ALIGNIS Clinical Records System

Patient Health Assessment

Please PRINT or WRITE Clearly

General Information

Patient Name: ______________________ Date: ____________

Provider Name: Dr. Robert A. Apuzzio, D.C.

Primary Care Physician's Name: ______________________

Patient Sex: M_____ F_____ Date of Birth: ____________ Social Security #: ____________

Patient Address: ______________________

Home Phone:/Cell Phone: ____________ Work Phone: ____________

Patient Employer: ____________ Patient Occupation: ____________

Subscriber Name: ____________ Relation to Patient: ____________

Subscriber Employer: ____________ Subscriber Social Security #: ____________

Referred for Treatment by: ______________________

Health Insurance Plan: ____________ Group #: ____________ Member #: ____________

Complaint History

e-mail: ______________________

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 ❒ Spasm ❒ Soreness ❒ Burning ❒ Throbbing ❒ Ache ❒ Tingling ❒ Weakness ❒ Dull ❒ Numbness ❒ Stiffness ❒ 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?

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

Explain: ______________________

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

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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

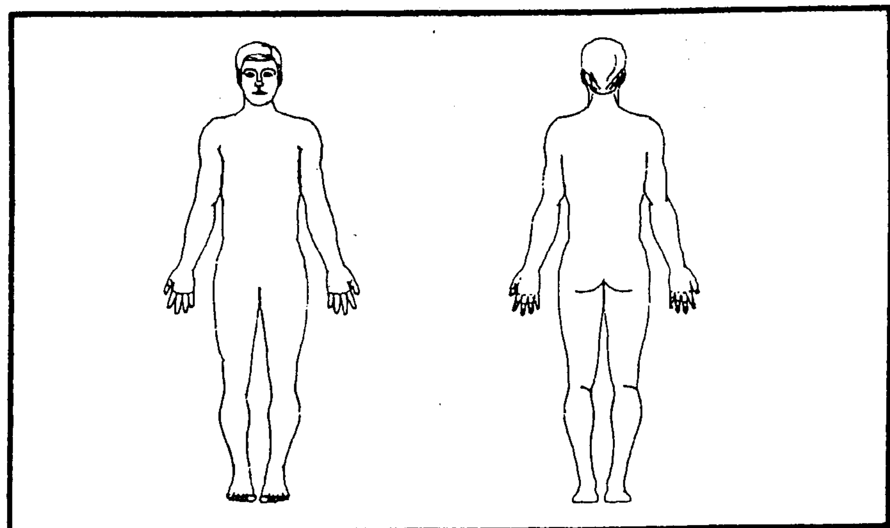
Please list: ________________________

____

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

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