CHIROPRACTIC
LAKE MERIDIAN
P.S.

PATIENT REGISTRATION FORM

Name _____MI _____ Last Name _____

Preferred Name _____

DOB _____

Email_____

Address _____

City _____State _____Zip _____

Cell Phone _____ Home Phone _____

Marital Status: ____ Single ____Married ____Separated ____Divorced ____Widowed

How did you hear about us? ___Doctor ___Friend ___Family Member ___Insurance Book ___Friend
___Website ___Social Media ___Other_____

Whom may we thank for referring you? _____

Primary Care Physician _____

Phone_____

Employment Status: ___Full-Time ___ Part-Time ___Self Employed ___ None ___Disabled ___Student

Patient's Employer _____Work Phone _____

Address _____

City _____State _____Zip _____

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LAKE MERIDIAN
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Emergency contact name _____

Phone_____

Relationship _____

Address _____

City_____State_____ Zip_____

Minor Consent: I authorize Lake Meridian to provide treatment for the minor listed above.

Parent Guardian _____Signature_____

Primary Insurance Name:_____ ID # _____

Subscriber Name:_____

Relationship to Subscriber: _____Self ___Spouse ____Child

Secondary Insurance Name:_____ ID # _____

Subscriber Name:_____

Relationship to Subscriber: _____Self ___Spouse ____Child

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Attorney's Name :_____

- Attorney's Phone # _____

Labor & Industries

- Date of Injury:_____ Claim # _____

Patient's Auto Insurance Name _____

- Phone #_____ Claim # _____

Other Driver Information: Name _____

- Address _____ City _____State _____Zip _____
- Drivers Ins. Co. _____
- Ins Co. phone # _____
- Claim # _____

Patient Signature_____

Date_____

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Current Symptoms

Name_____ Date_____

Reason for today's visit is a result of:
____Work Accident ____Auto Accident ____Sport Accident

____Trauma ____Chronic ____Check Up

Have you ever been treated by a Chiropractor before? ____Yes ____No

Major Concerns:

1. _____

How Intense? (0-Least; 10-Worst) 0 1 2 3 4 5 6 7 8 9 10

How Frequent? (Rarely - All the time) 25% 50% 75% 100%

Interfere with Work, Sleep, Daily Routine? W S D

2. _____

How Intense? (0-Least; 10-Worst) 0 1 2 3 4 5 6 7 8 9 10

How Frequent? (Rarely - All the time) 25% 50% 75% 100%

Interfere with Work, Sleep, Daily Routine? W S D

3. _____

How Intense? (0-Least; 10-Worst) 0 1 2 3 4 5 6 7 8 9 10

How Frequent? (Rarely - All the time) 25% 50% 75% 100%

Interfere with Work, Sleep, Daily Routine? W S D

4. _____

How Intense? (0-Least; 10-Worst) 0 1 2 3 4 5 6 7 8 9 10

How Frequent? (Rarely - All the time) 25% 50% 75% 100%

Interfere with Work, Sleep, Daily Routine? W S D

When did this first become a concern for you?_____

_____

Have you ever experienced these symptoms before? ____Yes ____No

If Yes, when?_____

Have you been treated for these past episodes(s)? ____Yes ____No

If Yes, by whom? Chiropractor MD Osteopath Physical Therapist
Massage Therapist Other_____

Is a doctor currently seeing you? ____Yes ____No
If Yes, by whom?_____

Goals of Treatment _____

Are you taking any of the following medications?

___Nerve Pills ___Pain Killers (or aspirin) ___Muscle Relaxers
___Insulin ___Stimulants ___Blood Thinners
___Hormones ___Birth Control ___Other_____

Are you wearing: ___Heel Lifts ___Arch Supports

Are any of the following in your family history?

___Caner ___Scoliosis ___Stroke
___Diabetes ___Heart Disease ___Blood Disease
___Blood Disease ___Multiple Sclerosis ___Other_____

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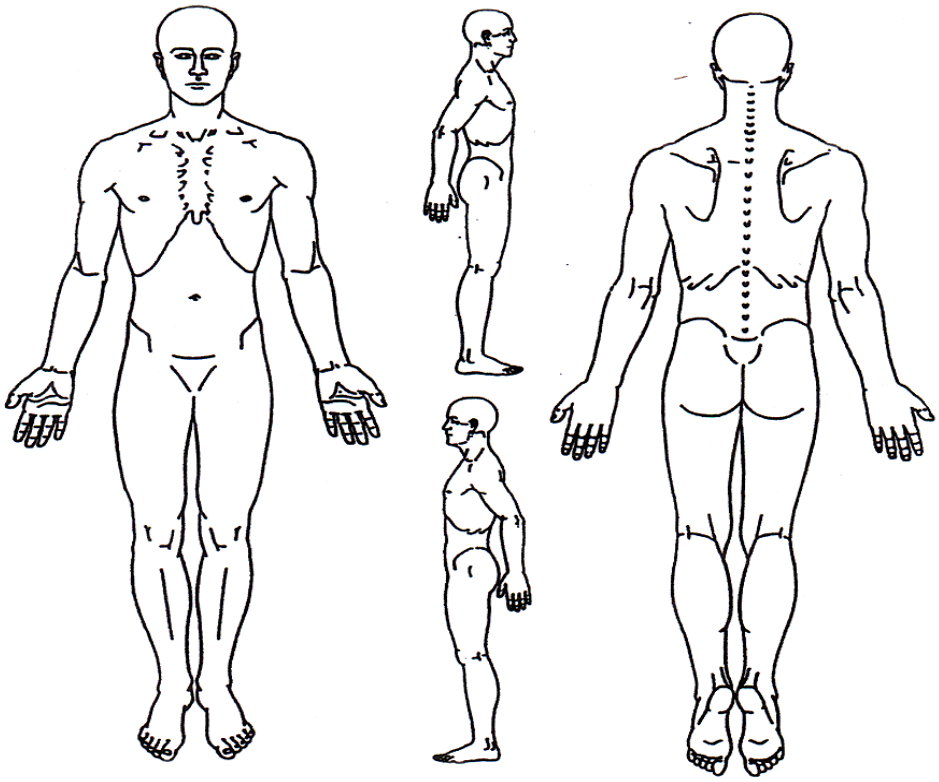
Indicate on the diagrams below the location/s and type of sensation/s you have been experiencing. Use the letters below to indicate the type of sensation. If the letters don't describe the sensation, write in your description of what you are feeling.

A - Ache	B - Burning	Co - Constrictive	C- Cramping	Cu- Cutting
D - Dull	N - Numbness	P - Pounding	S - Sharp	SH- Shooting
Sp - Spasm	St - Stinging	T - Tingling	TH - Throbbing	

O-Other_____



Recreational Activities:

Sports_____ How Often_____

Exercise_____ How Often_____

Hobbies_____ How Often_____

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Surgeries (please list the surgery and the year it was done)

Accidents (pleases list brief description and the year it happened)

Fractures (please list what was fractured and the year it happened)

Medical Conditions (Circle all that apply):

Alcoholism	Eczema	Pneumonia	Small Pox
Allergies	Epilepsy	Polio	Tuberculosis
Anemia	Heart Attach	Rheumatic	Typhoid Fever
Appendicitis	Hemophilia	Fever	Whooping
Arthritis	Hepatitis	Scarlet Fever	Cough
Cancer	Kidney Disease	Scoliosis	Other_____
Chicken Pox	Liver Disease	Sexually	None
Depression	Mumps	Transmitted	
Diabetes	Pleurisy	Disease	

Cigarettes	None	Light	Moderate	Heavy	Amount_____
Alcohol	None	Light	Moderate	Heavy	Amount_____
Recreational Drugs	None	Light	Moderate	Heavy	Amount_____

Signature_____Date_____

Name_____ Date_____

	Yes	No
1. Do you currently have any infections?		
2. Do you have spinal cancer?		
3. Do you have rheumatoid arthritis (RA)?		
4. Have you had a fracture in the past 3 months?		
5. Do you have osteoporosis? Do you know your score:		
6. Any spinal surgeries? Where:		
7. If so, how many in this region:		
8. Are you pregnant?		
9. Do you have any issues with abdominal pressure?		
10. Do you have any cardiac issues?		
11. Do you have any respiratory issues?		
12. Where do you feel most of your pain?		
13. How long have you had the pain here?		
14. On average, 0-10 scale (10 being highest), what is your pain level:		
15. What is the highest pain level: Lowest pain level:		

What is your goal of treatment?

Name_____ Date_____

FABQ

Here are some of the things which other patients have told us about their pain. For each statement, please circle any number from 0 to 6 to say how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely disagree			Unsure			Completely agree
1. My pain was caused by physical activity.	0	1	2	3	4	5	6
2. Physical activity makes my pain worse.	0	1	2	3	4	5	6
3. Physical activity might harm my back.	0	1	2	3	4	5	6
4. I should not do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6
5. I cannot do physical activities which (might) make my pain worse.	0	1	2	3	4	5	6

The following statements are about how your normal work affects or would affect your back pain.

	Completely disagree			Unsure			Completely agree
6. My pain was caused by my work or by an accident at work.	0	1	2	3	4	5	6
7. My work aggravated my pain.	0	1	2	3	4	5	6
8. I have a claim for compensation for my pain.	0	1	2	3	4	5	6
9. My work is too heavy for me.	0	1	2	3	4	5	6
10. My work makes or would make my pain worse.	0	1	2	3	4	5	6
11. My work might harm my back.	0	1	2	3	4	5	6
12. I should not do my normal work with my present pain.	0	1	2	3	4	5	6
13. I cannot do my normal work with my present pain.	0	1	2	3	4	5	6
14. I cannot do my normal work until my pain is treated.	0	1	2	3	4	5	6
15. I do not think that I will be back to my normal work within 3 months.	0	1	2	3	4	5	6
16. I do not think that I will ever be able to go back to work.	0	1	2	3	4	5	6

NECK BOURNEMOUTH QUESTIONNAIRE

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck 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. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____

Patient Name _____ Patient Signature _____

Examinner _____ Date _____ Score _____ (70)

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing 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. Over the past week, how much has your back 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. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short -form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.