## Stephenson Chiropractic Center Ted R. Stephenson, D.C.

Namo		Mailing Addross		
Name			Cell Phone()	
-	-			
			Male □ Female □ DL#	
	_	_	nt)	
•			Work Phone:()_	
			ZipCode	
			re they located?	
Have you ever had Chiropraction	c care before?	If yes, doctor's name:	· ·	
If you are experiencing any pai	n(neck, low back pa	iin, mid back pain, etc.) healtl	h problems	
1		For how long?		
2		For how long?		
3		For how long?		
4		For how long?		
Has the problem been getting v	worse or staying the	same?		
Currently or in the past have yo	ou ever experienced	any of these complaints whi	le working? □Yes □No	
If yes, describe what activities	at work that may be	causing you to experience th	nese complaints:	
Are there any other activities, in	ncidents, or events o	outside of work that may have	e caused these complaints? □Yes □No	
If yes, please explain:				
Have you at any time in the par	st ever suffered a wo	ork injury? □Yes □No If yes,	what is the date of injury?	
Do you have an attorney repres	senting you for this v	work injury? □Yes □No If ye	s, who is your attorney?	
Have you ever had any surgeri	es or hospitalization	s? □Yes □No If yes, please	list:	
Please list any injuries or illnes	ses not listed above	:		
Please indicate medications (o	ver the counter) / pro	escriptions you are currently	taking: □ Aspirin/Tylenol □Pain killers	
☐Muscle Relaxers ☐Insulin	□Tranquilizers □E	Birth Control Pills □Others		
Health Insurance Co. Name			Policyholder	
Name of spouse's health insurance (If applicable)			Policyholder	
Name of spouse's nealth insura	ance (If applicable) <sub>-</sub>		Policyholder	

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.

0 means no disability at all and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

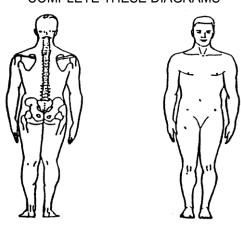
<u>0 1 2 3 4 5 6 7 8 9 10</u>

Completely Totally able to function unable to function

- \_\_\_\_1. **FAMILY/HOME RESPONSIBILITIES**: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.)
- \_\_\_\_2. **RECREATION**: hobbies, sports, and other similar leisure time activities.
- \_\_\_\_3. **SOCIAL ACTIVITY**: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.
- \_\_\_\_4. **OCCUPATION**: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker.
- \_\_\_\_5. **SELF CARE**: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.
- \_\_\_\_6. **LIFE SUPPORT ACTIVITY**: basic life supporting behaviors such as eating, sleeping, and breathing.

\*\*If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, numbness, burning, etc.

## COMPLETE THESE DIAGRAMS



Method of payment for today's charges:

□ CASH

□ CHECK

☐ CREDIT CARD

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

- 1. All first visit charges are payable when services are rendered.
- 2. The fee paid for x-rays is for analysis only. Texas State Law requires we maintain your x-rays. The film itself is the property of this office. Electronic copies may be sent to another facility with authorization only.

Patient's Signature	Date