

Chiropractic Physicians of Las Vegas

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Patient Information

Name _____ Date _____
Date of Birth _____ Social Security # _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Occupation _____
Employer _____ Business Phone _____
Sex: Male Female Height _____ Weight _____
Are you: Married Single Domestic Partnership Divorced Separated
Spouses Name: _____ # of Children _____
Emergency Contact Name _____ Relationship _____
Contact Phone _____
Your Insurance Carrier _____ Claim Number _____
Other Party's Insurance Carrier _____ Claim Number _____
Name of Attorney _____ Phone Number _____

Medical History

Have you ever been treated by a Chiropractor? Y N

Family History

Check applicable Father Mother Grandparent Sibling Other (Specify)

Anemia _____
Cancer _____
Diabetes _____
Heart Disease _____
High Blood Pressure _____
Stroke _____
Epilepsy _____
Psychological Disorder _____
Asthma _____
Hay fever, Hives _____
Kidney Disease _____
Glaucoma _____
Tuberculosis _____
Age at death _____

Personal History

List hospitalizations or surgeries have you had with corresponding dates

Have you been diagnosed with any diseases or disorders and when?

Allergies?

Medications?

Prior Fractures/ Broken Bones and where and when?

Please check any current symptoms below:

HEAD

_____headache
_____entire head
or R
_____back of head
R
_____forehead
_____migrane
R
_____head feels heavy
_____loss of smell
_____loss of taste
_____loss of balance
in arm L or R
_____loss of hearing
in fingers L or R
_____pain in ears
sleep”
_____ringing in ears
_____light headed
in fingers
_____sensitive to light
fingers
_____dizziness
fingers
strength

MID BACK

_____pain

NECK

_____pain
_____pain with movement
_____pinched nerve
_____feels “our of place”
_____stiffness
_____muscle spasms
_____grinding/popping
_____arthritis

SHOULDERS

_____pain in joints L or R
_____pain across shoulders
_____bursitis L or R
_____arthritis L or R
_____can’t raise arms
_____above shoulder
_____above head
_____tension

HANDS & ARMS

_____pain
_____upper arm L
_____forearm L or
_____hand L or R
_____fingers L or
_____pinched nerve
_____arm L or R
_____finger L or R
_____pins & needles
_____pins & needles
_____fingers go “to
_____cold hands
_____swollen joints
_____sore joints in
_____arthritis in
_____decreased grip

ABDOMEN

_____pain between shoulders
stomach

_____muscle spasms

LOW BACK

_____pain
_____pain increases with:
_____working
_____lifting
_____stooping
_____standing
_____sitting

feeling

_____bending
_____coughing

loss/gain

_____pinched nerve
_____slipped disc
_____feels "out of place"
_____arthritis
months? _____

_____muscle spasms

_____pinched nerve

_____muscle spasm L or R

HIPS, LEGS & FEET

_____pain
_____in buttocks L or R
_____hip joint L or R
_____down leg L or R
_____leg cramps
_____pins & needles
_____numbness

_____leg L or R
_____foot L or R

_____toes L or R
_____cold feet

_____foot cramps L or R
_____swollen ankles L or R

_____swollen feel L or R
_____pain in toe joints

_____nervous

_____gas
_____constipation
_____diarrhea

GENERAL

_____nervousness
_____irritable
_____depressed
_____fatigue
_____run down
_____loss of sleep
_____weight

WOMEN ONLY

pregnant? Y or N
how many

Automobile Accident Questionnaire:

Please explain in detail how your accident happened:

You were the: Driver_____ Front Passenger_____ Rear Passenger_____

Were you wearing a seatbelt? Y N

You were struck from: Behind_____ Front_____ Left Side_____ Right Side_____

Did you feel pain immediately after the accident? Y N

Where? Headache _____Neck_____ Middle Back_____ Lower
Back_____

Upper Extremities_____ Lower Extremities_____

Did you go to the Hospital or Urgent Care? Y N

If yes, did you go by ambulance? Y N

Have you received any treatment prior to coming to this office? Y N

If yes, what date? _____

Where? _____

What type of Treatment? _____

Have x-rays been taken following this accident? Y N

If yes, where and of what body part? _____

Have any MRI's or CT scans been taken following this accident? Y N
If yes, where and of what body part? _____

Have you ever been in a automobile accident before? Y N
If yes, what date? _____

If yes, are you having any residual pain? _____

Are you still under treatment for a prior accident? _____

Have you ever had any complaints in the involved area before? Y N
If yes, what were the complaints? _____

Are your work activities restricted as a result of this accident? Y N

Did you have to take time off work as a result of this accident? Y N
If yes, how many days have you missed as a result of this accident? _____

Have you returned to work since this accident? _____ Full time _____ Part time
_____ Full duty _____ Light duty

Is your sleep disturbed as a result of this accident? Y N
If yes, is it disturbed due to pain? Y N
How many hours do you sleep at night? _____

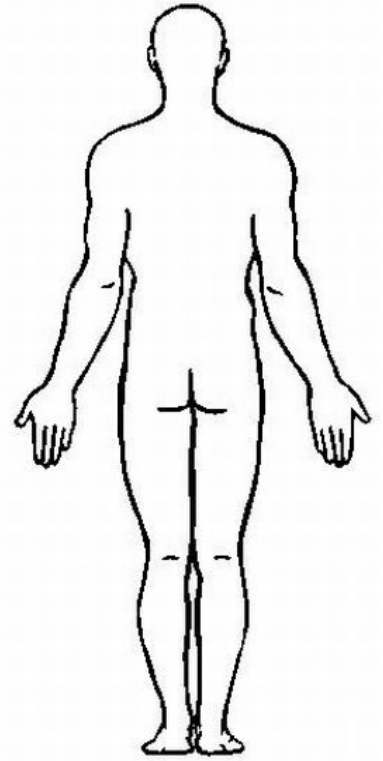
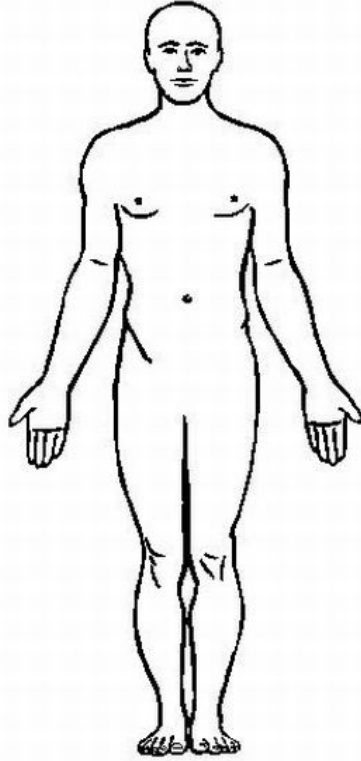
Is it difficult to sit, stand, walk, bend or lift as a result of this accident? Y N
How long can you:
Sit for? _____ minutes or hours
Stand for? _____ minutes or hours
Walk for? _____ minutes or hours

Since this injury are your symptoms: _____ worse _____ the same _____ better

Name: _____

Date: _____

Please draw where you pain is:



Please describe the pain:

___ Aching

___ Sharp

___ Throbbing

___ Tender

___ Nagging

___ Shooting

___ Burning

___ Numb

___ Tingling

___ Stabbing

___ Dull

How often do you experience the pain?

___ Constantly

___ Frequently

___ Intermittent

___ Occasionall

DUTIES UNDER DURESS/LOSS OF ENJOYMENT QUESTIONNAIRE

Patient Name: _____ Date: ____/____/20____

Complete the following summary as it relates to your work duties and your living duties and how the accident injury is **affecting** your overall performance at work and/or home.

Check which activity is affected by the accident injury which requires you to reduce the time you are capable of performing these activities.

Job description: _____

N/A Work	Reason for the difficulty		
_____ lifting	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
_____ bending	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
_____ sitting	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
_____ walking	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
_____ Computer duties	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
Other: _____	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness

N/A Studies/School	Reason for the difficulty		
_____ lifting	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
_____ bending	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
_____ sitting	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
_____ walking	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
_____ Computer duties	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
_____ studying	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
Other: _____	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness

N/A Domestic Duties	Reason for the difficulty		
_____ vacuuming	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
_____ Taking care of kids	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
_____ cleaning	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
_____ Preparing Meals	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
Other: _____	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue

N/A Household Duties	Reason for the difficulty		
_____ Yard work	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
_____ Transportation	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
_____ shopping	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue
_____ taking out trash	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Weakness
Other: _____	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted movement	<input type="checkbox"/> Fatigue