Clugston Chiropractic Center, P.C.

DATE: ___________

PATIENT INFORMATION

Name: ____________________ ☐ M ☐ F Birthdate: ____/____/____ Age: ______

Address: ____________________ City: ____________________ State: ________ Zip: ______

Social Security Number: ________-________-________ ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Home #: ____________________ Cell #: ____________________ Email: ____________________

Preferred contact method: ☐ Home ☐ Work ☐ Cell

Are you interested in receiving text appt. reminders? ☐ Y ☐ N If yes: Cell phone carrier ____________________

Spouse's Name: ____________________ Do you have children? ☐ Y ☐ N How Many? ________________

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

RACE: ☐ American Indian ☐ Asian ☐ Black, African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Decline

How did you hear about us? ____________________

EMERGENCY CONTACT

Name: ____________________ Relationship: ____________________ Phone: ____________________

INSURANCE INFORMATION

Insurance Company: ____________________ Contract No. ____________________ Group No. ____________

OCCUPATION

Employer Name: ____________________ Employer Phone No. ____________________

Occupation: ____________________ My job duties include: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

PATIENT COMPLAINTS (Please check all that apply)

Current	Past	Complaint
☐	☐	Neck pain
☐	☐	Neck Stiffness
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Head feels heavy
☐	☐	Twitching of face
☐	☐	Grating in neck
☐	☐	Muscle spasms in neck
☐	☐	Arm pain ☐ L / ☐ R
☐	☐	Arm Numbness ☐ L / ☐ R
☐	☐	Wrist pain ☐ L / ☐ R
☐	☐	Hand Numbness ☐ L / ☐ R
☐	☐	Cold Hands ☐ L / ☐ R
☐	☐	Pain in ears ☐ L / ☐ R

Current	Past	Complaint
☐	☐	Mid back pain
☐	☐	Mid back stiffness
☐	☐	Shoulder pain ☐ L / ☐ R
☐	☐	Shoulder tightness ☐ L / ☐ R
☐	☐	Rib pain ☐ L / ☐ R
☐	☐	Pain in side ☐ L / ☐ R
☐	☐	Chest Pain ☐ L / ☐ R
☐	☐	Low back pain
☐	☐	Low back stiffness
☐	☐	Hip pain ☐ L / ☐ R
☐	☐	Leg pain ☐ L / ☐ R
☐	☐	Leg numbness ☐ L / ☐ R
☐	☐	Knee pain ☐ L / ☐ R
☐	☐	Pain in feet ☐ L / ☐ R

Current	Past	Complaint
☐	☐	Feet Numbness ☐ L / ☐ R
☐	☐	Constipation
☐	☐	Poor circulation
☐	☐	High blood pressure
☐	☐	Asthma
☐	☐	Loss of balance
☐	☐	Loss of taste
☐	☐	Fatigue
☐	☐	Nervousness
☐	☐	Sleeping trouble
☐	☐	Arthritis
☐	☐	Painful joints
☐	☐	Swollen joints
☐	☐	Menstrual irregularity

HISTORY

Are your complaints related to an accident? ☐ yes ☐ no If yes, ☐ work related ☐ auto ☐ other ___________________

Does your pain interfere with your? ☐ Work ☐ Sleep ☐ Daily Routines ☐ Recreation

Is it possible that you are pregnant? ☐ no ☐ yes

Have you ever had any injuries, accidents, or falls *(even if you think you were not hurt at the time)*? ☐ No ☐ Yes, if yes please indicate below.

When? Month_______ Year_______ Type of injury: ____

When? Month_______ Year_______ Type of injury: ____

When? Month_______ Year_______ Type of injury: ____

Primary Care Physician Information

Practice Name: _________________________ Doctor Seen: ________________________ Office Phone #: ___________________

Please indicate any treatments/testing you have received and where

☐ Chiropractic Where: _______________________________________ Phone No. _____________________

☐ Physical Therapy Where: _______________________________________ Phone No. _____________________

☐ Surgery Where: _______________________________________ Phone No. _____________________

☐ MRI Where: _______________________________________ Phone No. _____________________

☐ CT Scan Where: _______________________________________ Phone No. _____________________

☐ Medical Doctor Where: _______________________________________ Phone No. _____________________

☐ Other _________________ Where: _______________________________________ Phone No. _____________________

SURGERIES

Surgery	Month/Year	Surgery	Month/Year
_____________________________	__________	____________________________	__________
_____________________________	__________	____________________________	__________

Have you had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Anemia	☐	☐	Anxiety
☐	☐	Bleeding disorders	☐	☐	Cancer	☐	☐	Chemical dependency
☐	☐	Depression	☐	☐	Diabetes	☐	☐	Epilepsy/Siezures
☐	☐	Fractures	☐	☐	Heart disease	☐	☐	Hepatitis
☐	☐	Hernia	☐	☐	Herniated disc	☐	☐	High cholesterol
☐	☐	Multiple sclerosis	☐	☐	Osteoporosis	☐	☐	Pacemaker
☐	☐	Parkinson's disease	☐	☐	Polio	☐	☐	Prostate problems
☐	☐	Prosthesis	☐	☐	Psychiatric care	☐	☐	Stroke
☐	☐	Suicide attempt	☐	☐	Thyroid problems	☐	☐	Tumors
☐	☐	Ulcers	☐	☐	Other ____			

MEDICATIONS, VITAMINS, AND SUPPLEMENTS

Medication	Dosage (ex. Mg)	Vitamin/Supplement	Dosage
______________________________	__________	___________________________	__________
______________________________	__________	___________________________	__________
______________________________	__________	___________________________	__________
______________________________	__________	___________________________	__________

ALLERGIES & MEDICATION ALLERGIES

ALLERGIC TO:________________________REACTION: ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

ALLERGIC TO:________________________REACTION: ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

ALLERGIC TO:________________________REACTION: ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

SOCIAL

My exercise level is: ☐ Intense ☐ Moderate ☐ Light ☐ Minimal ☐ None

My habits include: ☐ Smoking/Tobacco use _______packs/day (current smoker) ☐ never smoked ☐ former smoker

☐ Alcohol _______drinks/week

☐ Coffee _________cups/day ☐ Soda Pop _________cups/day ☐ Tea _________cups/day

☐ Recreational drug use ☐ Other ____

FAMILY

Please mark the conditions that relate to your parents, siblings, or grandparents.

	Diabetes	Heart Disease	Cancer	Stroke	Thyroid	Arthritis	Mental Illness	Auto Immune	Back/ Spine	High Blood Pressure	Osteoporosis	High cholesterol
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s) # of: _______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s) # of: _______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (maternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (maternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (fraternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (fraternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SUBJECTIVE FINDINGS *PAIN CLASSIFICATION*

CERVICAL:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
THORACIC	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
LUMBAR:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
PELVIC:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant

OBJECTIVE FINDINGS

CERVICAL: Muscle Spasms ☐ L ☐ R ☐ Fixations ______

THORACIC: Muscle Spasms ☐ L ☐ R ☐ Fixations ______

LUMBAR: Muscle Spasms ☐ L ☐ R ☐ Fixations ______

PELVIS: Muscle Spasms ☐ L ☐ R ☐ Fixations ______

RANGE OF MOTION	CERVICAL				LUMBAR			
	+	-	RESULT	NORM	+	-	RESULT	NORM
Flexion				45				90
Extension				45				30
Lateral Flexion				45R				30R
Lateral Flexion				45L				30L
Rotation				80R				30R
Rotation				80L				30L

NEUROLOGICAL

Absent	Hypoactive	Normal	Hyperactive	Hyperactive w/TC	Hyperactive w/SC
0	1+	2+	3+	4+	5+

C5	Biceps	L ______	R ______
C6	Brachioradialis	L ______	R ______
C7	Triceps	L ______	R ______
L2-4	Patellar	L ______	R ______
SI	Achilles	L ______	R ______

Babinski Reflex ☐ **POS** ☐ **NEG**

AREAS OF TENDERNESS

CERVICAL: ☐ L ☐ R _______

DORSAL: ☐ L ☐ R _______

LUMBAR: ☐ L ☐ R _______

PELVIC: ☐ L ☐ R _______

POSTURAL DISTORTION

HEAD TILT: ☐ L ☐ R

Shoulder High On: ☐ L ☐ R

Ilium High On: ☐ L ☐ R

Forward Head Carriage: ☐ Y ☐ N

ORTHOPEDIC TESTS

	L	R	N
Foraminal Compression………………………..	☐	☐	☐
Shoulder Depression…………………………….	☐	☐	☐
Cervical Syndrome……………………………….	☐	☐	☐
Supine Leg Check ………………………………..	☐	☐	☐
Soto-Hall ……………………………………………	☐	☐	☐
Minor's Sign……………………………………….	☐	☐	☐
Bechterew's Test…………………………………	☐	☐	☐
Kemp's………………………………………………	☐	☐	☐
Lindner's……………………………………………	☐	☐	☐
Braggard's…………………………………………	☐	☐	☐
Bilateral Leg lower/raise………………………..	☐	☐	☐
Heel and Toe Test…………………………………	☐	☐	☐
Nachla's Test……………………………………….	☐	☐	☐
Ely's Test……………………………………………	☐	☐	☐
Hibbs…………………………………………………	☐	☐	☐
Fabere-Patrick……………………………………..	☐	☐	☐
Gaenslen's Test……………………………………	☐	☐	☐
Lasegue's ______ L ______R…………………	☐	☐	☐
Apley's Scratch Test (shoulder)……………….	☐	☐	☐
Apley's Aprehension (knee)…………………….	☐	☐	☐

X-RAY REPORT & SPINAL ANALYSIS

At ☐	1L ☐		
Ax ☐	2 ☐		
3 ☐	3 ☐		
4 ☐	4 ☐		
5 ☐	5 ☐		
6 ☐			
7 ☐	L. Ilium		
1D ☐	PI ☐		
2 ☐	As ☐		
3 ☐	In ☐		
4 ☐	Ex ☐		
5 ☐			
6 ☐	R. Ilium		
7 ☐			
8 ☐	PI ☐		
9 ☐	As ☐		
10 ☐	In ☐		
11 ☐	Ex ☐		
12 ☐			

Osteophytic Changes C ☐ T ☐ L ☐

Degeneration C ☐ T ☐ L ☐

Loss of Lordotic Curve C ☐ L ☐

Spina Bifida

Sacralization L ☐ R ☐

Lumbarization L ☐ R ☐

Neuroforaminal Stenosis C ☐ L ☐

Scoliosis (Lateral Curve)

Cervical ☐ L ☐ R

Thoracic ☐ L ☐ R

Lumbar ☐ L ☐ R

Spondylolisthesis Grade _____________

Retrolisthesis Grade _____________

Compression Fracture

Osteoporosis

☐ mild ☐ moderate ☐ severe

Spinal Fusion

☐ congenital ☐ surgical

Ht. _______ Wt _______ Blood Pressure _______ Ambulatory ☐ Yes ☐ No Antalgia ☐ Yes ☐ No

Subluxation	Connective Tissue	Nerve Tissue	Bio Mech.	Symptom

Special Instructions:

____

____

____

CORRECTIVE CARE PLAN

☐ Daily visits for _______________ weeks

☐ 3 visits per week for __________ weeks

☐ 2 visits per week for __________ weeks

☐ 1 visit per week for ___________ weeks

☐ 1 visit every 2 weeks ☐ 1 visit per month

M T W TH F SA SU

☐ Spinal Manipulation

☐ Traction

☐ Ice ☐ Heat

☐ Spinal Decompression

☐ Laser

☐ Massage

☐ Exercises

____

Doctor Signature Date