

# Welcome to Levitan Chiropractic

Please Print Clearly and fill in completely.

Print Name \_\_\_\_\_ Email \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Please Check** ✓ Sex: Male  Female  Right handed  Left handed  Married  Single

## **Health History:**

Give reason for seeking chiropractic care: \_\_\_\_\_

Describe any health problems, including how long you've had them: \_\_\_\_\_

Are you under the care of any other doctor? Yes  No

If Yes, the conditions being treated for: \_\_\_\_\_

List any current Medications: \_\_\_\_\_

List any past surgeries & dates: \_\_\_\_\_

List any past accidents & dates: \_\_\_\_\_

List any x-rays you've had in the past 2 years: \_\_\_\_\_

## **Personal & Family History:**

Your Occupation: \_\_\_\_\_ Work Duties \_\_\_\_\_

Spouse's health status \_\_\_\_\_

Children's ages and health status: \_\_\_\_\_

## **Chiropractic History:**

Have you ever been to a Chiropractor before? Yes  No  If yes Doctor's Name \_\_\_\_\_

Date of last chiropractic visit \_\_\_\_\_ Reason for care \_\_\_\_\_

Date of last chiropractic x-rays \_\_\_\_\_ How long were you under care? \_\_\_\_\_

Are other family members under chiropractic care? - Yes  No  Who? \_\_\_\_\_

## **Wellness Commitment**

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Where did you hear about our clinic,  
or who referred you? \_\_\_\_\_

**FEMALES:** Please Check One ✓ Is there a possibility of you being pregnant? Yes  No

**Please Fill in Below** if you have had the following, or if you suffer from the following, **Please Check** ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

**Circle the areas where you have any problems.  
Please also describe these problems.**

**Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.**

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*Thank you for being complete and thorough.*  
**Your Signature Below Please**

**Date:** \_\_\_\_\_

## PROMIS–29 Profile v1.0

Please respond to each question or statement by marking one box per row.

<b><u>Physical Function</u></b>		<b>Without any difficulty</b>	<b>With a little difficulty</b>	<b>With some difficulty</b>	<b>With much difficulty</b>	<b>Unable to do</b>
1	Are you able to do chores such as vacuuming or yard work?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you able to go up and down stairs at a normal pace? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Are you able to go for a walk of at least 15 minutes? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Are you able to run errands and shop? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Anxiety</u></b>						
<b>In the past 7 days...</b>		<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
5	I felt fearful.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I found it hard to focus on anything other than my anxiety .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	My worries overwhelmed me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I felt uneasy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Depression</u></b>						
<b>In the past 7 days...</b>		<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
9	I felt worthless .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	I felt helpless .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	I felt depressed .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	I felt hopeless .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>Fatigue</u></b>						
<b>During the past 7 days...</b>		<b>Not at all</b>	<b>A little bit</b>	<b>Somewhat</b>	<b>Quite a bit</b>	<b>Very much</b>
13	I feel fatigued .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	I have trouble <u>starting</u> things because I am tired.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the past 7 days...</b>						
15	How run-down did you feel on average? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the past 7 days...</b>		<b>Not at all</b>	<b>A little bit</b>	<b>Somewhat</b>	<b>Quite a bit</b>	<b>Very much</b>
16	How fatigued were you on average?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## PROMIS–29 Profile v1.0

### Sleep Disturbance

**In the past 7 days...**

		Very poor	Poor	Fair	Good	Very good
17	My sleep quality was.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>In the past 7 days...</b>	<b>Not at all</b>	<b>A little bit</b>	<b>Somewhat</b>	<b>Quite a bit</b>	<b>Very much</b>
18	My sleep was refreshing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	I had a problem with my sleep .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	I had difficulty falling asleep .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Satisfaction with Social Role

**In the past 7 days...**

		Not at all	A little bit	Somewhat	Quite a bit	Very much
21	I am satisfied with how much work I can do (include work at home) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	I am satisfied with my ability to work (include work at home).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	I am satisfied with my ability to do regular personal and household responsibilities .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	I am satisfied with my ability to perform my daily routines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Pain Interference

**In the past 7 days...**

		Not at all	A little bit	Somewhat	Quite a bit	Very much
25	How much did pain interfere with your day to day activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	How much did pain interfere with work around the home? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	How much did pain interfere with your ability to participate in social activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	How much did pain interfere with your household chores? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Pain Intensity

**In the past 7 days...**

29	How would you rate your pain on average?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		0	1	2	3	4	5	6	7	8	9	10
		No pain										Worst imaginable pain