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%

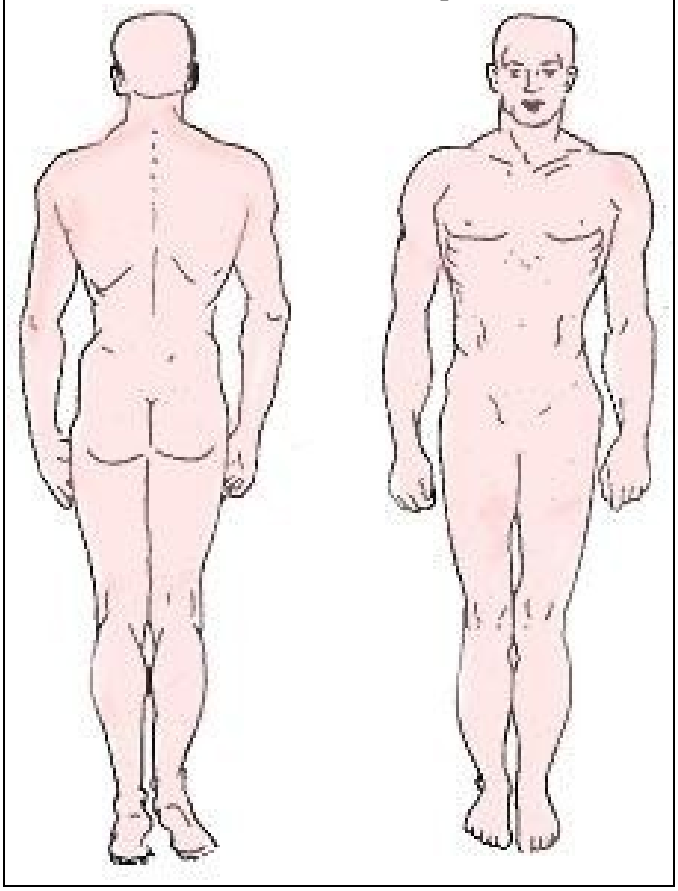
Where did you hear about our clinic,
or who referred you?_____

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		
Migraines		
Neck Pain		
Shoulder Pain		
Arm/Hand Pain		
Mid Back Pain		
Low Back Pain		
Hip Pain		
Leg/Foot Pain		
Disc Problems		
Arthritis		
Other joint pain		
Numbness		
Joint Swelling		
Dizziness		
Nausea		
Weakness		
Fatigue		
Nervousness		
Insomnia		
Heart Problems		
Frequent colds		
Nose Bleeds		
Ringing in Ears		
Earaches		
Hearing Loss		
Cough		
Chest pains		
Female problems		
Allergies		
Asthma		
Cancer		
Osteoporosis		
Diabetes		
Hypoglycemia		
Digestive problem		
Urinary Problems		
Skin conditions		
Other _____		

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.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____

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

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

PROMIS–29 Profile v1.0

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
17	My sleep quality was.....	☐	☐	☐	☐	☐
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
18	My sleep was refreshing.....	☐	☐	☐	☐	☐
19	I had a problem with my sleep	☐	☐	☐	☐	☐
20	I had difficulty falling asleep	☐	☐	☐	☐	☐

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)	☐	☐	☐	☐	☐
22	I am satisfied with my ability to work (include work at home)……	☐	☐	☐	☐	☐
23	I am satisfied with my ability to do regular personal and household responsibilities	☐	☐	☐	☐	☐
24	I am satisfied with my ability to perform my daily routines.....	☐	☐	☐	☐	☐

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?.....	☐	☐	☐	☐	☐
26	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
27	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
28	How much did pain interfere with your household chores?	☐	☐	☐	☐	☐

Pain Intensity

In the past 7 days…

29 How would you rate your pain on average?.....

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0 **No pain**	1	2	3	4	5	6	7	8	9	10 **Worst imaginable pain**

