

*** Taylorville Lifelong Chiropractic Center * New Patient Information Worksheet ***

Name: _____ SS# : _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Birth Date: _____

Employed By: _____ Spouse Name: _____

Spouse's Birth Date: _____ Spouse's SS#: _____

Referred By: (Friend) (Relative) (Newspaper Ad) (Yellow Pages) (Sign) (Other: _____)

Which one of our patient's can we thank for referring you? _____

Please circle your current symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain)

(Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain) (Chest

Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other): _____

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

List all surgeries in the past five years: _____

Have you ever had spinal surgery? (No) (Yes): _____

List any serious condition the doctor should be aware of: _____

Previous Chiropractor: _____ **Were you satisfied?** (No) (Yes)

***Females: Are you pregnant at this time?** (No) (Yes) **Due Date:** _____

Office Policies: *If I am accepted as a patient at the Taylorville Lifelong Chiropractic Center I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

Consent To Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Ed to proceed with any necessary treatment. I have read Dr. Ed's office policies and consent to treat information, and I agree with them by signing below:*

Signature: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____

Taylorville Lifelong Chiropractic Center

Dr. Ed Picone
400 W. Market
Taylorville, IL 62568
Ph: (217) 287-1040

Patient Health History Worksheet

Patient's Name: _____ Date: _____

Significant Past Health History

Have you ever been hospitalized?

- a) No
- b) Yes: Year: _____ Reason: _____

Have you ever had any surgeries?

- a) No
- b) Yes: _____

Significant Past Medical History

Have you seen another doctor for this condition?

- a) No
- b) Yes: Name: _____

Did this doctor recommend any treatment?

- a) No
- b) Yes: _____

Are you taking any medications?

- a) No
- b) Yes: _____

Significant Past Social History

Do you play any sports or exercise?

- a) No
- b) Yes: _____

How many hours do you sleep a night? _____

How many hours a week do you work? _____

Significant Family Medical History

Did your father have any health problems?

- a) No
- b) Yes: _____

Did your mother have any health problems?

- a) No
- b) Yes: _____

Did your sister(s) have any health problems?

- a) No
- b) Yes: _____

Did your brother(s) have any health problems?

- a) No
- b) Yes: _____

Did your grandpa have any health problems?

- a) No
- b) Yes: _____

Health Risk Factors

Do you drink alcohol?

- a) No
- b) Yes: _____

Do you smoke?

- a) No
- b) Yes: _____

Anything else the doctor should know about?

- a) No
- b) Yes: _____

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Patient's Name: _____ Date: _____

Please circle the number that most clearly describes your chief complaint(s) today:

1. Pain Intensity

(0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Mild Pain Moderate Pain Severe Pain Worst Possible Pain

2. Frequency of Pain

(0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Occasional Pain Intermittent Pain Frequent Pain Constant Pain
25% Of The Day 50% Of The Day 75% Of The Day 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

(0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
No Restrictions No Restrictions Need to go slowly Need some assistance Need 100% assistance

4. Travel (Driving, Riding, etc.)

(0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
On Long Trips On Long Trips On Long Trips On Short Trips On Short Trips

5. Work

(0) ----- (1) ----- (2) ----- (3) ----- (4)
Can Do Usual Work Can Do Usual Work Can Do 50% Can Do 25% Cannot Work
Plus Extra Work No Extra Work Of Usual Work Of Usual Work

6. Recreation

(0) ----- (1) ----- (2) ----- (3) ----- (4)
Can Do All Can Do Most Can Do Some Can Do A Few Cannot Do Any
Activities Activities Activities Activities Activities

7. Sleeping

(0) ----- (1) ----- (2) ----- (3) ----- (4)
Perfect Mildly Moderately Greatly Totally
Sleep Disturbed Disturbed Disturbed Disturbed

8. Lifting

(0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Increased Pain Increased Pain Increased Pain Increased Pain
With Heavy Weight With Heavy Weight With Moderate Weight With Light Weight With Any Weight

9. Walking

(0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Increased Pain Increased Pain Increased Pain Increased Pain
Any distance After One Mile After Half Mile After Quarter Mile With All Walking

10. Standing

(0) ----- (1) ----- (2) ----- (3) ----- (4)
No Pain Increased Pain Increased Pain Increased Pain Increased Pain
After Several Hours After Several Hours After One Hour After Half Hour With Any Standing

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Patient Health History Worksheet

Patient's Name: _____ Date: _____

Present Health History

When did your present condition begin?

- a) Gradual Onset (no specific date)
- b) Date: _____

What caused your present condition?

- a) No specific injury
- b) Home accident
- c) Work accident
- d) Auto accident

What happened to cause your present pain?

Have you ever had these symptoms before?

- a) No
- b) Yes: Date: _____

What time of day are your symptoms **better**?

- a) Morning
- b) Afternoon
- c) Evening
- d) All of the above (constant pain)

What time of day are your symptoms **worse**?

- a) Morning
- b) Afternoon
- c) Evening
- d) All of the above (constant pain)

Have you missed any work from this condition?

- a) No
- b) Yes: Date: _____

What makes your pain **better**?

- a) Rest
- b) Ice packs/Heating pads
- c) Prescriptions Medications
- d) Drug store medications (Ibuprofen, Advil)
- e) Other: _____

What makes your pain **worse**?

- a) Activity (work, repetitive motions)
- b) Ice packs/Heating pads
- c) Exercise
- d) Other: _____

What home remedies have you tried?

- a) Ice packs
- b) Heating pads/Hot tubs
- c) Exercise
- d) Other: _____

Please label the area(s) of today's pain:



