

# 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

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

Email: \_\_\_\_\_

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Legally Separated Spouse Name: \_\_\_\_\_

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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  Patient  Insurance (define 1)  
 Internet (define 2)  Office Sign  
Referral Name \_\_\_\_\_

Name: \_\_\_\_\_  
Email: \_\_\_\_\_ 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 stabbing

Do you perform moderately intense exercise 3 time per week?  No  Yes

Is 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? \_\_\_\_\_

List symptoms you have had recently:  Headache  Numbness or tingling in arms/hand or legs/feet  Fever

[ ] Difficulty sleeping Other: \_\_\_\_\_

List your Current 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: \_\_\_\_\_

List your Family Medical History (Example: maternal grandmother - high blood pressure, Father - heart attack)

Do you smoke or use tobacco products?  No  Yes Former Smoker?  No  Yes

Do you currently have significant problems with depression or anxiety?  No  Yes

Do 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? \_\_\_\_\_

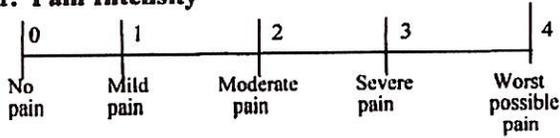
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Functional Rating Index

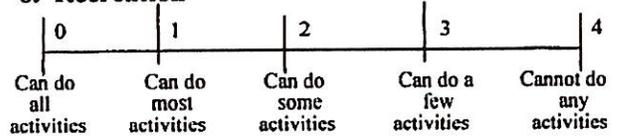
For use with Neck and/or Back Problems only

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.

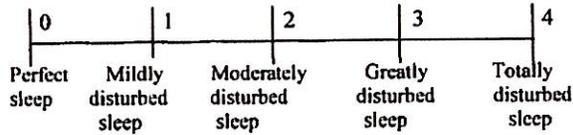
### 1. Pain Intensity



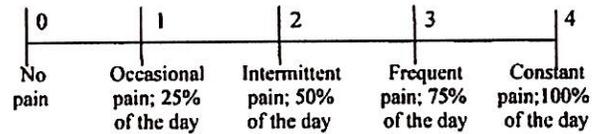
### 6. Recreation



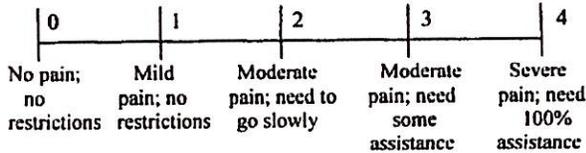
### 2. Sleeping



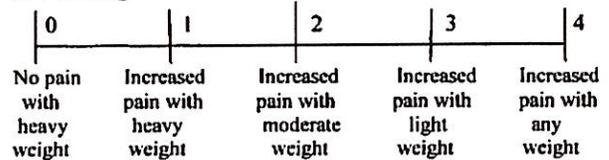
### 7. Frequency of Pain



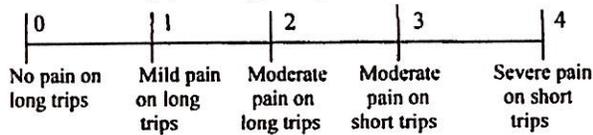
### 3. Personal Care (washing, dressing, etc.)



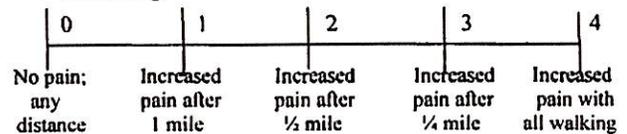
### 8. Lifting



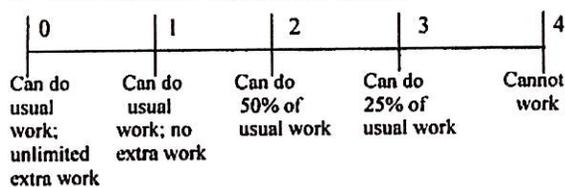
### 4. Traveling (driving, etc.)



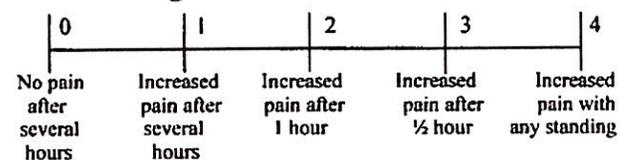
### 9. Walking



### 5. Work and/or household chores



### 10. Standing



FRI Score: \_\_\_\_\_

### Pain/Discomfort Level

Please circle a number on the 0-10 scale indicating your average pain/discomfort level lately.

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

\_\_\_\_\_  
Patient Name (printed)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
computer #