SPINE INSTITUTE OF SCHERERVILLE

833 W. Lincoln Hwy (Rte. 30) • Suite 310E • Schererville, IN 46375

Patient Name _____ Birthdate _____ Sex: M/F
Address _____ City _____
State _____ Zip _____ Home Phone _____ Cell Phone _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID# _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

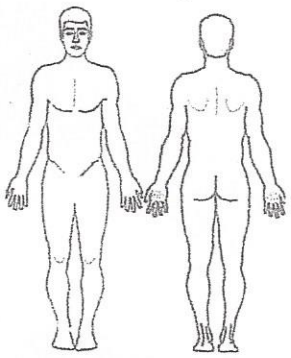
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began _____

How Problem Began _____



Current Complain (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores?)

(No interference) 0 1 2 3 4 5 6 7 8 9 10 (Unable to carry on any activities)

In general would you say your overall health right now is?

☐ Excellent ☐ Very Good ☐Good ☐Fair ☐Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ Yes ☐ No

Date(s) Taken _____ **what areas were taken?** _____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date) _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain) _____
☐ Osteoporosis
☐ Epilepsy/ Seizures
☐ Other Health Problems (Explain) _____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Stiffness/Pain
☐ Pain Unrelieved by Position or Rest
☐ Visual Disturbances
☐ Surgeries _____
☐ Tobacco Use – Type _____
Frequency _____/ Day
☐Medications _____

Family History:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, of if I am not eligible to receive health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____