The Chiropractic Office of Dr. Gene Ross
7020 Cold Harbor Rd.
Mechanicsville, VA 23111

PATIENT INFORMATION

Last Name ___________________________ First Name ___________________________ Middle ______________________
Date of Birth: ________________________ Social Security #: _______-______-_______
Home Address ____ Apt #_________________________
City ____ State _____________________ Zip______________________
Home Phone # ___________________________________Work Phone #____
Cell Phone# ____________________________________ Email Address: ____
Preferred Communication _______________________ Shoe Size: ____
Gender: M F Marital Status: S M D W Smoker? Y N Ethnicity: ______________________
Primary Insurance Company: ___________________________ Occupation: _____________________________________

PATIENT HISTORY

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye

☐ Other: ____

Please list **ALL Medications** you are taking, the **amount**, and the **reason** for each one:

____

____

____

My Certification

I certify that the above information is correct and I request services.

x ____ ___________________________________
Signature of patient or person acting on patient's behalf Date

MY Privacy

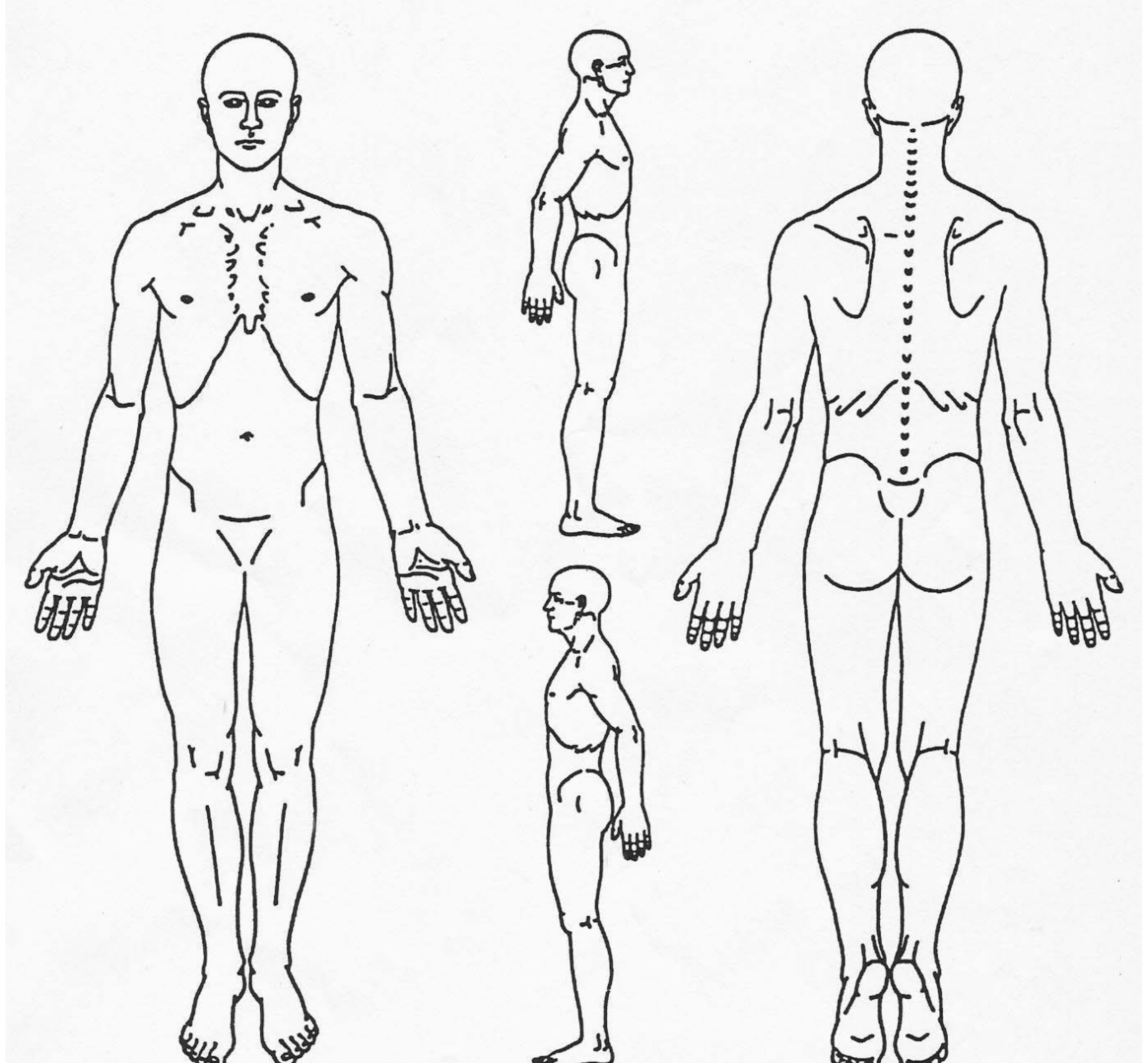
I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers'; Conduct normal healthcare operations such as quality assessments and accreditation.

x ____ ___________________________________
Signature of patient or person acting on patient's behalf Date

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

Ache	**Burning**	**Radiating Pain**	**Dull Pain**
Numbness	**Stabbing**	**Pins & Needles**	**Other**



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Place the number of how you would rate your pain next to each area of complaint on the diagram above.

How long have you experienced neck/back /other pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck/back/other pain? Y/N

SIGNATURE: ____ DATE: ____________________________

What is your **FIRST** major complaint? ____________________When did it begin? ______________
How did this problem begin (falling, lifting, etc.)? ______________________
Have you had this condition in the past? □ No □Yes
What interventions have you sought out for this complaint? ______________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:____

What makes your pain better (ice, heat, massage, etc.)____

What activities aggravate your condition (working, exercise, etc.)?________________________________

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What is your **SECOND** major complaint? ____________________When did it begin? ______________

How did this problem begin (falling, lifting, etc.)? ______________________
Have you had this condition in the past? □ No □Yes
What interventions have you sought out for this complaint? ______________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other:____

What makes your pain better (ice, heat, massage, etc.)____

What activities aggravate your condition (working, exercise, etc.)?________________________________

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

What is your **THIRD** major complaint? ______________________When did it begin? ________________

How did this problem begin (falling, lifting, etc.)? _________________________
Have you had this condition in the past? ☐ No ☐ Yes
What interventions have you sought out for this complaint? _________________________
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other:____

What makes your pain better (ice, heat, massage, etc.)____

What activities aggravate your condition (working, exercise, etc.)?____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What is your **FOURTH** major complaint? ______________________When did it begin? ________________

How did this problem begin (falling, lifting, etc.)? _________________________
Have you had this condition in the past? ☐ No ☐ Yes
What interventions have you sought out for this complaint? _________________________
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other:____

What makes your pain better (ice, heat, massage, etc.)____

What activities aggravate your condition (working, exercise, etc.)?____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)