* Lawson Chiropractic Office * New Patient Information Worksheet*

Name: ___________________________________ SS#: _____________________ Age: _____

Address: ________________________ City: ________________: State: ________ Zip: _______

Home Phone: _________________ Work Phone: ________________ Birth Date: ____________

Employed By: ____________________________ Spouse Name: ________________________

Spouse's Birth Date: ____________________ Spouse's SS#: ____________________

Referred By: (Friend) (Relative) (Website) (Google Search) (Other : ____________________)

Which one of our patient's should we thank for referring you? ____________________

Please circle your current symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain)

(Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain)

(Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other: ________________________)

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

List all surgeries in the past five years: ____

Have you ever had spinal surgery? (No) (Yes: ____________________________________)

List any serious condition the doctor should be aware of: ______________________________

Previous Chiropractor: ______________________________ Were you satisfied? (No) (Yes)

*Females: Are you pregnant at this time? (No) (Yes) Due Date: ______________________

Office Policies: *If I am accepted as a patient at the Lawson Chiropractic Office I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care.*

Consent to Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Lawson to proceed with any necessary treatment. I have read Dr. Lawson's office policies and consent to treat information, and I agree with them by signing below:*

Signature: ____ Date: ________________

Parent/Guardian's Signature: ______________________________ Date: ________________

Dr. Marc G. Lawson, D.C., Q.M.E.
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Work/Cell: 858-576-6329

Patient's Name.______________________________ **Date**________________

(Please ***circle the number*** *which most closely describes your "Activities Of Daily living" today)*

1. Pain Intensity

(0)	(1)	(2)	(3)	(4)
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency of Pain

(0)	(1)	(2)	(3)	(4)
No Pain	Occasional Pain 25% of the day	Intermittent Pain 50% of the Day	Frequent Pain 75% of the Day	Constant Pain 100% of the Day

3. Personal Care (Washing, Dressing, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% Assistance

4. Travel (Driving, Riding, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain On Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

(0)	(1)	(2)	(3)	(4)
Can Do Usual Work Plus Extra Work	Can Do Usual Work No Extra Work	Can Do 50% of Usual Work	Can Do 25% of Usual Work	Cannot Work

6. Recreation

(0)	(1)	(2)	(3)	(4)
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

7. Sleeping

(0)	(1)	(2)	(3)	(4)
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

(0)	(1)	(2)	(3)	(4)
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Heavy Weight

9. Walking

(0)	(1)	(2)	(3)	(4)
No Pain Any Distance	Increased Pain After One Mile	Increased Pain After Half Mile	Increased Pain After Quarter Mile	Increased Pain With All Walking

10. Standing

(0)	(1)	(2)	(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Standing

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Patient Health History Worksheet

Patient's Name:____Date:__________________

Significant Past Health History

Have you ever been hospitalized?
a) No
b) Yes (Year: _________) (Reason: _________________)

Have you had any surgeries?
a) No
b) Yes: (Year: _________) (Reason: _________________)

Do you have any significant health problems?
a) No
b) Yes: (Year: _________) (Reason: _________________)

Significant Past Medical History

Have you seen another doctor for this condition?
a) No
b) Yes: (Name:___________________________________)

Did this doctor recommend any treatment?
a) No
b) Yes:: (____)

Are you taking any medications?
a) No
b) Yes: (____)

Significant Past Social History

Do you play any sports or exercise?
a) No
b) Yes: (____)

How many hours do you sleep a night? (__________)

How many hours a week do you work? (__________)

Significant Family Medical History

Did your father have any health problems?
a) No
b) Yes: (____)

Did your mother have any health problems?
a) No
b) Yes (____)

Did your brother(s) have any health problems?
a) No
b) Yes: (____)

Did your sister(s) have any health problems?
a) No
b) Yes: (____)

Did your grandfather have any health problems?
a) No
b) Yes: (____)

Did your grandmother have any health problems?
a) No
b) Yes: (____)

Health Risk Factors

Do you drink alcohol?
a) No
b) Yes: (____)

Do you smoke?
a) No
b) Yes: (____)

Anything else the doctor should know about?
a) No
b) Yes: (____)

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Patient Health History Worksheet

Patient's Name:____Date:__________________

Present Health History

When did your present condition begin?

a) Gradual Onset (no specific date)
b) Date:__________________________

What caused your present condition?
a) No specific injury
b) Home accident
c) Work Accident
d) Auto Accident

What happened to cause your present pain?

____
____
____
____
____

Have you ever had these symptoms before?
a) No
b) Yes: (Date:_____________________________.-

What time of day are your symptoms better?
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

What time of day are your symptoms worse?
a) Morning b)
Afternoon c)
Evening
d) All of the above (constant pain)

Have you missed any work from this condition?
a) No
b) Yes: (Date:)

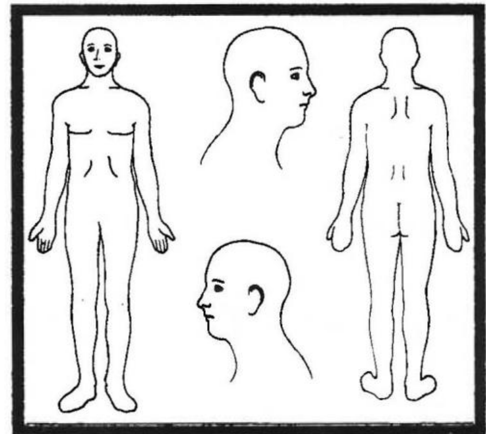
What makes your pain better?

a) Rest
b) Ice packs/Heating pads
c) Prescription Medications
d) Drug store medications (Ibuprofen, Advil)
e) Other: (_________________________________)

What makes your pain worse?
a) Activity (work, repetitive motions)
b) Ice packs/Heating pads
d) Driving (or riding) in car
e) Other: (_________________________________)

What home remedies have you tried?
a) Ice packs
b) Heating pads/Hot tubs
c) Exercise
d) Other: (_________________________________)

Please Label the Area(s) of Today's Pain



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