

Dr. Christopher J. Bott
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This update is required by your insurance company so that we can better treat you as a patient. Please answer all questions. Remember most health insurance plans do 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 TREATMENT 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?
(REMINDER-most insurance plans DO NOT pay for maintenance, routine or preventative care)

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. INTERMITTENTLY (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 _____

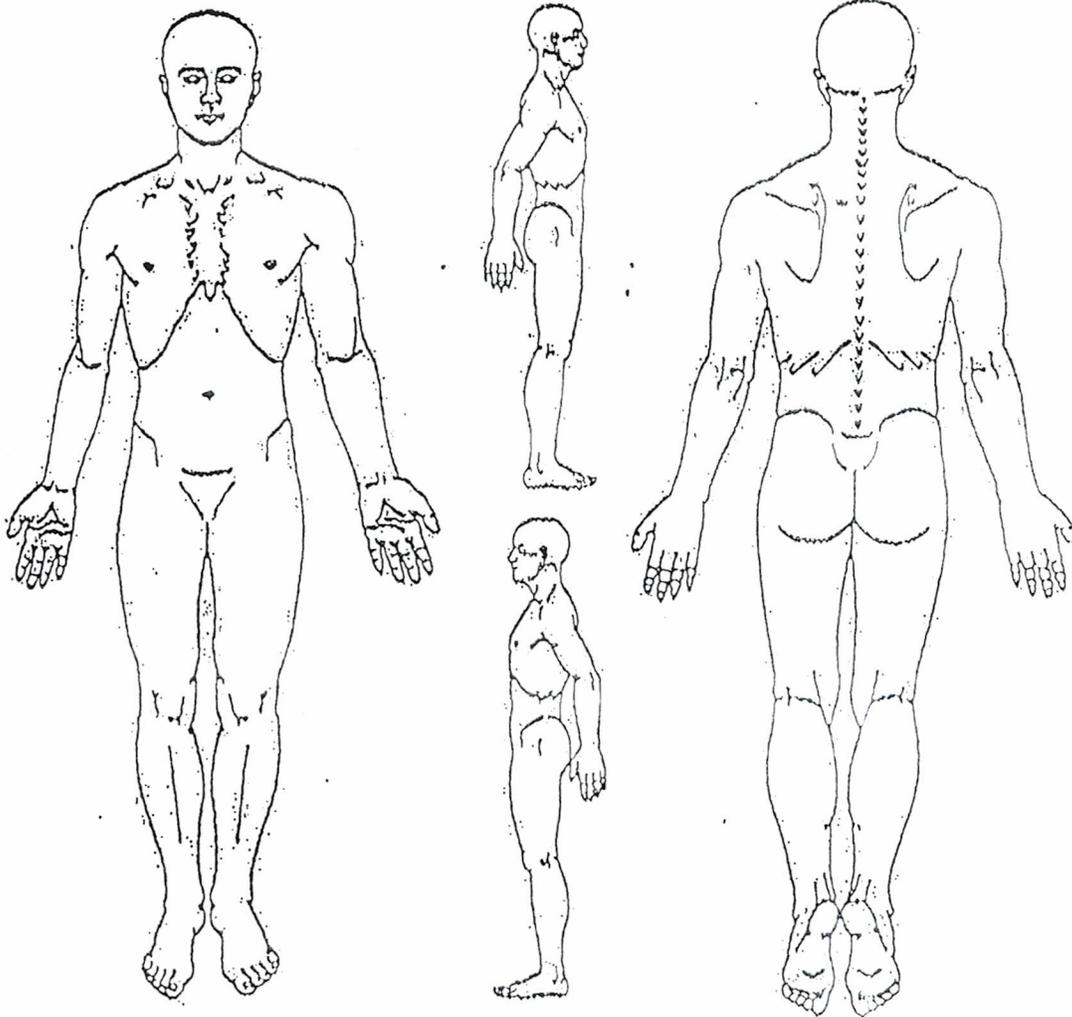
WHAT DO YOU THINK IS CAUSING YOUR CONDITION? WHAT ARE YOUR CONCERNS?

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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