Keith W. Fady, D.C., P.A.
14100 Walsingham Rd., Ste. 35
Largo, FL 33774
727-596-1885

PT# _____

PATIENT INFORMATION

Date: _____

Name: _____ Age: _____
Address: _____ City: _____ State: ___ Zip: _____
Birthdate: _____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail Address: _____ Sex: Male Female
Marital Status: Single Married Separated Widowed Divorced # of Children: _____
Employer: _____ Referred by: _____
Employer Address: _____ Job Title: _____
Spouse's Name: _____ Spouse's Employer: _____
By what name may we call you? _____

Medical Information:

Present Complaint: _____
What can't you do now that you could do before this condition? _____
_____
When did the condition begin? _____ How did it develop? _____
What makes it feel better? _____ Worse? _____
Have you ever been involved in an Auto Accident? Never Within two years Over 2 years ago
Other Doctors that have treated this condition: _____
_____
Previous Medical Problems/Surgeries: _____
_____
_____
Previous Chiropractic Care: Yes No Name: _____

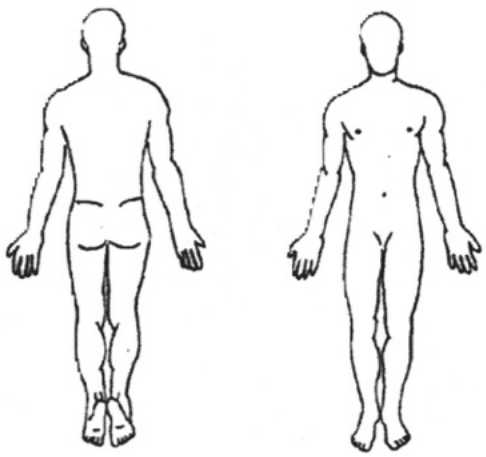
PLEASE RATE YOUR PAIN/STIFFNESS BELOW (CIRCLE SEVERITY).

1 = Minimal and 10 = Severe

Neck Pain: 0 1 2 3 4 5 6 7 8 9 10
Headaches: 0 1 2 3 4 5 6 7 8 9 10
Mid Back Pain (between shoulder blades): 0 1 2 3 4 5 6 7 8 9 10
Lower Back Pain: 0 1 2 3 4 5 6 7 8 9 10
Leg and/or Buttock Pain: 0 1 2 3 4 5 6 7 8 9 10
Other: _____ 0 1 2 3 4 5 6 7 8 9 10
Other: _____ 0 1 2 3 4 5 6 7 8 9 10

USE THESE SYMBOLS BELOW TO MARK LOCATION OF SYMPTOMS

ACHE….AAAAA
SHARP PAIN….////
NUMBNESS….=====
PINS & NEEDLES…..00000



Doctor's Use: _____
_____
_____
_____
_____
_____

Check any of the following conditions you have EVER had in the past:

__ Pneumonia
__ Rheumatic Fever
__ Chicken Pox
__ Diabetes
__ Mental Disorder
__ Mumps
__ Pleurisy
__ Arthritis
__ Epilepsy
__ Cancer
__ Influenza
__ Heart Disease
__ Lowback pain
__ Measles
__ Thyroid
__ Anemia
__ Polio
__ Tuberculosis
__ Whooping cough

Check any of the following conditions you CURRENTLY have or have had in the last 6 months:

__ Low Back pain
__ Pain Between shoulders
__ Neck pain
__ Arm pain
__ Joint pain/stiffness
__ Walking problems
__ Problems chewing
__ General stiffness
__ Nervousness
__ Numbness
__ Paralysis
__ Dizziness
__ Forgetfulness
__ Confusion/depression
__ Fainting
__ Convulsions
__ Cold/Tingling extremities
__ Stress
__ Menstrual irregularity
__ Menstrual cramping
__ Vaginal pain/infections
__ Poor/Excessive appetite
__ Excessive thirst
__ Frequent nausea
__ Vomiting
__ Diarrhea
__ Constipation
__ Hemorrhoids
__ Liver problems
__ Gall bladder problems
__ Weight trouble
__ Abdominal cramps
__ Gas/Bloating after meals
__ Heartburn
__ Black/Bloody stool
__ Colitis
__ Bladder trouble
__ Painful/Excessive urination
__ Discolored urine
__ Prostate/Sexual dysfunction
__ Breast pain/lumps
__ Fatigue
__ Allergies
__ Loss of sleep
__ Fever
__ Headaches
__ Short breath
__ Blood Pressure problems
__ Irregular Heartbeat
__ Heart problems
__ Vision problems
__ Lung problems
__ Varicose veins
__ Ankle swelling
__ Stroke
__ Chest pain
__ Dental problems
__ Sore throat
__ Earaches
__ Hearing difficulty
__ Stuffed nose

Females: Are you currently Pregnant? Y or N **Start-date of last period:**_____

Are you presently taking: __ Pain pills __ Aspirin __ Muscle relaxers __ Birth Control Pills __ Insulin __ Vitamins __ Tranquilizers Other _____

Who is your Medical Doctor? _____

Do you sleep on your: __ Back __ Side __ Stomach **Type of Pillow:** __ Orthopedic __ Feather __ Foam __ Fiberfill

Type of Bedding you currently use: __ Firm Mattress __ Soft Mattress __ Waterbed **Age of Bedding:** ____ Years

Social History:

Coffee:	None	Light	Moderate	Heavy
Tea:	None	Light	Moderate	Heavy
Alcohol:	None	Light	Moderate	Heavy
Cigarettes:	None	Light	Moderate	Heavy
White Sugar:	None	Light	Moderate	Heavy
White Flour:	None	Light	Moderate	Heavy

Circle below your HABITS in the following activities:

Exercise:	None	Light	Moderate	Heavy
Appetite:	None	Light	Moderate	Heavy

Sleep: # of hours sleep per night: _____
Quality of Sleep: Good Fair Poor
Any additional comments: _____
_____

In case of an Emergency, please notify:

Name: _____
Relationship: _____
Address: _____
_____
Phone:_____ Home
_____ Work
_____ Cell

Doctor's Use: _____
_____
_____
_____

X _____ /
(Signature of Patient / Guardian) **(Date)**

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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, etc.)

0	1	2	3	4
No pain on long 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 unlimited 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. 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

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 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 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Keith W. Fady, D.C., P.A.
14100 Walsingham Rd.,Suite 35
Largo, Fl 33774
727-596-1885