Optimal Family Chiropractic, LLC
22 Plaza Road
Flanders, NJ 07836
973-584-4888
Dr. Brenda L. Rooney

Initial Patient Health Assessment Form

General Information:

Patient Name: _____, Date: _____/_____/20_____

Patient's Address: _____.

City: _____, State: _____, Zip Code: _____

Home Phone #: _____-_____-_____, Work Phone #:_____-_____-_____,

Cell #:_____-_____-_____ E-mail address: _____,

Date of Birth: _____/_____/_____ Sex: □ M, □ F, □ Transgender

Social Security #:_____-_____-_____.

□ Married, □ Widowed, □ Single, □ Minor, □ Significant other, □ Separated, □ Divorced,

□ Partnered for _____ years

Patient Occupation: _____,

Patient's Employer/School: _____.

Patient's Employer/School address: _____.

Patient's Employer/School Phone #: _____-_____-_____

Health Insurance Plan: _____, Group #:_____

Member ID #: _____,

Other Health Insurance: _____, Group #:_____

Member ID #: _____.

***Name of Insured** (if other than you):_____.

Relation to Patient: _____,

Date of Birth: _____/_____/_____ Insured Social Security #: _____-_____-_____.

Insured's Employer: _____.

Who may we thank for referring you to the office for treatment? _____.

Health Insurance Plan: _____, Group #:_____

Member ID #: _____,

Other Health Insurance: _____.

In case of an Emergency, contact: Name: _____

Relationship: _____, Home #:_____-_____-_____, Work #:_____-_____-_____,

Cell #:_____-_____-_____,

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Symptom/Condition History:

1) Please describe your current condition and how the problem began:_____
_____

2) How long have you had this problem? _____

3) What caused your problem? (Check appropriate box below) or explain: _____
_____

□ Auto accident □ Work related accident □ No specific reason
□ Gradual □ Sudden □ other type of accident, please explain below:
_____

4) How would you describe your pain? (Mark all that pertains to your pain)

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

5) How would you ***rate the intensity*** of your pain right now? (Circle a number)

0	1	2	3	4	5	6	7	8	9	10
(No Pain)	(Minimal)		(Mild)		(moderate)		(severe)		(unbearable)	

6) How often is the ***pain present during*** your waking day? (Check appropriate box)

□ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

7) **Pain Scale**: ***0 is no pain & 10 is the worst possible pain***, please ***circle*** the number below that indicates the amount of pain you are experiencing right now.

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

0	1	2	3	4	5	6	7	8	9	10
(No Pain)	(Minimal)		(Mild)		(moderate)		(severe)		(unbearable)	

8) Since your problem began, is your pain getting, □ Better, □ Worse, □ Staying the same.

9) What makes your problem better?

□ Nothing □ Walking □ Standing □ Sitting □ Lying down □ Moving □ Rest
□ Others: _____

10) What makes your problem worse?

□ Nothing □ Walking □ Standing □ Sitting □ Lying down □ Moving □ Rest
□ Others: _____

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Symptom/Condition History Continued:

11) Are you currently taking any medications for this condition or any other conditions? Please name your condition(s), the medications name, the amount taken daily (mg), and how many times a day you take the medication (1/2/3etc…).

_____
_____
_____
_____
_____

12) Do you take any vitamins, herbs, or nutritional supplements? □ Yes, □ No, if yes, please give the name of the product, the amount taken daily (mg), and how many times a day you take them (1/2/3etc…).

_____
_____
_____
_____
_____

13) Were you previously treated for this condition? □ Yes, □ No, if yes, in your own words please describe below which professional provider diagnosed your condition, and the outcome of the treatment.

□ MD/□ DO □ Chiropractor □ Physical Therapy □ Acupuncturist
□ Others: _____

Please explain in detail: _____
_____
_____
_____
_____

14) What were the approximate dates of your treatments, the type of treatments, and your response to your treatments? _____
_____
_____
_____

15) How physical is your activity at work?
□ Mostly sitting □ Light manual □ Moderate manual □ Heavy manual

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Symptom/Condition History Continued:

16) Do you exercise?

□ No regular exercise □ 1-2 times/week □ 3-4 times/week □ 5-7 times/week
□ Cardiovascular □ Stretching □ Weight Machine □ Free Weights □ Yoga
Please explain: _____
_____
_____
□ Sports in school and/ or □ Travel team, Please explain: _____
_____
_____

17) What is your general stress level?

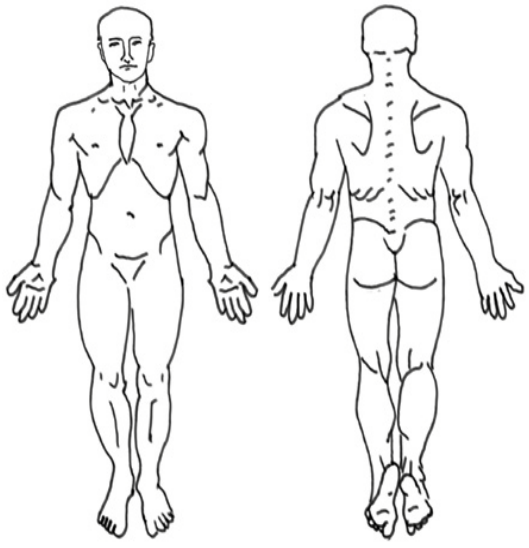
□ No Stress □ Minimal Stress □ Moderate Stress □ Very Stressed

18) Is your problem affecting your ability to work or do other routine daily activities?

□ No effect □ Have some restrictions but can function □ Need some assistance with activities
□ cannot function without assistance □ cannot work □ totally disabled

On the Anatomical Diagram below

Please mark with the letters below where you are experiencing pain or other symptoms right now.
A = ACHE, B = BURNING, N = NUMBNESS, S = STABBING, P/N = PINS & NEEDLES (TINGLING),
S/S = SHARP SHOOTING, W = WEEKNESS IN MUSCLES
OTHERS: _____



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Family History

Please review the list below of diseases and conditions and Mark an X to indicate any current health conditions of a family member. Please leave the spaces blank that do not apply to any family member. If you where adopted please mark □ Yes and please leave the Family History blank.

Conditions	Father	Mother	Spouse	Brother(s)		Sister(s)		Children(s)	
	Age ( )	Age ( )	Age ( )	Age ( )	Age ( )	Age ( )	Age ( )	Age ( )	Age ( )
Back Conditions									
Neck Conditions									
Disc Problems back									
Neuritis									
Neuralgia									
Pinched nerve									
Scoliosis									
Epilepsy									
Osteoarthritis									
Rheumatoid Arthritis									
Bursitis									
Depression									
Stomach Conditions									
Constipation									
Headaches									
Migraine Headaches									
Asthma-Hay Fever									
Sinus Conditions									
Lung Conditions									
Emphysema									
COPD									
Heart Conditions									
By Pass									
Hypertension									
Kidney Conditions									
Liver Conditions									
Cancer									
Insomnia									
Diabetes Type I									
Diabetes Type II									

If the above parents or siblings were deceased, how old were they, and what condition did they pass away from?

_____

_____

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Past or Present Symptoms, Conditions or Habits:

Please check the box indicating whether this applies to past or present.

Symptoms/Conditions:	**Past**	**Present**	**Diagnosis Date**
*Rheumatoid arthritis	□	□	____/____/_____
Osteoarthritis	□	□	____/____/_____
Ankylosing spondylitis	□	□	____/____/_____
Bone fractures: _____	□	□	____/____/_____
Malignancy of the spine	□	□	____/____/_____
Infection of the bones or joints	□	□	____/____/_____
Myelopathy	□	□	____/____/_____
Cauda Equina syndrome	□	□	____/____/_____
Carotid artery problems	□	□	____/____/_____
Aneurysm	□	□	____/____/_____
*Instability of joints	□	□	____/____/_____
Benign tumors of the spine	□	□	____/____/_____
Osteoporosis	□	□	____/____/_____
Bleeding disorders	□	□	____/____/_____
Nerve problems	□	□	____/____/_____
Multiple Sclerosis	□	□	____/____/_____
Anticoagulants/blood thinning therapy	□	□	____/____/_____
*Dizziness	□	□	____/____/_____
Drop Attacks	□	□	____/____/_____
Double vision	□	□	____/____/_____
Difficulty speaking	□	□	____/____/_____
Difficulty swallowing	□	□	____/____/_____
Nausea	□	□	____/____/_____
Numbness □ R/□ L _____	□	□	____/____/_____
Nystagmus	□	□	____/____/_____
Neck pain □ R/□ L	□	□	____/____/_____
Jaw pain □ R/□ L	□	□	____/____/_____
TMJ/TMD	□	□	____/____/_____
Headaches: Type: _____	□	□	____/____/_____
Fainting spells	□	□	____/____/_____
High blood pressure	□	□	____/____/_____
Stroke	□	□	____/____/_____
Transient ischemic attacks	□	□	____/____/_____
*Shoulder pain □ R/□ L	□	□	____/____/_____
□ Arm/□ Hand pain □ R/□ L	□	□	____/____/_____
Neck Pain	□	□	____/____/_____
Upper back pain	□	□	____/____/_____
Lower back pain	□	□	____/____/_____
Hip pain □ R/□ L	□	□	____/____/_____
Knee pain □ R/□ L	□	□	____/____/_____
□ Ankle/□ Foot pain □ R/□ L		□	____/____/_____

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Past or Present Symptoms, Conditions or Habits Continued:

Symptoms/Conditions:	**Past**	**Present**	**Diagnosis Date**
Fatigue	□	□	____/____/_____
Respiratory condition	□	□	____/____/_____
Digestive problems	□	□	____/____/_____
Kidney problems	□	□	____/____/_____
Menstrual problems	□	□	____/____/_____
□ Sinus/□ allergy/□ asthma conditions	□	□	____/____/_____
□ Weight Gain/□ Loss _____lb	□	□	____/____/_____
Cancer Type: _____	□	□	____/____/_____
Skin condition	□	□	____/____/_____
Diabetes: □ Type I /□ Type II	□	□	____/____/_____
Prostate problems	□	□	____/____/_____

*Tobacco use: # Packs per day □ 1, □ 2, □ 3, brand of cigarettes: _____,
Onset of smoking: _____/_____/_____, how many years have you been smoking? _____.

Alcohol use: # of drinks per day □ 1, □ 2, □ 3 or □ _____, type of Alcohol: □ Beer, □ Wine, &
□ Other liquor: _____.

Caffeine use: # of Cups per day □ 1, □ 2, □ 3 or □ _____.

Pregnancy:

* Pregnancy Vaginal Delivery Dates: ____/____/_____, ____/____/_____, ____/____/_____
* Pregnancy C-Section Delivery Dates: ____/____/_____, ____/____/_____, ____/____/_____
Epidural Injections: how many _____, and dates: ____/____/_____, ____/____/_____,

***Surgery Dates:** _____/_____/_____, _____/_____/_____, _____/_____/_____, _____/_____/_____,
Surgery: Please explain what type of surgery you had in the past: _____
_____
_____
_____
_____

*Is there any other condition or information that you feel is important to you and would like Dr. Rooney to be aware of and if so, please explain: _____?
_____
_____

Patient's Signature: _____, Date: _____/_____/20_____

Guardian Signature: _____, Date: _____/_____/20_____
(If the patient is a minor)