The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____

2. RECREATION: hobbies, sports, and other similar leisure time activities. _____

3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____

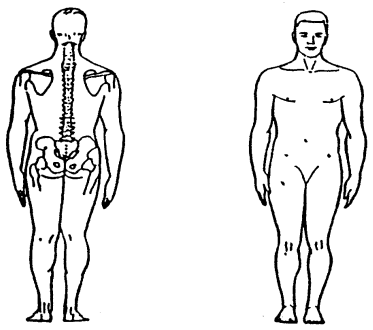
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: _____ CASH _____ CHECK _____ CREDIT CARD _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature _____Date_____

Name _____ Address _____

City _____ State _____ Zip _____ Home ph# _____

Cell# (For confirming appt. schedule): _____ Carrier: __Verizon __ATT Wireless __T-Mobile Other _____

E-mail Address (For confirming appointment schedule) : _____

SSN _____ Date of birth _____ Age _____ Height _____ Weight _____

Male___ Female ___ Single___ Married __ Divorced __ # of children _____ Name of spouse (or parent) _____

Employer _____ Address _____

City _____ State _____ Zip _____ Wk phn _____ Occupation _____

What is the name of your family physician? _____What city are they located in? _____

Have you ever had Chiropractic care before? _____ If yes, doctor name: _____ Date of last visit _____

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting___ worse or____ staying the same? Currently or in the past have you ever experienced any of these complaints while working? ___ If yes, please describe what activities at work may be causing you these complaints:_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____

If yes, please explain: _____

Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of injury? _____

Do you have an attorney representing you for this work injury? _____ Yes _____ No If yes, who is your attorney? _____

Have you been involved in an auto accident in the last 12 months? _____ Yes _____ No If yes, date of the auto accident?_____

Do you have an attorney representing you for this auto accident? _____ Yes _____ No If yes, who is your attorney? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

If due to an auto accident, what is the name of your auto insurance company? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any current or past injuries and illnesses not listed above: _____

Please check all medications (over the counter and/or prescribed) you are currently taking: __ Aspirin/Tylenol __ Pain killers __ Muscle Relaxer __ Insulin __ Birth Control Pills __ Sleeping Pills ___ Anti-depressants ___ Others _____

Health Insurance Co. Name _____ Policyholder _____

Name of Spouse's health insurance (If applicable) _____ Policyholder _____

Spouse's Health Insurance Claims address _____ Policy number _____