LONGNER Chiropractic

"DEDICATED TO GETTING SICK PEOPLE WELL AND KEEPING THEM THAT WAY."

NAME:_____
(FIRST) (LAST) (M.I.)

ADDRESS:_____
(CITY) (STATE) (ZIP)

HOME PHONE:_____ CELL PHONE:_____

EMAIL ADDRESS:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NO._____

REFERRED TO THIS OFFICE BY:_____

REASON FOR YOUR VISIT:_____

DATE OF INJURY:_____

NAME OF EMPLOYER:_____

JOB TITLE:_____ WORK PHONE:_____

NAME OF INS. COMPANY:_____

GROUP #:_____ POLICY #:_____

WORK OR AUTO RELATED? ☐ YES ☐ NO

(**IF APPLICABLE**)
SPOUSES NAME:_____
(FIRST) (LAST) (M.I.)

DATE OF BIRTH:_____ SOCIAL SECURITY NO.:_____

PLEASE NOTE THAT WE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY TO YOU.
YOU WILL BE RESPONSIBLE FOR PAYMENT IN THE EVENT THAT YOUR INSURANCE COMPANY FAILS TO MAKE TIMELY AND/OR PROPER PAYMENT.
PATIENTS ARE RESPONSIBLE FOR ANY ITEMS ISSUED AND NOT COVERED BY THE INSURANCE COMPANY AND FOR THE YEARLY DEDUCTABLE IF APPLIED TO ANY OFFICE VISIT RECEIEVED HERE.
WITH MY SIGNATURE, I HEREBY STATE THAT ALL OF THE ABOVE INFORMATION WAS TRUTHFUL AND ACCURATE.
I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

SIGNED:_____ DATE:_____

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FRI:____

FOR EACH ITEM BELOW, CIRCLE *ONE* OF THE NUMBERS WHICH MOST CLOSELY DESCRIBES YOUR CONDITION RIGHT NOW

NAME:_____ DATE:_____

	0	1	2	3	4
1. **PAIN INTENSITY**	NO PAIN	MILD	MODERATE	SEVERE	WORST EVER
2. **SLEEPING**	PERFECT SLEEP	MILDLY DISTURBED	MODERATELY DISTURBED	GREATLY DISTURBED	TOTALLY DISTURBED
3. **PERSONAL CARE** (WASHING,DRESSING,ECT.)	NO PAIN OR RESTRICTION	MILD PAIN NO RESTRICTION	MODERATE NEED TO GO SLOW	MODERATE NEED ASSISTANCE	SEVERE 100% ASSISTANCE
4. **TRAVEL** (DRIVING, ECT.)	NO PAIN ON LONG TRIPS	MILD PAIN ON LONG TRIPS	MODERATE PAIN ON LONG TRIPS	MODERATE PAIN ON SHORT TRIPS	SEVER PAIN ON ON SHORT TRIPS
5. **WORK** (JOB OR HOME)	CAN DO USUAL WORK	CAN DO USUAL WORK NO EXTRA WORK	CAN DO 50% OF USUAL WORK	CAN DO 25% OF USUAL WORK	CANNOT WORK
6. **RECREATION**	CAN DO ALL ACTIVITIES	CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVITIES	CAN DO A FEW ACTIVITIES	CAN DO NO ACTIVITIES
7. **FREQUENCY OF PAIN**	NO PAIN	OCCASIONAL PAIN 25% OF THE DAY	INTERMITTEN PAIN 50% OF THE DAY	FREQUENT PAIN 75% OF THE DAY	CONSISTANT PAIN 100% OF THE DAY
8. **LIFTING** WEIGHT	NO PAIN	INCREASED PAIN WITH HEAVY WEIGHT	INCREASED PAIN WITH MODERATE WEIGHT	INCREASED PAIN WITH LIGHT	INCREASED PAIN WITH ANY WEIGHT
9. **WALKING**	NO PAIN AT ANY DISTANCE	INCREASED PAIN AFTER 1 MILE	INCREASED PAIN AFTER ½ MILE	INCREASED PAIN AFTER ¼ MILE	INCREASED PAIN WITH ANY WALKING
10. **STANDING**	NO PAIN AFTER AFTER SEVERAL HOURS	INCREADED PAIN AFTER SEVERAL HOURS	INCREASED PAIN AFTER 1 HOUR	INCREASED PAIN AFTER ½ HOUR	INCREASED PAIN WITH ANY STANDING

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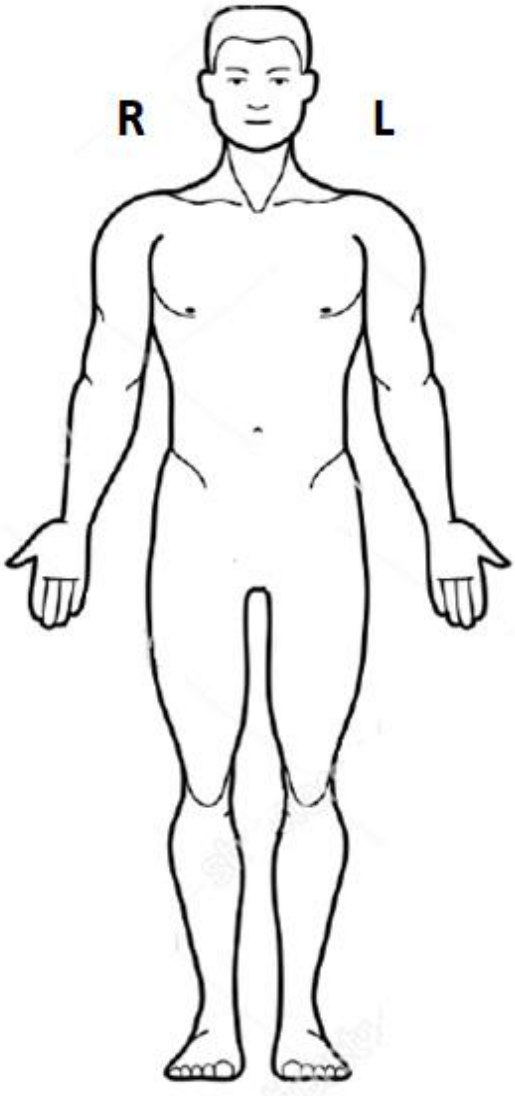
Write the corresponding letter directly on the area where you feel the pain.

NAME: _____ DATE: _____

A= ACHE **B=BURNING** **N=NUMBNESS**

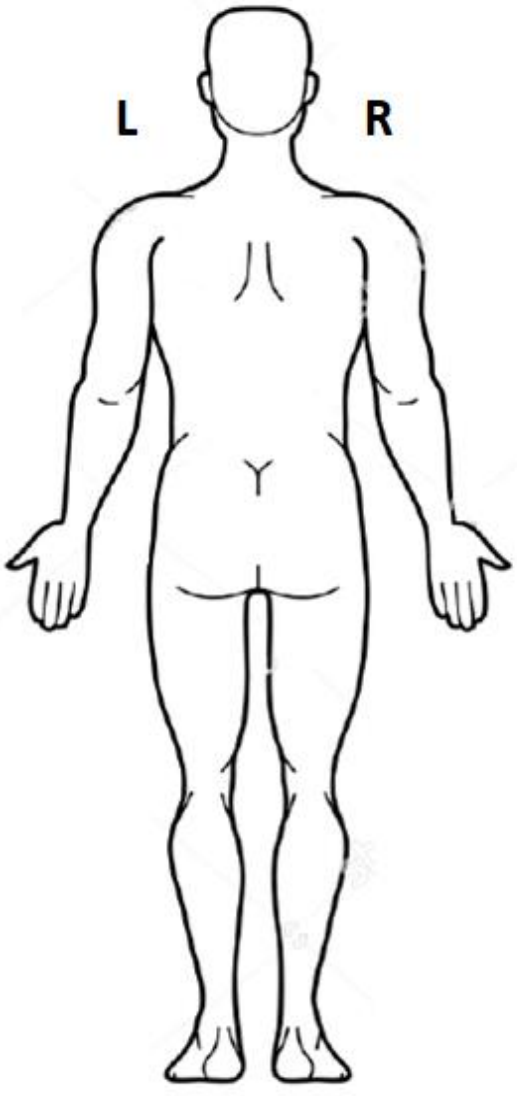
P= PINS& NEEDLES **S=STABBING** **T= TINGLING**

O=OTHER



RIGHT SIDE

LEFT SIDE



SIGNED:_____ DATE:_____