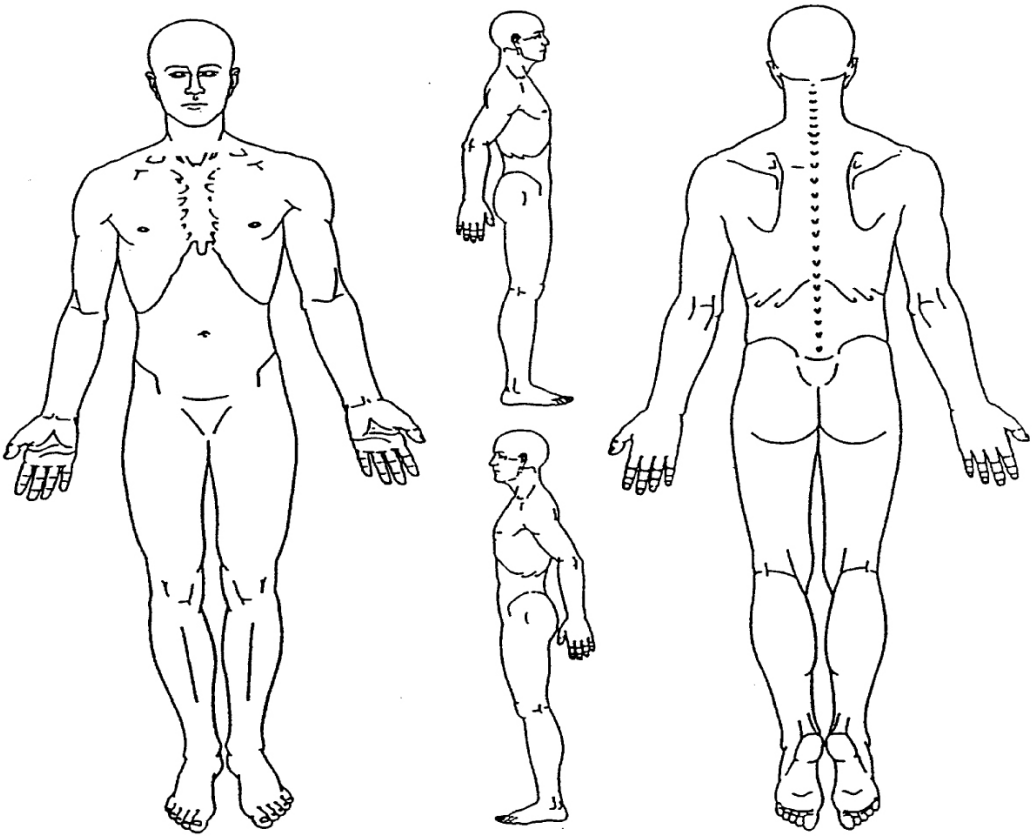
History of cancer □ History of HIV/AIDS □ Use of anabolic steroids □ Use of intravenous drugs □ Blood transfusions □

* 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..... 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_____

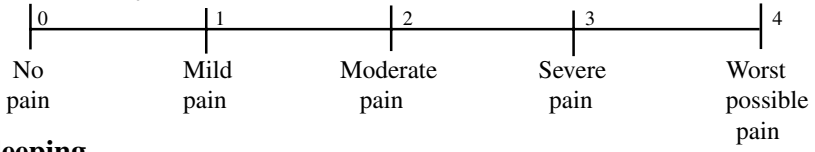
form 102

Functional Rating Index

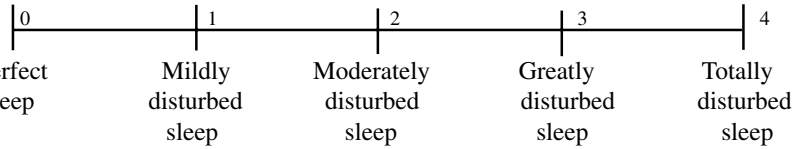
For use with **Neck and/or Back Problems** only.

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.**

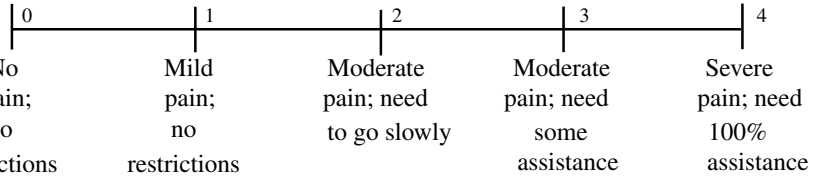
1. Pain Intensity



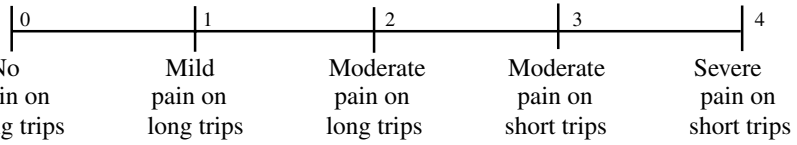
2. Sleeping



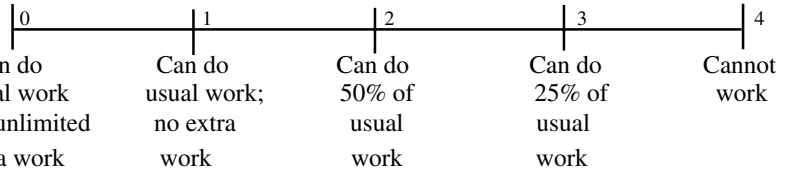
3. Personal Care (washing, dressing, etc.)



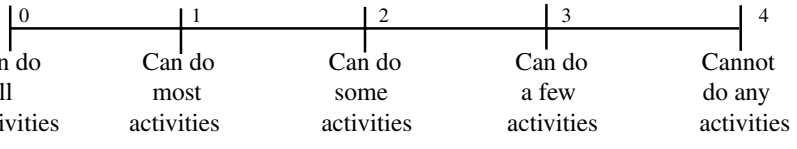
4. Travel (driving, etc.)



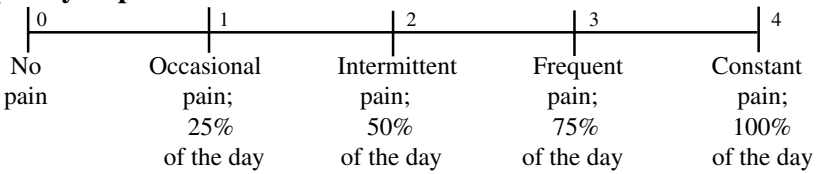
5. Work



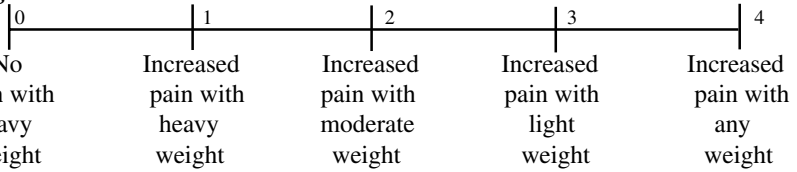
6. Recreation



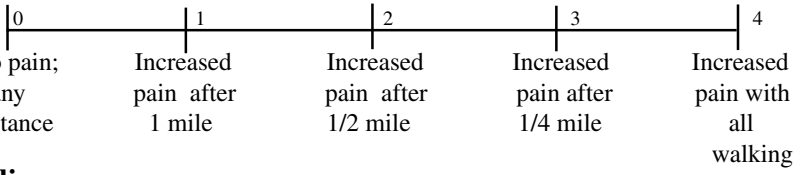
7. Frequency of pain



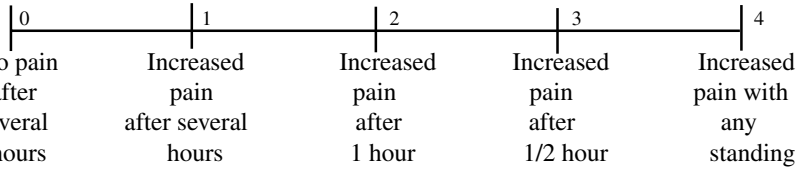
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

PEAK PERFORMANCE
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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.

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