Neck & Back Pain Specialists

NBPS Patient Information Form

Purpose: To determine if any of your health problems can be helped out with our Methods

Name ________________________________ Phone (home)________________________ (Work)__________________

Address__________________________________ City______________________ State.______ Zip_________________

Date of Birth ____________________________ Email Address____

CHECK OFF ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

- ☐ Low Back pain
- ☐ Pain between Shoulder Blades
- ☐ Neck Pain
- ☐ Tension Headaches
- ☐ Tired Fatigue
- ☐ Wrist Hand Pain
- ☐ Numbing: Tingling in Arms or Hands
- ☐ Numbing: Tingling in Legs or Feet
- ☐ Elbow pain
- ☐ Shoulder Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle Foot Pain
- ☐ Ringing in Ears
- ☐ Dizziness
- ☐ Nervous
- ☐ Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive Problems
- ☐ Weight Trouble

Which of the above is worst?____

How long have you had it?____

When it is at its worst, how does it feel?____

Does this cause you to be:

- ☐ Moody
- ☐ Irritable
- ☐ Restricted On daily Activities

Does this affect your Work:

- ☐ Decision Making
- ☐ Poor Attitude
- ☐ Decreased Productivity
- ☐ Unable to Work Long Hours

Does this affect your Life:

- ☐ Lose of Patience with spouse or children
- ☐ Restricted household Duties
- ☐ Ability to excersise or Practice in Sports
- ☐ Interferes with ability to Participate in Hobbies or other Desired Activities

HOW DID YOU HEAR ABOUT US:

- ☐ L.A. Fitness
- ☐ Walk In
- ☐ Mailer
- ☐ Yellow Pages
- ☐ Insurance Book
- ☐ Patient Referral____
- ☐ Attorney Referral_______________________________________
- ☐ Internet (Specify)_______________________________________
- ☐ Doctor Referral____
- ☐ Other____

I (signature)____________________________________consent to allow NBPS Doctors to perform a consultation and examination (if necessary) in order to determine if I am a good candidate for care at the office and also to determine if they are willing to accept my case. This is Not a guarantee of acceptance.

NBPS CONSULTATION FORM

Patient's Name_______________________________ Date_______________________

1. Have you been to a Chiropractor before? If yes, When and Purpose of visit?
2. Which of your major complaints bother you the most?
3. How did your complaint(s) start? Date of injury?
4. When was the last time it bothered you?
5. What were you doing?
6. What do you do to get rid of the pain? Are you taking any medications or supplements?
7. What makes it feel worse? When it is at its worst how does it feel?
8. How would you describe your Pain? (Dull achy, sharp, radiating, burning, etc…)
9. Does your pain radiate into your arms or legs? Do you have numbness?
10. On a scale 1-10 (10 being worst), how would you rate your pain?
11. Is your pain Constant, Frequent, Occasional, or Intermittent?
12. Prior Accidents/injuries:____
Hospitilization_______________________Surgeries_____________________________
Allergies_____________________________Drink/Smoke__________________________
13. How does this affect you? How do you modify your day? Compare a day with the pain to a day without?

a. Home b. Work c. Outside activities

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(Life, career, marriage, relationships, hobbies, sports, interests, energy, mood, enjoyment of life)?

14. Has this gotten better on its own, stayed the same, or gotten worse?
15. What are you hoping to get out of this visit?