Dr. N.J. Ambrosino
Chiropractic Physician/Acupuncture Therapist
Accident/WC Injury/Rehabilitative Care
Pain Management Care

Patient Information Form

DATE_____

Last Name _____First Name _____Middle Initial _____

Address_____

City _____ State _____ Zip _____

Home Phone (_____)_____-_____ Alternate # (_____)_____-_____

Work Phone (_____)_____-_____ ext #_____

Email _____

Birthday _____/_____/_____

Age _____ Sex: M / F Marital Status M S W D # of Children_____

Occupation _____ Employer _____

Address_____

City _____ State _____ Zip _____

Spouse's Name _____

Occupation _____

Employer _____

Person Responsible for this Account _____

Health Plan _____

Subscriber's Name _____ ID# _____

Group# _____

1. How did you hear about our office?

_____

2. Is your injury related to work? NO YES

If yes, date of injury _____/_____/_____

Did you the report injury to your supervisor? NO YES

3. Is your injury related to an auto accident? NO YES

If yes, date of accident _____/_____/_____

Was a police report filed? NO YES

4. Please list the name of the of the doctor who cares for you & your family

Doctor's Name: _____

Doctor's Address:
_____
_____

What is the primary reason for your visit today?
_____
_____
_____
_____
_____
_____

PLEASE MARK THE AREAS OF YOUR COMPLAINT OR SYMPTOMS

1. Please describe your complaint:
•Sharp Pain •Dull Pain •Ache •Weak •Throbbing •Numbness & Tingling •Shooting •Burning

2. Frequency:

•Constant (76-100%) •Frequent (51-75%) •Occasional (26-50%) •Intermittent (25% or less)

3. Indicate intensity of your pain at its lowest and highest level
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Pain)

4. Are your symptoms
•Decreasing •Not changing •Getting worse

5. Symptoms are worse in the
•Morning •Afternoon •Night •Same all day.

6. Does the problem/pain radiate or travel (shoot) to any other areas in your body?
Where?_____

7. Do you have any numbness or tingling in your body?
Where?_____

6. When did your problem begin? Give Specific Date If Possible
_____

7. Describe how your problem began:
_____

_____

8. Have you been treated for this condition before •Yes •No

If yes, by whom? •Chiropractor • Medical Doctor •Physical Therapist • Massage Therapist
•Other _____

Are you currently being seen? • Yes •No
If yes, how often and what treatments:
_____

9. What makes your problem better?
•Nothing •Lying down •Walking •Standing •Sitting •Movement/Exercise •Inactivity

10. What makes your problem worse?
•Nothing •Lying down •Walking •Standing •Sitting •Movement/Exercise •Inactivity

11. How would you rate your general stress level?
•Little or No Stress •Minimal Stress •Moderate Stress •Greatly Stressed

12. General Physical Activity:
•No regular exercise •Light exercise •Moderate exercise •Strenuous exercise

13. Are your complaints affecting your ability to be active?

•No effect •Able to perform light duty work and household tasks. •Need limited assistance to perform tasks. •Need assistance often.•Have a significant inability to function without assistance. • I am totally disabled (impaired). Cannot care for myself.

14. Physical activity at work:
•Sitting 50% or more of work day •Light manual labor •Manual labor •Heavy manual labor •Repetitive motion

15. Has your work status changed because of this complaint? •YES •NO

16. What is your current work status?
•Full time, no restrictions. •Full time, with restrictions. • Part time, no restrictions. •Part time, with restrictions. • Off work due to restrictions. •Unemployed. •Retired, restrictions •Full time homemaker. •Full time student

17. Do You Have a Permanent Disability: Location _____
Rating Percentage _____ % Date received _____

Mark All That Apply:

Symptom: Past/Present	Symptom: Past/Present	Symptom: Past/Present
Neck Pain: ❑/❑	**Headache/Migraines: ❑/❑**	**Emphysema: ❑/❑**
Jaw Pain: ❑/❑	**Dizziness: ❑/❑**	**Allergies/Sinus Problems: ❑/❑**
Shoulder Pain: ❑/❑	**Epilepsy/Seizures: ❑/❑**	**Ulcers: ❑/❑**
Arm/Elbow Pain: ❑/❑	**Nervousness: ❑/❑**	**Acid Reflux: ❑/❑**
Wrist/Hand Pain: ❑/❑	**Depression: ❑/❑**	**Irritable Bowel: ❑/❑**
Upper Back Pain: ❑/❑	**Memory Loss: ❑/❑**	**Kidney/Bladder Infections: ❑/❑**
Lower Back Pain: ❑/❑	**Sleeping Problems: ❑/❑**	**Kidney Stones: ❑/❑**
Hip or Leg Pain: ❑/❑	**Chronic Fatigue: ❑/❑**	**Hepatitis: ❑/❑**
Knee Pain: ❑/❑	**High Blood Pressure: ❑/❑**	**Diabetes: ❑/❑**
Foot/Ankle Pain: ❑/❑	**Heart Problems: ❑/❑**	**Aortic Aneurysm: ❑/❑**
Stiff Swollen Joints: ❑/❑	**Chest Pain/Angina: ❑/❑**	**Excessive Weight gain/Loss: ❑/❑**
Arthritis: ❑/❑	**Asthma: ❑/❑**	**Cancer: ❑/❑**

Height: _____Ft. _____In. Weight _____lbs.

Tobacco Use: ❑Never ❑Infrequent 1/2 pack/wk ❑Moderate 1 pack/wk ❑Heavy 2+ Packs/wk

Alcohol Use: ❑Never ❑Infrequent 1-2 per wk ❑Moderate 3-5 per wk ❑Heavy 6+ per wk

Caffeine Use: ❑Never ❑Infrequent 1-2 per wk ❑Moderate 3-5 per wk ❑Heavy 6+ per wk

Drug/Medications:

_____

Surgeries/Hospitalizations:

_____

Previous Illnesses:

_____

Previous Traumas:

_____

Please Check the appropriate boxes if there is a history of family illnesses:

(Please Circle M for mother's side of family, F for father's side of family)

- ❑**Heart disease M F**
- ❑**Back Problems M F**
- ❑**High Blood Pressure M F**
- ❑**Migraines M F**
- ❑**Lung Problems M F**
- ❑**Epilepsy/Seizures M F**
- ❑**Arthritis M F**
- ❑**Allergies/Asthma M F**
- ❑**Diabetes M F**
- ❑**Cancer M F**

Patient/Guardian Signature _____

Date_____