ALIGNIS Clinical Records System

Patient Health Assessment

Please PRINT or WRITE Clearly

General Information

Email address: _____

Patient Name: _____ Date: _____

Provider Name: Michael A. Irhin, D.C.

Primary Care Physician's Name: _____

Patient Sex: M____ F____ Date of Birth: _____ Age: _____ Social Security #: _____

Patient Address: _____ Marital Status: S M O

Home Phone: _____ Cell Phone: _____

Patient Employer: _____ Patient Occupation: _____

Subscriber Name: _____ /D.o.B. _____ Relation to Patient: _____

Subscriber Employer: _____ Subscriber Social Security #: _____

Referred for Treatment by: _____

Health Insurance Plan: _____ Group #: _____ Member #: _____

Complaint History

1. Describe your current complaint and how the problem began: _____

_____

How long have you had this condition? _____ **Date of onset:** _____

2. How would you describe pain?

❒ Sharp ❒ Soreness ❒ Throbbing ❒ Tingling ❒ Dull ❒ Stiffness
❒ Spasm ❒ Burning ❒ Ache ❒ Weakness ❒ Numbness ❒ Shooting

3. How would you rate the intensity of your pain? *(Circle the appropriate number)*

0 1 2 3 4 5 6 7 8 9 10

(no pain) *(moderate pain)* *(terrible/unbearable pain)*

4. How often is the pain present?

❒ Constant (81-100%) ❒ Frequent (51-80%) ❒ Occasional (26-50%) ❒ Intermittent (25% or less)

5. Since your problem began is the pain:

❒ Getting worse ❒ Getting better ❒ Staying the same

6. How did your problem begin? **Explain:** _____

❒ An auto accident ❒ Work related accident ❒ Other type of accident
❒ Gradual ❒ Sudden ❒ No specific reason

7. What makes your problem better?

❒ Nothing ❒ Walking ❒ Standing ❒ Sitting ❒ Moving around/exercise ❒ Lying down ❒ Inactivity

8. What makes your problem worse?

❒ Nothing ❒ Walking ❒ Standing ❒ Sitting ❒ Moving around/exercise ❒ Lying down ❒ Inactivity

9. Are you currently taking any medications? ❒ Yes ❒ No

If yes, please describe _____

10. Were you previously treated for an earlier occurrence of this *same* condition? ❒ Yes ❒ No

If yes, by whom? ❒ MD ❒ Chiropractor ❒ Physical therapist ❒ Other _____

What were the approximate dates, type of treatment and the results? _____

_____

11. What is your physical activity at work?

❒ Mostly sitting ❒ Light manual labor ❒ Moderate manual labor ❒ Heavy manual labor

(OVER PLEASE)

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Patient Health Assessment (cont.)

12. Do you exercise?

❒ No regular exercise ❒ 1-2 times a week ❒ 3-4 times a week ❒ 5-7 times a week
❒ Cardiovascular ❒ Stretching ❒ Weight Machine ❒ Free Weights ❒ Sports _____ Type

13. What is your present general stress level:

❒ No stress ❒ Minimal stress ❒ Moderate stress ❒ Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

❒ No effect ❒ Have some limited physical restrictions, but can function
❒ Need some assistance with daily activities ❒ Cannot work
❒ Cannot function without assistance ❒ Totally disabled

Past Or Present Symptoms, Conditions Or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	❒	❒	High blood pressure	❒	❒
Shoulder pain	❒	❒	Heart condition	❒	❒
Arm/elbow pain	❒	❒	Respiratory condition	❒	❒
Hand pain	❒	❒	Digestive problems	❒	❒
Upper back pain	❒	❒	Kidney/bladder problem	❒	❒
Lower back pain	❒	❒	Menstrual problems	❒	❒
Pain in upper leg or hip	❒	❒	Breast soreness/lump	❒	❒
Pain in lower leg or knee	❒	❒	Sinus conditions	❒	❒
Pain in ankle or foot	❒	❒	Allergies/asthma	❒	❒
Jaw pain	❒	❒	Cancer	❒	❒
Swelling/stiffness of joints	❒	❒	Stroke	❒	❒
Headaches	❒	❒	Excessive weight loss/gain	❒	❒
Dizziness	❒	❒	Skin condition	❒	❒
Fainting spells	❒	❒	Arthritis	❒	❒
Convulsions	❒	❒	Diabetes	❒	❒
General prolonged fatigue	❒	❒	Prostate condition	❒	❒
Condition of uterus/ovaries	❒	❒			

Tobacco use:
❒ **Past** ❒ **Present**
❒ Occasional ❒ Moderate ❒ Heavy

Alcohol use:
❒ **Past** ❒ **Present**
❒ Occasional ❒ Moderate ❒ Heavy

Caffeine use: *(Coffee, tea, soft drinks)*
❒ **Past** ❒ **Present**
❒ Occasional ❒ Moderate ❒ Heavy

Pregnancy: ❒ **Past** ❒ **Present**

Surgical Procedure:
❒ **Past** ❒ **Present**

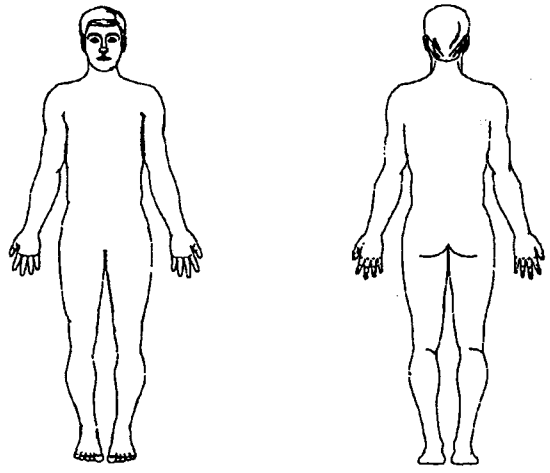
Please list: _____

_____

Comments: _____

_____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date