*deBarros Chiropractic Clinic*
*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

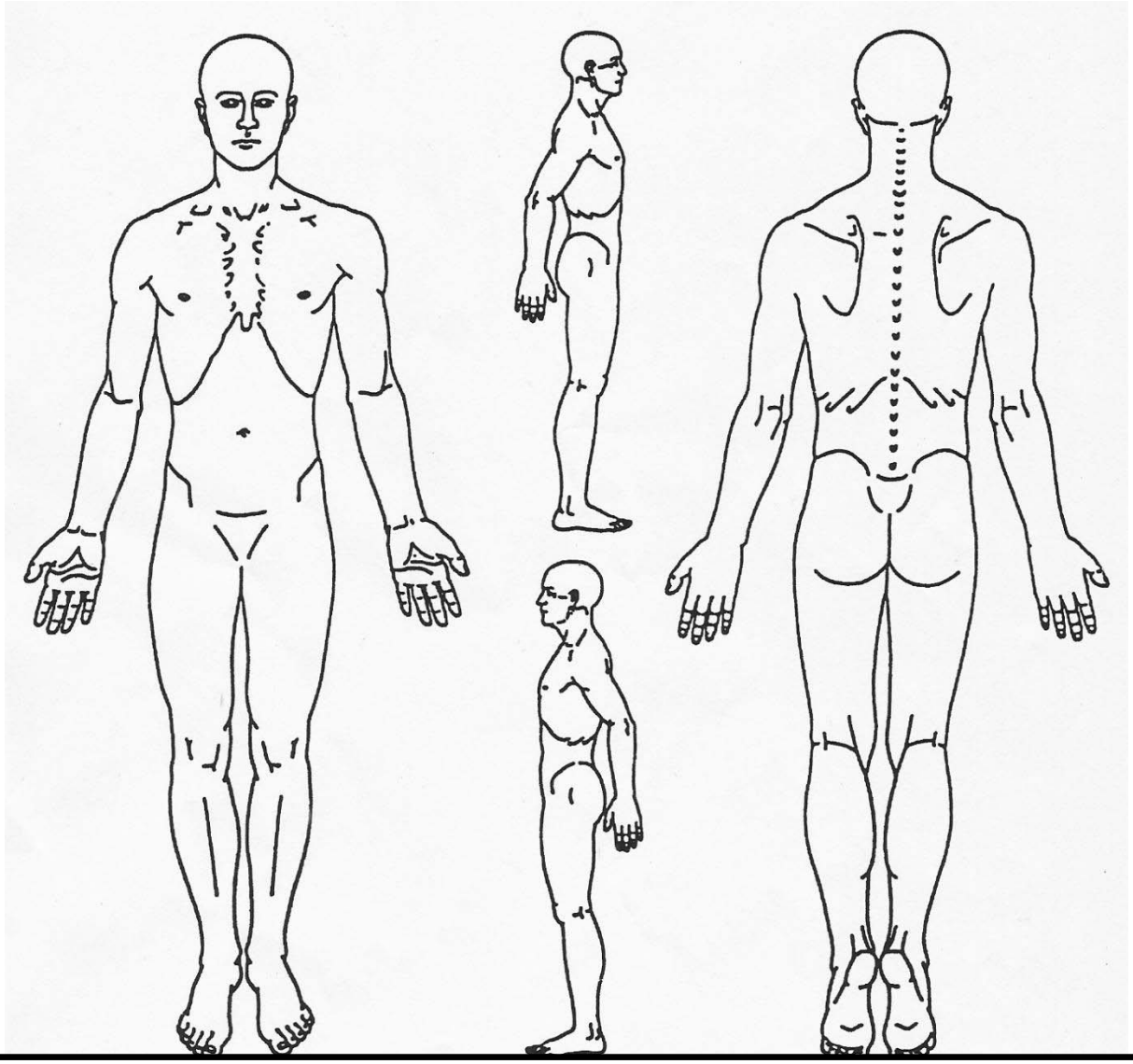
I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who 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) ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ (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)