Movement Rx Pain Relief

Powered by Rochester Spine + Sports Chiropractic, PLLC
135 Sully's Trail, Suite 5, Pittsford, NY 14534 | 585-626-4500 (Office) | 585-348-9102 (Fax)

Please take a few minutes to complete this questionnaire. We want you to know that it is our sincere desire to help in any way we can, and your answers will assist this process. Thank you.

PERSONAL INFORMATION:

Date:

First Name: Initial: Last Name:

How would you like to be addressed by our staff?

☐ Male ☐ Female Age: Birth Date: Are you interested in receiving our newsletter? ☐ Yes ☐ No

Home Phone: Cell Phone: Email:

Address:

City: State Zip Code

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name: Number of Children:

Emergency Contact: Relationship: Home Phone:

Referred By (Friend, Family, Physician, etc.):

WORK INFORMATION:

Occupation: Employer: Work Phone:

HEALTH INFORMATION:

Family Physician: May our office inform your physician of our exam findings, diagnosis, and treatment plan? ☐ Yes ☐ No

Address:

City: State: Zip Code:

Please provide health insurance card to the front desk for copying ***OR*** complete the following information

Do You Have Health Insurance? ☐ Yes ☐ No Insurance Company Name:

ID #: Group #: **Subscriber's DOB:**

Previous Chiropractic Care? ☐ Yes ☐ No If Yes, when and for what problem?

Is Today's Visit Due to A Work-Related Injury: ☐ Yes ☐ No Is Today's Visit Due to A Personal Injury/Auto Accident: ☐ Yes ☐ No

If yes to either question, please check with receptionist, additional information may be needed.

What is your goal from treatment?

What are your top 3 health concerns?

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CHIEF COMPLAINT: _____ Patient Full Name: _____

Chief complaint or why are you seeking care? _____

Date of Onset: _____ Was the Onset: ☐ Gradual ☐ Sudden Since onset, has it gotten: ☐ Worse ☐ Better

Have you experienced this problem before? ☐ Yes ☐ No If Yes, When? _____

Describe what caused the pain: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR CHIEF COMPLAINT:

Describe the quality of the complaint/pain:

- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ other: _____

Does any of the following make the pain worse:

- ☐ lifting/bending/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ other: _____

Describe if pain is in a single spot or does it spread out:

- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ burning, sharp stabbing, tingling, numb
- ☐ other: _____

Does any of the following make it better:

- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ other: _____

How often are you aware of the pain:

- ☐ intermittent (less than 25% of time when awake)
- ☐ occasional (25-50% of time when awake)
- ☐ frequent (50-75% of time when awake)
- ☐ constant (75-100% of time when awake)

Does it interfere with your daily activities:

- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

Have you detected any possible relationship of your current chief complaint with any of the following:

☐ Muscle Weakness ☐ Bowel/Bladder Problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other: _____

Does your pain ever awaken you from a sound sleep? ☐ Yes ☐ No Have you tried any self-treatment? ☐ Yes ☐ No

If Yes, explain: _____ Results: _____

Have you lost consciousness or had double vision recently? ☐ Yes ☐ No Are you currently pregnant? ☐ Yes ☐ No

Have you had any loss of bladder or bowel control? ☐ Yes ☐ No Are you losing weight now, without trying? ☐ Yes ☐ No

Are you currently taking anti-coagulant/blood thinning medication? ☐ Yes ☐ No

Do you currently smoke or have you ever smoked? ☐ Yes ☐ No If Yes, how long and amount? _____

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HEALTH HISTORY:

Patient Full Name:

Have you **ever** had a **stroke** or issue with **blood clotting**? ☐ Yes ☐ No If yes, when:

Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? ☐ Yes ☐ No If yes, explain:

Have you ever had any major illnesses, injuries, broken bones, hospitalizations, accidents, surgeries, x-rays, MRI's or CT scans? ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries/X-ray	Physician Seen / Treatment	Response to Treatment

Are you presently taking any prescription drugs, over-the-counter drugs, vitamins, or supplements? ☐ Yes ☐ No

Product/Drug	Reason	Dosage	Frequency

FAMILY HISTORY:

Please list any diseases, disorders, or major illnesses of your family members.

Father:

Mother:

Brother(s):

Sister(s):

Children:

Other:

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PLEASE WRITE IN A NUMBER: (1) PRESENTLY HAVE OR (2) PREVIOUSLY HAD

GENERAL HISTORY	EYES, EARS, NOSE, THROAT	MUSCULOSKELETAL	CARDIOVASCULAR
Cancer	Asthma	Arthritis	Hardening of arteries
Stroke	Colds	Bursitis	High blood pressure
Osteoporosis	Sore throat	Foot Trouble	Low blood pressure
Allergies	Deafness	Hernia (where)	Pain over heart
Convulsions	Dental decay	Low back pain	Poor circulation
Dizziness	Ear ache/noises	Neck pain/stiffness	Rapid heart beat
Fatigue	Ear discharge	Shoulder blade pain	Slow heart beat
Fever	Sinus infection	**Pain or numbness in:**	Swelling of ankles
HIV	Enlarged glands	Shoulders	**GASTROINTESTINAL**
Headache	Enlarged thyroid	Arms	Excessive belching or gas
Nervousness/depression	Nose bleeds	Elbows	Colitis
Multiple Sclerosis	Gum trouble	Hands	Colon trouble
Neuralgia	Difficulty swallowing/speaking	Hips	Constipation
Numbness	Nasal obstruction	Legs	Diarrhea
Sweats	**URINARY**	Knees	Difficult digestion
Tremors	Bed-wetting	Feet	Abdominal distention
Liver trouble	Blood in urine	Painful tailbone	Excessive hunger
Jaundice	Frequent urination	Poor posture	Gall bladder trouble
RESPIRATORY	Kidney infection or stones	Sciatica	Hemorrhoids
Chest pain	Painful urination	Spinal curvature/Scoliosis	Intestinal worms
Chronic cough	Pus in urine	**GENITO**	Nausea
Difficult breathing		Prostate trouble	Pain over stomach
TB (Tuberculosis)		Painful menstruation	Poor appetite
Spitting up blood		Hot flashes	Vomiting
Spitting up phlegm		Irregular cycle	Vomiting blood
Wheezing		Lumps in breasts	

LIFESTYLE:

I understand "servings" and portion sizes for Carbohydrates, Protein, Fat with each meal? ☐ Yes ☐ No

I eat five fruits and vegetables every day? ☐ Yes ☐ No I exercise 20-45 minutes every day? ☐ Yes ☐ No

My favorite fruit or vegetable is: _____ My favorite activity or sport is: _____

Do you have a workout partner or personal trainer? ☐ Yes ☐ No

How many hours of sleep do you get per night? ☐

Do you experience night sweats? ☐ Yes ☐ No

Do you awake refreshed? ☐ Yes ☐ No

Place a mark indicating your current health:

Poor Health — **Optimal Health**

Do you take time for yourself every day to focus on Gratitude, Love, and Personal expansion? ☐ Yes ☐ No

I am stressed at work? ☐ Yes ☐ No I am stressed at home? ☐ Yes ☐ No

Place a mark indicating your current level:

0 — 10

No Stress — **Worst Possible Stress**

What type of treatment are you interested in? ☐ Pain Relief ☐ Optimizing Health ☐ Functional improvement ☐ All three

Are you interested in other services which may help your condition or improve your health?

☐ Nutritional Support ☐ Rehabilitation ☐ Orthotics ☐ Exercise ☐ Weight Loss

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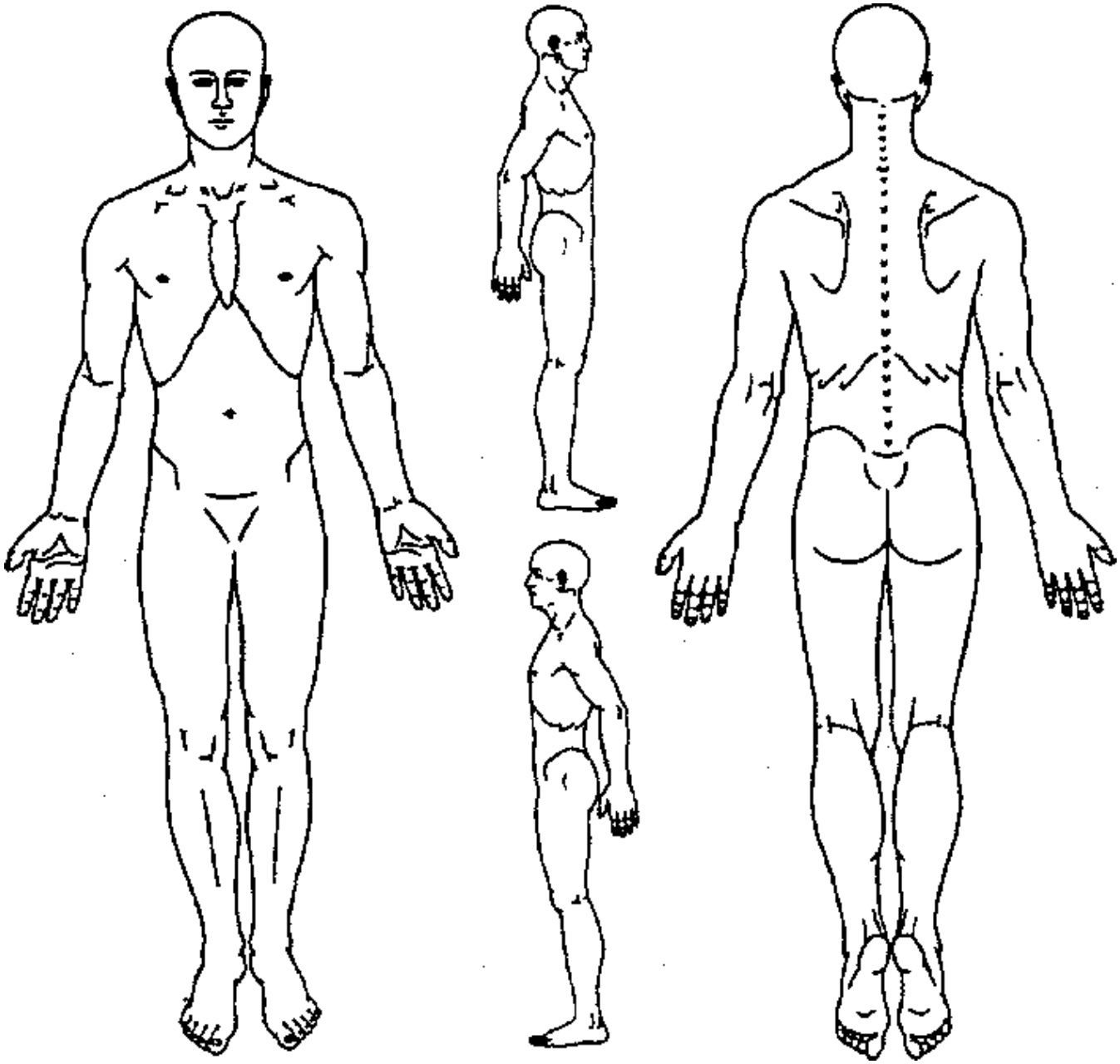
PAIN DIAGRAM:

Patient Full Name:

After printing form, please indicate any location where you are experiencing pain using the descriptive key below.



Use the following letters to indicate the type and location of discomfort:
A - Aching
B - Burning
N - Numbness/Tingling
P - Pins and Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

0 10

No Pain **Worst Possible Pain**

PAIN SCALE

Place a mark indicating your current pain on the above scale