Community Chiropractic Center, LLC

70 West Allendale Avenue, Suite A, Allendale, NJ 07410

GENERAL INFORMATION FORM

Today's Date_____ **Patient SS#** _____ **Patient Office ID#**_____

Patient Name _____ **Employer** _____

Address _____ **Address** _____

_____ _____

City State Zip **City State Zip**

Sex ☐ M ☐ F Age _____ Date of Birth_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone# _____ Work#_____ Cell# _____

Best time and phone # to reach you _____ Email:_____

Occupation _____ Employer's Phone _____

Spouse's Name _____ Spouse's Birth date _____

Spouse's Occupation _____ Spouse's Employer _____

Number of Children _____

How did you hear of Dr. Franchini? ☐ Advertisement ☐ Friend/Family ☐ at an Event ☐ Other_____

Whom may we thank for referring you? _____

Family Doctor/Primary Care Physician_____ Phone #_____ City _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____ Phones: H:_____ W:_____ C:_____

INSURANCE INFORMATION

Subscriber's Name _____ Birth Date_____ Relationship to Patient _____

Insurance Company Name _____ Policy # _____

Insurance Company Address _____ Group/Claim # _____

_____ Subscriber SS# _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Birth Date_____ Relationship to Patient _____

Insurance Company Name _____ Policy # _____

Insurance Company Address _____ Group/Claim # _____

_____ Subscriber SS# _____

FOR NO FAULT AND WORKER'S COMPENSATION:

Attorney Information (for Personal Injury, Worker's Compensation, No Fault)

Name _____ Contact Person _____

Address _____ Phone _____

_____ Fax _____

City State Zip

Date of Injury _____ Time _____ State _____

CHIEF COMPLAINT QUESTIONNAIRE

1. Reason for visit. If this is a motor vehicle accident or on the job injury, please notify the staff. _____

   _____

   _____

2. What do you hope will happen as a result of this visit?

   _____

3. When did your symptom(s) appear? Choose one:
   - ☐ I don't know how it began
   - ☐ It comes and goes
   - ☐ I've had it a long time (about _____years)
   - ☐ Specific injury (date of injury _____)
   - ☐ On the job

4. Explain how the injury happened

   _____

   _____

   _____

5. Overall my state of health is ☐ Excellent ☐ Good ☐ Fair ☐ Improving ☐ Failing

6. Rate the severity of your **low back** pain on a scale from 1 (least pain) to 10 (severe pain)
   1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning_____/10

7. Rate the severity of your **leg pain** on a scale from 1 (least pain) to 10 (severe pain)
   1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning_____/10

8. Rate the severity of your **neck pain** on a scale from 1 (least pain) to 10 (severe pain)
   1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning_____/10

9. Rate the severity of your **arm pain** on a scale from 1 (least pain) to 10 (severe pain)
   1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning_____/10

10. Rate the severity of your **_____ pain** on a scale from 1 (least pain) to 10 (severe pain)
    1. Right now _____/10 2. At its worst today _____/10 3. At its worst overall since beginning_____/10

11. Do you have the following problems? Please check all that apply:

Weakness	☐ arms	☐ hands	☐ legs	☐ feet	☐ none
Numbness (loss of feeling)	☐ arms	☐ hands	☐ legs	☐ feet	☐ none
Tingling (falling asleep)	☐ arms	☐ hands	☐ legs	☐ feet	☐ none

12. Is your pain worse at night? ☐ Yes ☐ No Does your pain awaken you from sleep? ☐ Yes ☐ No
13. Does coughing affect your pain? ☐ Yes ☐ No Do your legs hurt/tire when you walk far? ☐ Yes ☐ No
14. Lost or gained weight recently? ☐ Yes ☐ No Experienced night sweats? ☐ Yes ☐ No
15. Been out of the country? ☐ Yes ☐ No Lost bladder or bowel control? ☐ Yes ☐ No
16. Have trouble with sexual function? ☐ Yes ☐ No Seen a primary care physician in the last year? ☐ Yes ☐ No
17. Since your problem began, the condition has ☐ Increased ☐ Decreased ☐ Not Changed
18. Does your problem "flare up" and get worse at any point? _____
19. Are your complaints affecting your ability to work or otherwise be active?
    - ☐ No effect
    - ☐ Some physical restrictions
    - ☐ Need limited assistance with common everyday tasks
    - ☐ Have a significant inability to function without assistance
    - ☐ Totally disabled (impaired) and cannot care for self
20. Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

21. Describe your pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

22. What makes your problems worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down
☐ Lifting ☐ Twisting ☐ Movement ☐ Rising from a chair

23. What makes your problems better? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down
☐ Lifting ☐ Twisting ☐ Movement ☐ Hot shower/hot pack
☐ Cold pack ☐ Rise from chair ☐ Physical activity

24. When you wake up, the problem is ☐ Better ☐ Worse ☐ No Change

25. As the day goes along the problem gets ☐ Better ☐ Worse ☐ No Change

26. How often do you have this pain? ☐ Constantly (76-100%) ☐ Frequently (51-75%)
☐ Occasionally (26-50%) ☐ Intermittently (25% or less)

27. Have you injured this area before? ☐ Yes ☐ No If yes, how many times have you experienced this problem?
☐ 1-4 ☐ 5-8 ☐ 8+

28. What treatment have you already received for your current condition?
☐ Medications ☐ Surgery ☐ Chiropractic Services ☐ Physical Therapy ☐ Other _____ ☐ None

29. Name, address and telephone number of doctor(s)/healthcare providers who have treated you for this condition:

Dr._____ Dr._____ Dr._____

_____ _____ _____

_____ _____ _____

City State Zip City State Zip City State Zip

30. Current medications, including vitamins, supplements, and over-the-counters

Medication Name	**Reason**	**Medication Name**	**Reason**
1)		5)	
2)		6)	
3)		7)	
4)		8)	

31. **Surgeries** (dates & reason) Please include all surgeries, especially spinal procedures_____

_____

_____

32. **Hospitalizations** (dates & reason) _____

_____

_____

33. **Fractures/Dislocations/Falls/Car Accidents/Trauma** _____

_____

_____

34. **Scars** _____

35. **Known Allergies**_____

36. **Please circle** all the conditions you currently have or had previously

Heart attack	Emphysema	Heart murmur	Angina	Asthma
High Blood Pressure	Anemia	Stroke/TIA	Bleeding disorder	Varicose Veins
Sexual difficulty	Stomach Ulcer	Enlarged Prostate	Duodenal problems	Menstrual problems
Tuberculosis	Colon problems	Migraine Headaches	Diabetes	HIV/AIDS
Hepatitis	Scoliosis	Cirrhosis	Kidney stones	Kidney infection
Psoriasis	Depression	Dizziness	Fatigue	Weight gain/loss
Degenerative Arthritis	Rheumatoid Arthritis	Prosthetic joints/pins/screws		Jaw Pain
Cancer type: _____				Lupus
Chest pains	Abdominal Pain	Gall Bladder		
Painful Urination	Frequent Urination	Incontinence		

EXERCISE ACTIVITY

37. Do you do any exercise on a regular basis? ☐ Yes ☐ No # Days per week _____

If yes, specify _____

38. Are you a member of a gym/fitness facility? ☐ Yes ☐ No Which? _____

WORK ACTIVITY

39. ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

HABITS

40. ☐ Smoking Packs per week _____ If yes, last chest x-ray _____
☐ Smokeless Tobacco If yes, last dental visit _____ ☐ Used to smoke, but quit. How long ago? _____
☐ Alcohol Drinks per week _____ ☐ Coffee/Caffeine Cups per day _____
☐ High stress level Reason _____

FEMALE HEALTH QUESTIONS

41. Do you have an OB/GYN Provider? If yes, Dr.'s name: _____ Last visit _____
42. Are you pregnant? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No If yes, how many pregnancies? _____
43. Complications during pregnancy/delivery? ☐ Yes ☐ No If yes, describe _____
44. Number of children and age(s) _____
45. Date of last menstrual period _____ Birth control? Method _____
46. Have you ever had a PAP smear? ☐ Yes ☐ No If yes, approximate date _____
47. Have you ever had a mammogram? ☐ Yes ☐ No
48. Any history of breast, ovarian, cervical, uterine cancers/polyps/growths in you or family? ☐ Yes ☐ No
49. Ever had a routine or baseline EKG done? ☐ Yes ☐ No
50. Have you checked your cholesterol levels? ☐ Yes ☐ No

MALE HEALTH QUESTIONS

51. Have you ever had a digital prostate exam? ☐ Yes ☐ No 52. PSA test? Blood test for prostate cancer ☐ Yes ☐ No
53. Ever had a routine or baseline EKG done? ☐ Yes ☐ No 54. Have you checked your cholesterol levels? ☐ Yes ☐ No

PLEASE FILL OUT PAIN DIAGRAM ON NEXT PAGE