DR. JUNE M. SHELL, DC PATIENT HEALTH ASSESSMENT

FILL OUT LEFT TO RIGHT

Patient Name:_____ Preferred 1st Name:_____ Today's Date:_____/____/____
Social Security No.:_____ Date of Birth: ____/____/_____ Sex: M F
Home Address:_____ City:_____ State:_____ Zip:_____
Home Phone No:_____ **Cell Phone**: _____ **e-mail** _____
Status: Single Married Widowed Other Spouses Name:_____ Children: No Yes # _____
Employer:_____ Occupation:_____ How Long?_____
Employer's Address:_____ City:_____ State:_____ Zip:_____
Insured's Name:_____ Insured's DOB:____/____/____ Relation to Patient:_____
Insured's S.S. No.:_____ Ins. Co. _____ Primary Care Dr. _____
Insured's Employer:_____ Insured's Occupation:_____ **Referred by**: _____

COMPLAINT HISTORY:

1. **Describe your current complaint**:_____
   Date of Onset:___/___/___ Time of Day:_____AM/PM

2. How many days have you experienced symptoms prior to seeking care here? □ Less than eight days □ More than eight days

3. The number of previous episodes of the current complaint you have experienced in your lifetime?
   Think carefully, this is very important: □ 0-3 episodes □ 4-7 episodes □ 8 or more episodes

4. Describe the pain:
   □ Dull □ Ache □ Sharp □ Stiffness □ Spasm □Soreness □ Boring
   □ Shooting □ Burning □ Throbbing □ Weakness □ Numbness □ Tingling □ Stabbing

5. Rate the intensity:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Low Pain Moderate Pain Intense Pain Emergency

6. How often is the pain present?
   □ Constant (81-100%) □ Frequent (51-80%) □ Occasional (26-50%) □ Intermittent (25% or less)

7. Time of day when your problem is the worse?_____AM/PM Time of day when your condition is the best?_____AM/PM

8. Since your problem began is the pain or dysfunction: □ Getting worse □ Getting better □ Staying the same

9. How did your problem begin?
   □ Gradual □ Sudden □ No Specific Reason □ Auto Accident □ Work Accident
   Explain what triggered your problem:_____

10. What makes your problem better?
    □ Nothing □ Walking □ Standing □ Sitting □ Movement □ Medication □ Stretching □ Chiropractic treatment
    □ Massage □ Ice □ Heat □ Exercise □ Inactivity □ Lying down

11. What makes your problem worse:
    □ Nothing □ Walking □ Standing □ Sitting □ Movement □ Stairs □ Driving □ Lifting □ Sleeping □ Stretching
    □ Massage □ Ice □ Heat □ Exercise □ Inactivity □ Lying down

12. Are you currently taking any medications/supplements? □Yes □ No If yes, describe:_____

13. Were you previously treated for an earlier occurrence of this same condition? □ Yes □ No
    If yes, by whom? □ MD □ Chiropractor □ Phys. Therapist □ Other:_____
    Dr's. name and location:_____ Were X-rays taken? □ Yes □ No
    Approximate dates, type and results of treatment:_____

14. What most accurately describes your physical activity at work?
    □ Computer workstation □ Standing w/o motion □ Light manual labor □ Moderate manual labor □ Heavy manual labor

15. Are there any repetitive activities which affect your condition? Example: Repetitive keyboard & mouse entry at computer workstation
    □ Yes □ No If yes, please list them _____

16. Do you exercise?
    □ No regular exercise □ 1-2 times a week □ 3-4 times a week □ 5-7 times a week
    □ Cardiovascular exercise □ Stretching □ Machine Weights □ Free Weights □ Other_____

17. Rate your general stress level; □ No stress □ Minimal stress □ Moderate stress □ Intense stress

18. Is your problem affecting your ability to work or perform normal daily activities?
    □ No effect □ Some limited physical restrictions, but can function □ Need some assistant with daily activities
    □ Cannot work □ Cannot function without assistance □ Totally disabled

19. Activities of daily life affected: □ **Be**nding □ **L**ifting □ **W**alking □ **St**anding □ **Si**tting □ **D**ressing □ **Ba**thing □ **Sl**eeping □ **Sp**orts □ **Ex**ercise □ **C**omputer □ **Dr**iving □ **Co**oking □ **Cl**eaning □ Dealing with **ch**ildren □ **G**ardening

20. Lifestyle:

□ Tobacco use:	□ Past	□ Present	□ Occasional	□ Moderate	□ Heavy
□ Alcohol use:	□ Past	□ Present	□ Occasional	□ Moderate	□ Heavy
□ Coffee, Tea, Soda use:	□ Past	□ Present	□ Occasional	□ Moderate	□ Heavy
□ OTC drug (aspirin, etc):	□ Past	□ Present	□ Occasional	□ Moderate	□ Heavy

21. Family Health History: Associate Health Problems family members _____

_____

22. Deaths - immediate family-parents/siblings Relative Cause Age at death

_____

_____

Instructions: The following scales have been designed to find out abut your pain and how it is affecting you. Please circle the number that best describes the question asked. Please indicate (B) for back and/or (N) for neck pain above the number.

1. On the average, how would you rate your pain right now.

No pain _____ worse

0 1 2 3 4 5 6 7 8 9 10

2. How much has your pain interfered with you daily activities (housework, dressing, waking, stairs, getting in/out of bed/chair)?

No interference _____ Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. How much has your pain interfered with your ability to take part in recreational, social, and family activities?

No interference _____ Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. How have you felt your work (both inside and outside the home) has affected/or would affect your pain?

No worse _____ Much worse

0 1 2 3 4 5 6 7 8 9 10

5. How much have you been able to control (reduce/help) your pain on your own?

Completely control it _____ No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

PAST or PRESENT SYMPTOMS/CONDITIONS

Symptom/Condition	Past	Present	Symptom/Condition	Past	Present	System/Condition	Past	Present
Neck Pain	□	□	Artificial Bones/Joints	□	□	Menstrual problems	□	□
Shoulder pain	□	□	High/Low blood pressure	□	□	Breast soreness/lumps	□	□
Arm/Elbow pain	□	□	Heart Condition/Pacemaker	□	□	Gynecological disorder	□	□
Wrist/Hand pain	□	□	Allergies/Asthma	□	□	Pregnancy	□	□
Upper Back pain	□	□	Respiratory condition	□	□	Skin condition	□	□
Lower Back pain	□	□	Sinus condition	□	□	Diabetes – Type I/Type II	□	□
Hip/Thigh pain	□	□	Stroke/Vascular disease	□	□	Excessive/difficult urination	□	□
Knee/Leg pain	□	□	Gastrointestinal condition	□	□	Diarrhea/Constipation	□	□
Ankle/Foot pain	□	□	Kidney/Urine Bladder	□	□	Prostate condition	□	□
Jaw pain/dysfunction	□	□	Liver/Gallbladder	□	□	Fainting/Seizures/Epilepsy	□	□
Headaches	□	□	Ear/Nose/Throat condition	□	□	Dizziness/ringing in ears	□	□
Arthritis/Swollen/Stiff joints	□	□	Excessive weight gain/loss	□	□	Anemia/Blood disorder	□	□
Skeletal anomaly/Scoliosis	□	□	Cancer/Leukemia	□	□	Plastic Surgery	□	□
Disc Disease/Herniation	□	□	Psychiatric condition	□	□	Sexual Disease/HIV+/AIDS	□	□
						Endocrine Disorders	□	□

List any other Medical condition(s) you've experienced: _____

List any surgeries and/or hospitalization w/dates: _____

List any accidents, sports injuries, falls, etc. w/dates: _____

If you feel more comfortable with another person present during the exam and/or treatments, please inform the Doctor verbally and check the appropriate box: ☐ Yes, this is important to me. ☐ No, this is not an issue

_____ _____

Patient's Signature Date Dr. June M. Shell, DC Date