# INTERMEDIATE CARE
# CELEBRATION FAMILY CHIROPRACTIC
# Scoliosis Reduction Center

604 Front Street Celebration, FL 34747 Phone: 321-939-2328

Today's Date: _____

## PATIENT DEMOGRAPHICS

Name: _____ Has Any of Your Demographics Information Changed: ❑ Yes ❑ No

Has Your Insurance Information Changed: ❑ Yes ❑ No Has Your Work Information Changed: ❑ Yes ❑ No

## HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day

How long does it last? ☐ constant ☐ on and off during the day ☐ It comes and goes throughout the week

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

**If yes**, identify type: ☐Auto ☐Work ☐ Home ☐Other (*please explain*):_____

Date of Accident: ____/____/____ Approximately what time that day?_____am _____pm

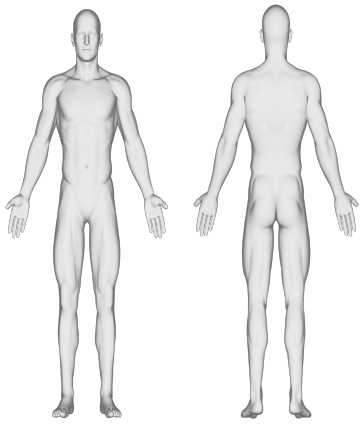
Have you reported this accident to anyone? ☐ No ☐ Yes **If yes,** to whom:_____

Condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

**If yes**, when: _____ by whom?_____ How long were you under care?_____

What were the results? _____

Name of Previous Chiropractor:_____ ☐ N/A



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
**R**=Radiating **B**=Burning **D**=Dull **A**=Aching **N**=Numbness **S**=Sharp/ Stabbing **T**=Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

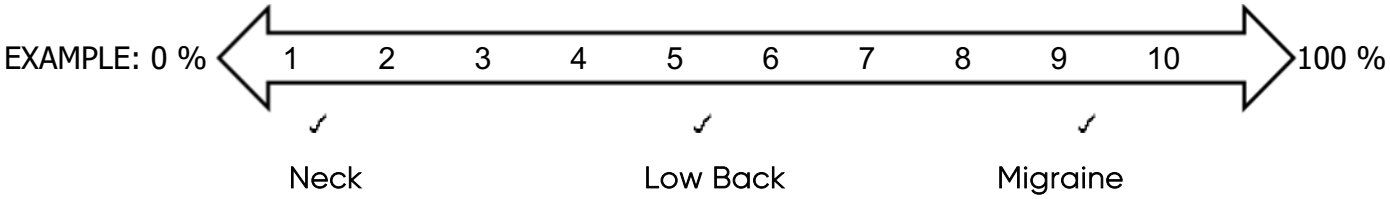
_____

_____

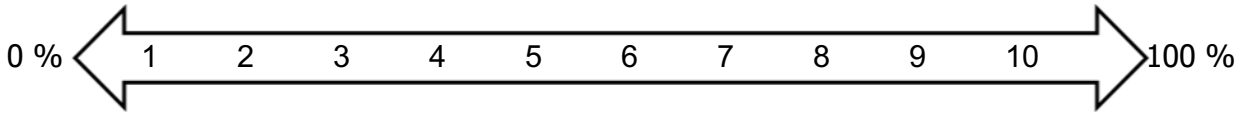
Name:_____ Date:_____

**Instructions:** Please circle the number that best describes the question being asked and indicate where your pain is located for each circle.

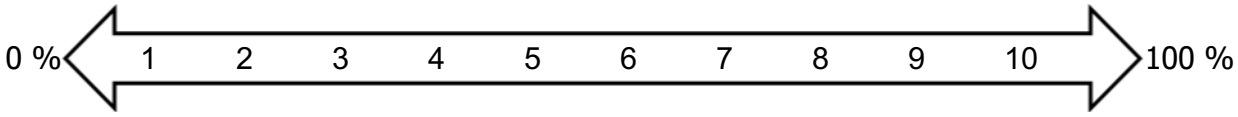
**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please see example below.



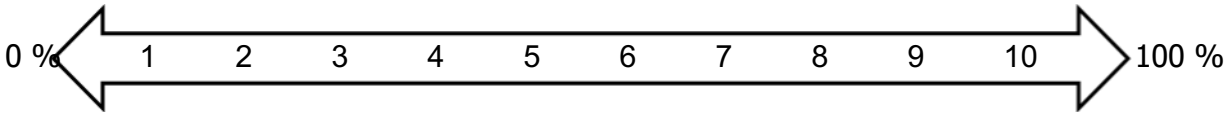

If you have a brace, do you have any discomfort from the brace? If you do not have a brace, write N/A



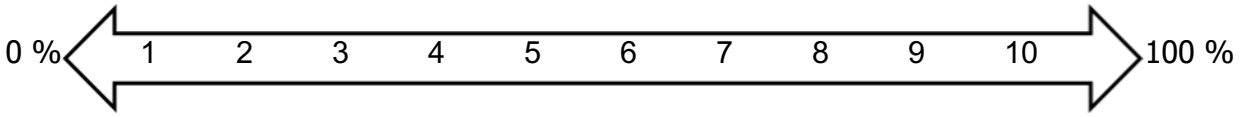

How is your pain RIGHT NOW? Not pertaining to the brace if you have one



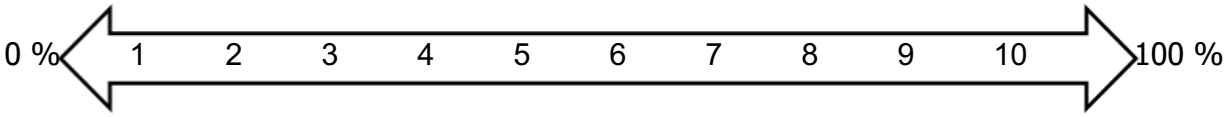

What is your TYPICAL or AVERAGE pain? Not pertaining to the brace if you have one




What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)? Not pertaining to the brace if you have one




What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)? Not pertaining to the brace if you have one




List prescription & non-prescription drugs you take: _____

_____

Name:_____ Date:_____

Since your most recent intensive care, what health changes have you experienced (i.e., better posture, less pain)?_____

_____

Do you have any new concerns since last intensive care? (i.e stiffness, pain, discomfort)?___

_____

_____

Were you recommended to purchase a ScoliBrace? Yes/No

If Yes, did you purchase a ScoliBrace? Yes/No

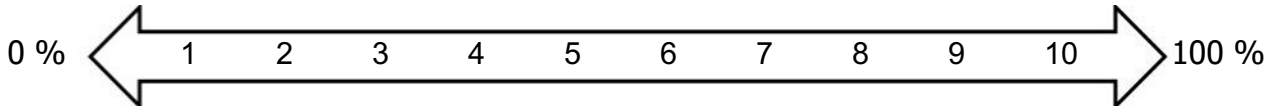
If Purchased, how many hours per day do you wear it? _____

Were you recommended to purchase a Scoliosis Traction Chair for home use? Yes/No

If **Yes**, did you purchase a Scoliosis Traction Chair? Yes/No

If Purchased, how often do you use it? _____

Rate how well have you followed your home care recommendations below.




Explain why you gave yourself that rating:_____

_____

Do you currently see a chiropractor? Yes/No _____

If **Yes,** how often? _____

Have you seen any other doctors regarding you condition? Yes/No

If **Yes**, who did you see and what was the result?_____

_____

What are your current goals? (i.e. continue to reduce curvature, maintain, prevent surgery)_

_____

_____

Name:_____ Date:_____

## ACTIVITIES OF DAILY LIVING

Identify how your current condition is affecting your ability to carry out daily activities that are routinely part of your life:

| | | | | |
|---|---|---|---|---|
| Carrying Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Climbing Stairs | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Household Chores | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Lifting Children | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Reading/Concentration | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Dressing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Washing/Bathing/Shaving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sexual Activities | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sleep | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Yard Work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sweeping/Vacuuming | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Dishes | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Laundry | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Taking out Garbage | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Other | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Other | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |

**Please give us more information regarding your most restricted activity due to your condition and your usual ability before you suffered from your condition.**

| LIST RESTRICTED ACTIVITY: | | CURRENT ACTIVITY LEVEL | USUAL ACTIVITY LEVEL |
|---|---|---|---|
| EXAMPLE: | Walking without pain | ¼ Mile | 2 Miles |
| EXAMPLE: | Sitting without pain | 15 minutes | 4 Hours |

_____

_____

_____

_____

I hereby authorize payment to be made directly to Celebration Family Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Celebration Family Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature_____ Date Completed_____

Doctor's Signature _____ Date Form Reviewed_____