ALIGNIS Clinical Records System

# Patient Health Assessment

*Please PRINT or WRITE Clearly*

## General Information

Patient Name:________________________ Date:____________

Provider Name:________________________

Primary Care Physician's Name:________________________

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

Patient Address:________________________

Home 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

**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 ❐ Soreness ❐ Throbbing ❐ Tingling ❐ Dull ❐ Stiffness
❐ Spasm ❐ Burning ❐ Ache ❐ Weakness ❐ Numbness ❐ 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?** **Explain:** ____________
❐ An auto accident ❐ Work related accident ❐ Other type of accident
❐ Gradual ❐ Sudden ❐ No specific reason

**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.)

**2. 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

**3. What is your present general stress level:**

❐ No stress ❐ Minimal stress ❐ Moderate stress ❐ Greatly stressed

**4. Is your problem affecting your ability to work or do other routine daily activities?**

- ❐ No effect
- ❐ Need some assistance with daily activities
- ❐ Cannot function without assistance
- ❐ Have some limited physical restrictions, but can function
- ❐ Cannot work
- ❐ 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

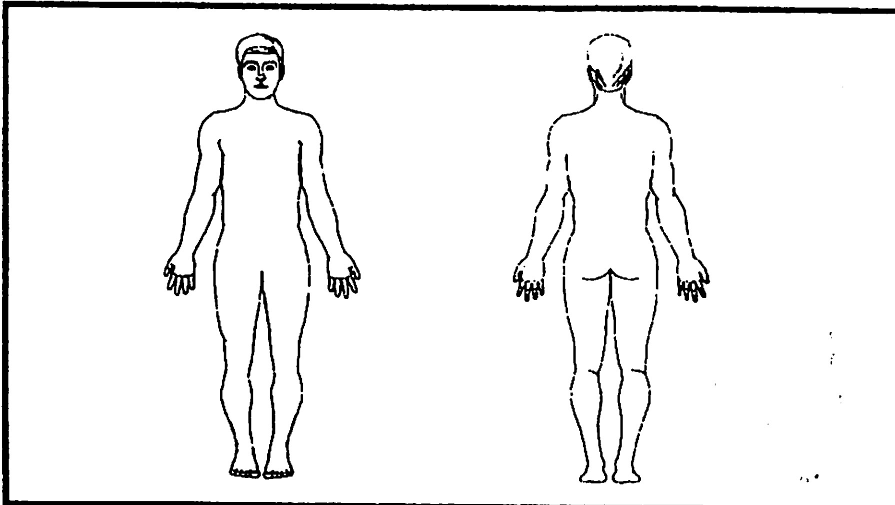
**Pregnancy:** ❐ Past ❐ Present

**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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