InMotion PAIN SOLUTIONS

1967 51st Street NE, Cedar Rapids IA 52402
319-200-1495

PATIENT HEALTH HISTORY

☐ New Patient
☐ Reactivate (1 yr)

Legal Name (*First, Middle, Last*):		Today's Date:
Street Address:		Home Phone: ☐ Preferred
City / State / Zip:		Work Phone: ☐ Preferred
Social Security #:	Birthdate:	Cell Phone: ☐ Preferred
Email:	Sex: ☐ Male ☐ Female	Cell Carrier: (for text reminders)

Race: ☐ White/Caucasian ☐ African American/Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaska Native
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other: _____

Occupation:	Employer:
Primary Medical Doctor:	Medical Doctor Clinic & City:
Emergency Contact:	Emergency Contact's Phone:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name:
Spouse's Phone:	Spouse's Date of Birth:

How Did You Hear About Us? (*Check all that apply*) ☐ I have been a past patient ☐ Referred by (name): _____
☐ Newspaper ☐ Radio ☐ TV ☐ Internet ☐ Mailer ☐ Event ☐ Yellow Pages ☐ Other: _____

PRESENTING ILLNESS / CHIEF COMPLAINT

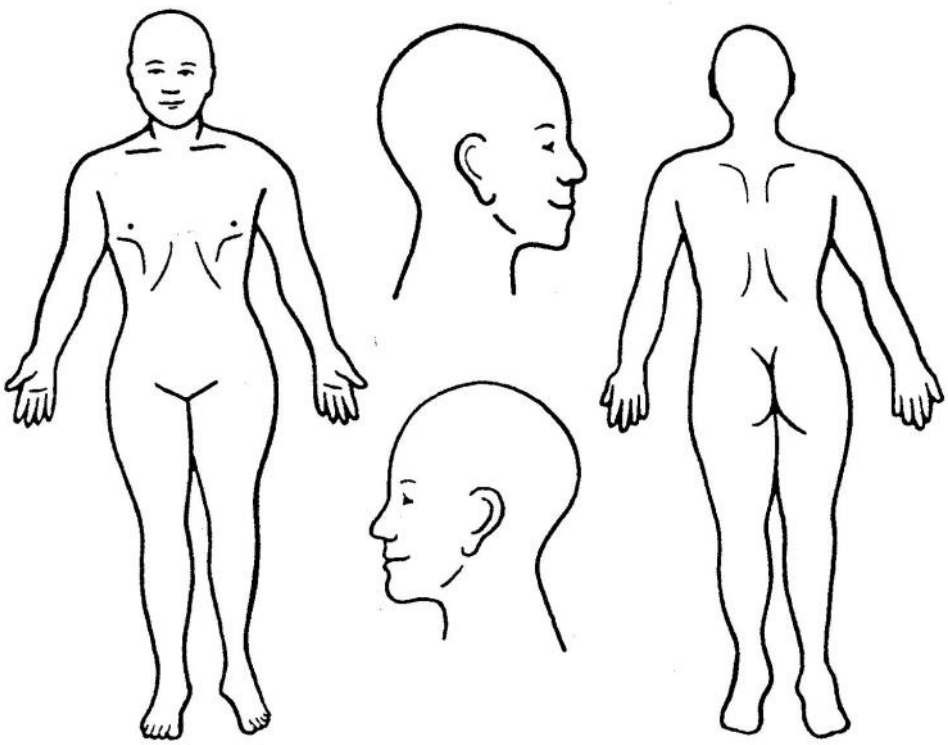
What are your symptoms:

Symptoms developed from: ☐ Work Related ☐ Auto Accident ☐ Other:

FEMALES: Are you pregnant? ☐ No ☐ Yes If Yes, Due Date: Doctor:

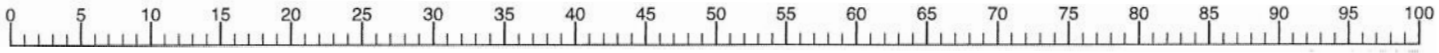
Show us your pain. Use the symbols from the box on the left to indicate the location and type of pain you are having.

XXX	Burning
(((	Aching
000	Pins & Needles
- - -	Numbness
: : :	Sharp Pains



RATE YOUR PAIN

Circle the number that best describes your pain level. If there is more than one area of pain, please write the pain area (e.g. "back" or "neck") above the number that you circled.



NO PAIN INTOLERABLE

Please answer these next 4 questions using a pain scale of 0—10, with 0 being "no pain" and 10 being "the worst pain"

1) What is your pain level right now? _____
2) What is your pain most of the time? _____
3) What is your pain level at its best? _____
4) What is your pain level at its worst? _____

How often are you at a ZERO pain level? ☐ At least once a day ☐ A few times a week ☐ Once a week ☐ Once every other week ☐ Once a month ☐ Other: _____

SYSTEMS REVIEW

Please put an "X" next to any areas for which you have problems.

____ Eyes ____ Lungs/Breathing ____ Muscles ____ Psychological ____ Allergies
____ Ears, Nose, Mouth, Throat ____ Intestines ____ Nerves ____ Internal Organs ____ Other: _____
____ Heart ____ Urinary ____ Skin ____ Blood

Please describe: _____

Treating Doctor Initials: _____

MEDICAL HISTORY

Have you ever seen a chiropractor? ☐ No ☐ Yes If Yes, Doctor's Name: Clinic:

Do you have any allergies? ☐ No ☐ Yes If Yes, please describe:

List major illnesses, injuries, falls, hospitalizations, accidents, or surgeries: ☐ None

Date	Condition(s)	Treating Doctor	Results
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications
			☐ Full Recovery ☐ Complications

List current prescriptions, over-the-counter medications, and supplements: ☐ None

Name	Dosage *(mg, mL, …)*	Form *(Tablets, Caps…)*	How Often *(times per day, wk, mo)*	Duration *Chronic*	*As Needed*	*Unknown*
			x's per			
			x's per			
			x's per			
			x's per			

FAMILY HEALTH HISTORY

Put a "X" next to medical conditions of your blood relatives (mother, father, brothers, sisters, children)

____ Heart Disease Who: _____
____ Diabetes Who: _____
____ Arthritis Who: _____
____ Cancer Type: _____ Who: _____