

Wenger Chiropractic Group Patient Information

Patient ID# (office use): _____ Today's Date: _____

First name _____ M.I. _____ Last Name _____ Nick Name _____

Address _____ City _____ State _____ Zip Code _____

Gender: Male/Female
Social Security # _____ Primary Language _____ Date of Birth _____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated Spouse Name: _____

Race: (Choose most appropriate)

☐ White ☐ African American or Black ☐ Asian ☐ Hawaiian or Pacific Islander
☐ American Indian or Alaska native ☐ Decline to specify

Ethnicity: (Choose most Appropriate)

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to Specify

Contact preference for appointment reminders:

☐ Text Message Preferred _____ ☐ Phone Call _____
CELL PHONE Cell / Home / Work Phone

☐ Do Not Contact for Appointment Reminders

Emergency Contact Name _____ Phone Number _____ Family Doctor Name _____ Family Doctor Office _____

Primary Insurance _____ Member ID _____ Group Number _____

Primary Insured Name _____ Employer Name _____ HSA / HRA / Neither

Who Referred You To Us? ☐ Physician ☐ Internet ☐ Office Sign ☐ Patient _____

I authorize the following person(s) to have access to my personal health information:

Name: _____ Phone Number: _____

MEDICAL HISTORY

Patient ID #: _____

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

What is the primary reason/problem/condition you have come in for chiropractic treatment?

Have you had similar problems before? ☐ No ☐ Yes If yes, When? _____Have you had Chiropractic care in the past? ☐ No ☐ Yes

Are there any other issues/problems you wish the doctor to know about: _____

Have you had any recent falls, traumas or other accidents? ☐ No ☐ Yes Describe: _____What is the initial date of injury or onset of this condition? _____ Are you off from work? ☐ No ☐ Yes

Rate your restriction of performing activities of daily living on a scale from 0 to 10

(no restriction) 0 1 2 3 4 5 6 7 8 9 10 (severe restriction)

Over the past 2 weeks what is your average level of pain on a scale from 0 to 10?

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain) What level is your pain today? ____/10

Is your pain or discomfort? (Mark with a ✓) ☐ continuous ☐ off and on ☐ getting worse ☐ sharp or stabbingList symptoms you have had recently: ☐ Headache ☐ Numbness or tingling in arms/hand or legs/feet ☐ FeverDo you perform moderately intense exercise 3 time per week? ☐ No ☐ YesIs your MD currently co-treating your condition? ☐ No ☐ Yes If yes, who: _____

What recent diagnostic studies (x-ray, MRI, CT, blood work) have you had? _____

Taken where? _____

[] Difficulty sleeping Other: _____

List your Current Primary Medications: _____

Medication Allergies: _____

List your Allergies: ☐ None ☐ Seasonal/Pollen ☐ Food ☐ Animals ☐ X-Ray Dye ☐ Other: _____List any Surgeries: ☐ None ☐ Neck ☐ Back ☐ Hip ☐ Knee ☐ Shoulder ☐ Brain ☐ Other: _____List your Medical Conditions: ☐ None ☐ High Blood Pressure ☐ Diabetes ☐ Stroke ☐ Cancer☐ Other: _____Do you smoke or use tobacco products? ☐ No ☐ Yes Former Smoker? ☐ No ☐ YesDo you have currently have significant problems with depression or anxiety? ☐ No ☐ YesDo you drink alcohol? ☐ No ☐ Yes – How many per day? _____Do you drink caffeine? ☐ No ☐ Yes – How many per day? _____Do you exercise? ☐ No ☐ Yes: What forms and how often? _____

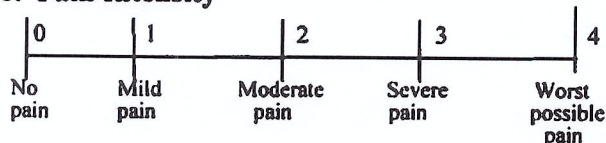
Patient Signature: _____ Date: _____

Functional Rating Index

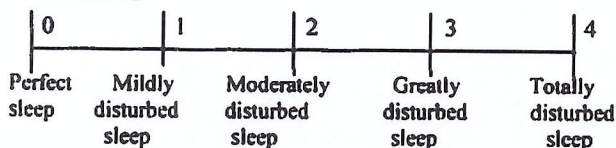
For use with Neck and/or Back Problems only

In order to properly assess your condition, we must understand how much your neck and/or back problem has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

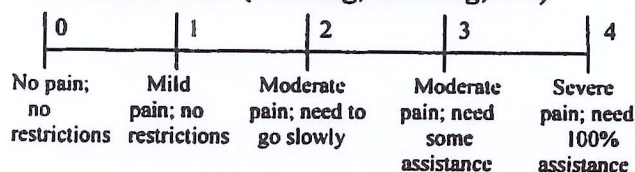
1. Pain Intensity



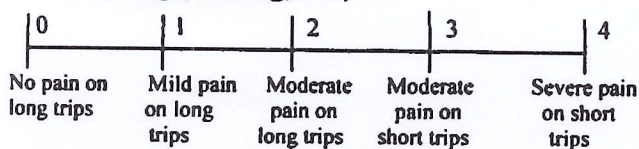
2. Sleeping



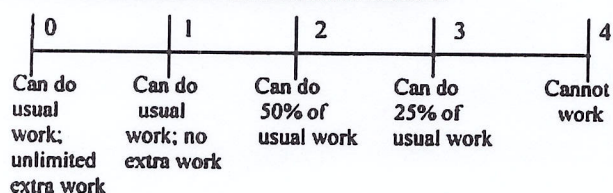
3. Personal Care (washing, dressing, etc.)



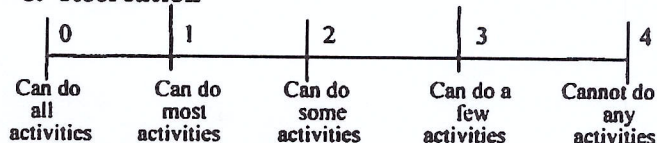
4. Traveling (driving, etc.)



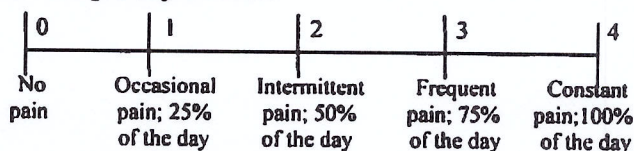
5. Work and/or household chores



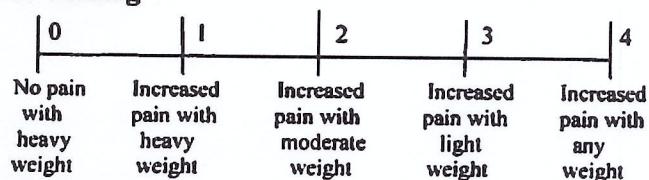
6. Recreation



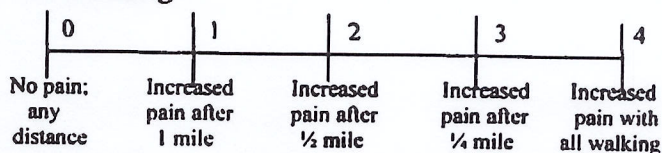
7. Frequency of Pain



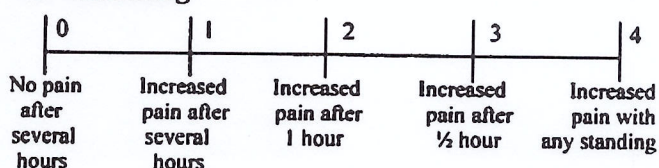
8. Lifting



9. Walking



10. Standing



FRI Score: _____

Patient Specific Functional Scale (PSFS)

Please list up to three (3) things you cannot do or are having difficulty doing because of your problem. Then rate them 0 (unable to perform) to 10 (able to perform activity at same level as before injury or problem).

- One Word
- _____
 - _____
 - _____

Unable (circle) Able

0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

0 1 2 3 4 5 6 7 8 9 10

Pain/Discomfort Level

Please circle a number on the 0-10 scale indicating your pain/discomfort as of today

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unimaginable pain)

Patient Name (printed) _____

Patient Signature _____

Date _____

computer # _____