

First Visit Date: \_\_\_\_\_

### Patient Information

Dodge Chiropractic, PLLC, at Soulitudes Wellness Center, 1387 Fairport Road, Building 500, Suite 520, Fairport, NY 14450

**Patient to complete the following sections:**

Patient Last Name	First Name	MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth
Patient Address		City		State	Zip Code
Home Phone #	Work Phone #		Height	Weight	
In case of emergency contact:	Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W	# of Children		Social Security #	
Referred By:	Previous chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Email: <i>(Always Kept Private)</i>			

**Insurance Information:**

Insured Last Name	First Name	MI	Insurance ID #	Date of Birth
Employer		Insurance Company Name		
Is Illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Do you have secondary insurance that might cover this injury/illness: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, other insurance company name:	

**Primary Care Physician Information:**

Doctor's Last Name	First Name	Have you seen your primary doctor for this complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date: _____		
Address	City	State	Zip Code	Phone Number

**History of Injury or Current Complaint:**

Please briefly describe your injury or current complaint and date of onset: \_\_\_\_\_

When does your complaint feel worse? AM PM Please explain: \_\_\_\_\_

Does your pain interrupt your sleep? No Yes Please explain: \_\_\_\_\_

What activity is affected most due to this complaint? \_\_\_\_\_

**Previous Conditions and Treatment:**

Please briefly list any previous medical conditions and treatment: \_\_\_\_\_

List all medications and supplements: \_\_\_\_\_

Do you have any allergies NO YES Please explain: \_\_\_\_\_

List all dates of hospital visits and/or types of surgeries: \_\_\_\_\_

Are any of these conditions in your family history?  Autoimmune disorders  Cancer  GI disorders  
 Heart disease  Neurological  Arthritis  Diabetes  Kidney disease  Seizures

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If patient required assistance to complete this form, sign your name and state relationship ( i.e.,parent, translator)

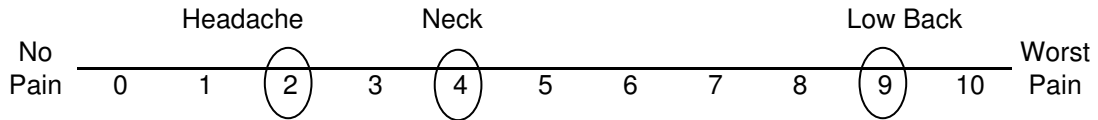
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Quadruple Visual Analogue Scale

**INSTRUCTIONS:** Please circle the number that best describes the question being asked.

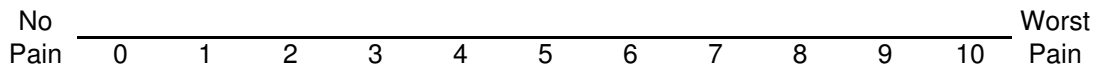
**NOTE:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at min/max using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

**Example:**

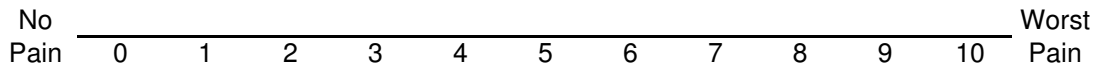


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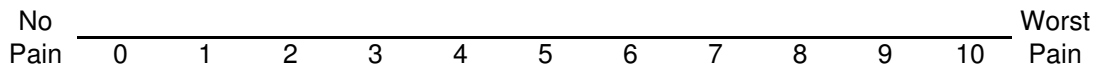
1. What is your pain **RIGHT NOW**?



2. What is your **TYPICAL** or **AVERAGE** pain?

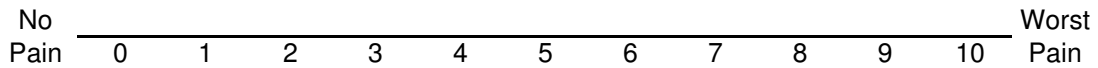


3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? \_\_\_\_\_ %

4. What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? \_\_\_\_\_ %

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_ Score \_\_\_\_\_

Score: #1 \_\_\_\_\_ + #2 \_\_\_\_\_ + #4 \_\_\_\_\_ = \_\_\_\_\_ /3x10= \_\_\_\_\_  Low Intensity = <50  
 High Intensity = >50

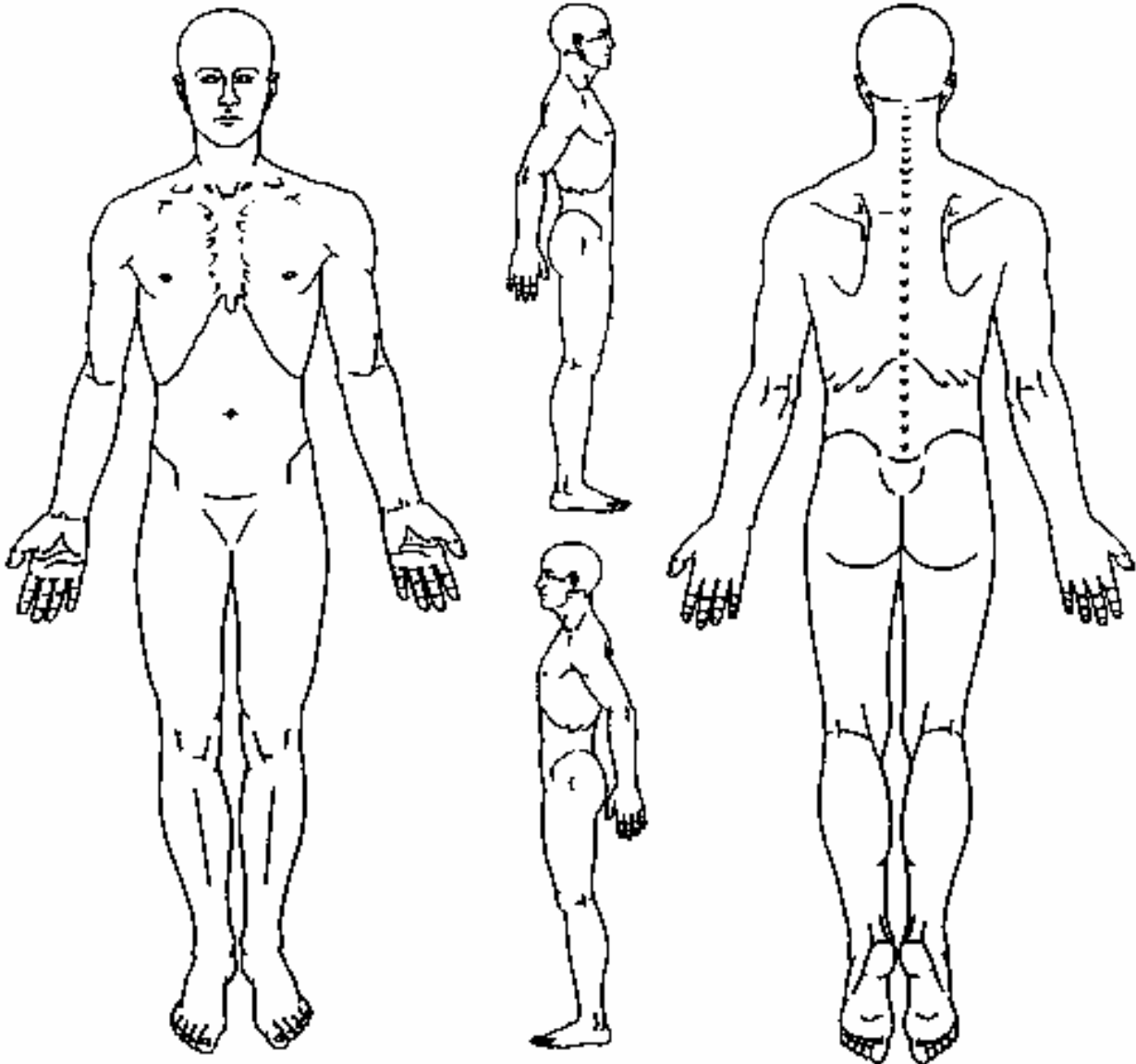
## Pain Diagram

NAME \_\_\_\_\_

DATE \_\_\_\_\_

How long have you had neck pain \_\_\_\_\_ years \_\_\_\_\_ months \_\_\_\_\_ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



**A** = ACHE

**B** = BURNING

**N** = NUMBNESS

**P** = PINS & NEEDLES

**S** = STABBING

**O** = OTHER

\_\_\_\_\_  
Patient Signature