Dr. Christopher J. Bott
Causeway Chiropractic
145 East Bay Ave. Manahawkin, New Jersey 08050
609-361-1800 609-361-8400 Fax

This update is required by your insurance company so that we can better treat you as a patient. Please answer all questions. Remember your health insurance does not pay for "maintenance or preventative care."

NAME ______________________________ DATE ____________
DATE OF BIRTH ________________ OCCUPATION ________________
ADDRESS: ____
PHONE ________________ EMAIL ______________________

PRIMARY CARE PRACTITIONER ______________________________
LAST PHYSICAL EXAM ___________ LAST BLOOD WORK ___________
LAST EYE EXAM ___________ LAST DENTAL EXAM ___________
HEIGHT ______ WEIGHT ______ R / L HANDED ___________
HAS WEIGHT CHANGED IN THE PAST (3) MONTHS? HOW MUCH? ___________

SINCE YOUR LAST ADJUSTMENT AT THIS OFFICE HAVE YOU BEEN INVOLVED:

- IN A MOTOR VEHICLE ACCIDENT? (DATE & INJURIES)
  ____
  ____
- HAVE YOU EXPERIENCED ANY PHYSICAL TRAUMA? (SPORTS, SLIP/FALL…)
  ____
  ____
- HAVE YOU HAD ANY SURGERY/MEDICAL PROCEDURES PERFORMED?:
  ____
  ____
- HAVE YOU HAD ANY CHANGES IN YOUR OVERALL HEALTH?:
  ____
  ____

ADDITIONAL COMMENTS:
____
____
____

CURRENT HISTORY

WHAT ARE YOUR PRESENT SYMPTOMS/PURPOSE OF THIS CONSULTATION?

____

____

WHEN DID YOUR SYMPTOM(S) START?: ____

HOW DID YOUR INJURY OCCUR? ____

____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOM(S)?:

A. CONSTANTLY (76-100% OF THE DAY) B. FREQUENTLY (51-75% OF THE DAY)

C. OCCASIONALLY (26-50% OF THE DAY) D. INTERMITTENLY (0-25% OF THE DAY)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

A. SHARP B. DULL ACHE C. NUMB

D. SHOOTING E. BURNING F. TINGLING

WHAT TREATMENT HAVE YOU RECEIVED (INCLUDING HOME CARE)? ______________

____

HAS YOUR PAIN INCREASED, DECREASED OR STAYED THE SAME? _______________

HOW HAS YOUR SLEEP QUALITY BEEN AFFECTED BY YOUR SYMPTOM(S)? __________

____

DOES YOUR PAIN INCREASE WITH COUGHING, SNEEZING, BOWEL MOVEMENT? ______

HOW DOES STANDING, SITTING, OR LYING AFFECT YOUR PAIN? ________________

HOW DOES TIME OF DAY AFFECT YOUR SYMPTOM(S)? (AM VS. PM) _____________

____

HOW HAVE YOUR DAILY ACTIVITIES CHANGED? ______________________________

____

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? Y / N

IF SO, WITH WHOM DID YOU TREAT?:

A. ANOTHER CHIROPRACTOR B. MEDICAL PRACTITIONER

C.PHYSICAL THERAPIST D.OTHER ______________________________

WHAT DO YOU THINK IS CAUSING YOUR CONDITION? WHAT ARE YOUR CONCERNS?

____

____

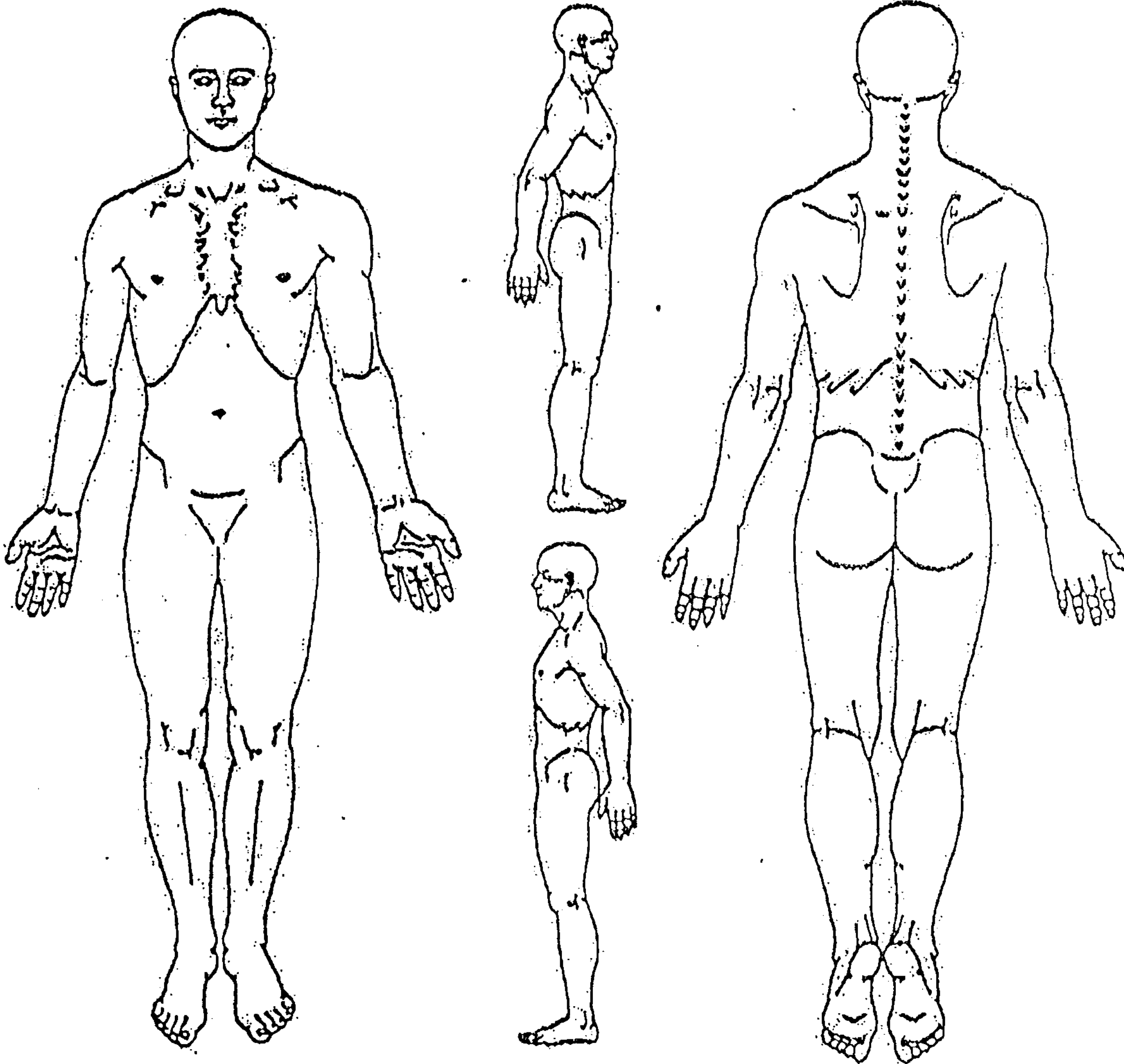
PATIENT'S SIGNATURE: ______________________________ **DATE:** __________

DOCTOR'S SIGNATURE: ______________________________ **DATE:** __________

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	Ache	B =	Burning	R =	Radiating Pain	D =	Dull Pain
N =	Numbness	S =	Stabbing	P =	Pins & Needles	O =	Other



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

NAME: (please print)______________________________

How long have you experienced neck/back pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck/back pain? _____ YES _____ NO

SIGNATURE:______________________________ DATE:______________

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