

## Finnegan Family Chiropractic \* New Patient Information Worksheet

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (H/C): \_\_\_\_\_ (W): \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Email: \_\_\_\_\_ Referred By: (Friend) (Relative) (Sign) (Other \_\_\_\_\_)

Which one of our patient's should we thank for referring you?: \_\_\_\_\_

### Please Circle Your CURRENT Symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder / Upper Arm Pain) Forearm / Wrist / Hand 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) (Other: \_\_\_\_\_)

List all surgeries in the past five (5) years: \_\_\_\_\_

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

List any serious conditions the doctor should be aware of: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Were you satisfied? (No) (Yes)

**\*Pregnancy Release:** *This is to certify that to the best of my knowledge I am not pregnant and Dr. Finnegan and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.*

Are you pregnant at this time? (No) (Yes) Due Date: \_\_\_\_\_

**Office Policies:** *If I am accepted as a patient at Finnegan Family Chiropractic, I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without talking with the doctor, 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. Finnegan to proceed with any necessary treatment. I have read Dr. Finnegan's office policies and consent to treat information, and I agree with them by signing below. I understand that I can receive a copy of the Informed Consent upon request.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Please circle the number which most closely 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  
 No 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 Needs some assistance Needs 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 All 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

# Finnegan Family Chiropractic \* New Patient Information Worksheet

## Patient Health History Worksheet

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Significant Past Health History

Have you even been hospitalized?

- a) No  
 b) Yes: (Year: \_\_\_\_\_)  
 (Reason: \_\_\_\_\_)

Have you had any surgeries?

- a) No  
 b) Yes: (Year: \_\_\_\_\_)  
 (Reason: \_\_\_\_\_)

Do you have any significant health problems?

- a) No  
 b) Yes: \_\_\_\_\_

### Significant Past Medical History

Have you seen another doctor for this condition?

- a) No  
 b) Yes: \_\_\_\_\_

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 exercises?

- 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 brother(s) have any health problems?

- a) No  
 b) Yes: \_\_\_\_\_

Did your sister(s) have any health problems?

- a) No  
 b) Yes: \_\_\_\_\_

Did your grandfather have any health problems?

- a) No  
 b) Yes: \_\_\_\_\_

Did your grandmother 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: \_\_\_\_\_

Patient Health History Worksheet

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Present Health History

When did your 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) None 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 / Heat
c) Prescription Medication
d) Drug store Medication (ibuprofen, Advil)
e) Other: \_\_\_\_\_

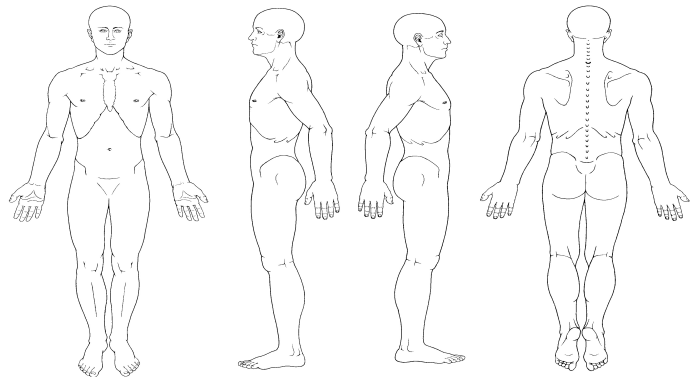
What makes your pain worse?

- a) Activity (work, repetitive motions)
b) Ice / Heat
c) Driving (or riding) in a car
d) Other: \_\_\_\_\_

What home remedies have you tried?

- a) Ice
b) Heat / Hot shower
c) Exercise
d) Other: \_\_\_\_\_

Please Label The Area(s) Of Today's Pain



\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_