



BACK IN MOTION

Sports Injuries Clinic, LLC

Patient Registration

Last Name: _____ First Name: _____ Gender: Male Female

Home Number: _____ Cell Number: _____ Work Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Date of Birth (MM/DD/YYYY): _____

Marital Status: Single Married Other If married please give spouse name: _____

Primary Care Physician: _____

Employment Information

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____

Contact Number: _____

How did you hear about us? (If referred, please provide name): _____

I hereby authorize Back In Motion Sports Injuries Clinic and independent providers to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to said providers all money to which I am entitled for health expenses relative to the services performed from time to time. I understand I am financially responsible for any and all charges.

Signature: _____ Date: _____



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Sports Injuries Clinic, LLC

Patient Medical History

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE

The information you provide helps your doctor provide you with the highest level of care.

Patient Name:

Date:

PRESCRIPTION MEDICATION				
<input type="checkbox"/> Allergy/Asthma	<input type="checkbox"/> Anti-inflammatory	<input type="checkbox"/> Attention Deficit	<input type="checkbox"/> Cortico-steroids	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Anti-coagulant	<input type="checkbox"/> Anti-seizure	<input type="checkbox"/> Birth Control	<input type="checkbox"/> Diuretic	<input type="checkbox"/> Pain Reliever
<input type="checkbox"/> Anti-depressant	<input type="checkbox"/> Antibiotic	<input type="checkbox"/> Blood Pressure/Cholesterol	<input type="checkbox"/> Hormone Replacement	<input type="checkbox"/> Prednisone
SLEEPING POSITION				
<input type="checkbox"/> Back	<input type="checkbox"/> Left Side	<input type="checkbox"/> Right Side	<input type="checkbox"/> Stomach	
MEDICAL CONDITIONS				
Past Pres	Past Pres	Past Pres	Past Pres	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Lung Disorder/ Emphysema	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Prostate Problems	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Psychiatric Disorder	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Skin Condition	
		<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Stroke	
SURGERIES				
<input type="checkbox"/> Abdominal Organ	<input type="checkbox"/> Cardiovascular Procedure	<input type="checkbox"/> Foot-right	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Ankle/leg-right	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Foot-left	<input type="checkbox"/> Knee-right	<input type="checkbox"/> TMJ-right
<input type="checkbox"/> Ankle/leg-left	<input type="checkbox"/> Elbow-right	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Knee-left	<input type="checkbox"/> TMJ-left
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Elbow-left	<input type="checkbox"/> Hernia	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Tonsil
<input type="checkbox"/> Brain	<input type="checkbox"/> Finger/hand-right	<input type="checkbox"/> Hip/thigh-left	<input type="checkbox"/> Shoulder-left	<input type="checkbox"/> Wrist-right
<input type="checkbox"/> Breast	<input type="checkbox"/> Finger/hand-left	<input type="checkbox"/> Hip/thigh-right	<input type="checkbox"/> Shoulder-right	<input type="checkbox"/> Wrist-left
			<input type="checkbox"/> Spinal Injections	<input type="checkbox"/> No Prior Surgery
ALLERGIES				
<input type="checkbox"/> Adhesives/tape	<input type="checkbox"/> Eggs	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Milk/Lactose	<input type="checkbox"/> Soy
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Fish/Shellfish	<input type="checkbox"/> Latex	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Sulfites
				<input type="checkbox"/> Wheat/Gluten
SOCIAL HISTORY				
<input type="checkbox"/> Alcohol drink 1-2 per week	<input type="checkbox"/> Caffeine less than 1 per day	<input type="checkbox"/> Chewing tobacco more than 1 can per day	<input type="checkbox"/> Smoke 1 pack or less per day	
<input type="checkbox"/> Alcohol drinks 3-4 per week	<input type="checkbox"/> Caffeine more than 3 per day	<input type="checkbox"/> Chewing tobacco less than 1 can per day	<input type="checkbox"/> Smoke more than 1 pack per day	
<input type="checkbox"/> Alcohol drinks 5+ per week		<input type="checkbox"/> Exercise 1-2 times per week	<input type="checkbox"/> Wear seatbelts always	
<input type="checkbox"/> Caffeine 1-3 per day		<input type="checkbox"/> Exercise 3-4 times per week	<input type="checkbox"/> Wear seatbelts never	
		<input type="checkbox"/> Exercise 5-7 times per week	<input type="checkbox"/> Wear seatbelts usually	
FAMILY HISTORY				
Par Sib	Par Sib	Par Sib	Par Sib	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Psychiatric	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	
			<input type="checkbox"/> Thyroid	
SUBSTANCE USE				
Past Pres	Past Pres	Past Pres	Past Pres	
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Barbiturate	<input type="checkbox"/> Crystal Meth	<input type="checkbox"/> Marijuana	
<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Heroin	<input type="checkbox"/> Other _____	
CHILDREN				
<input type="checkbox"/> Male	Age(s): _____	<input type="checkbox"/> Female	Ages(s): _____	
OCCUPATIONAL ACTIVITIES				
<input type="checkbox"/> Administration	<input type="checkbox"/> Construction	<input type="checkbox"/> Healthcare	<input type="checkbox"/> Home Services	<input type="checkbox"/> Student
<input type="checkbox"/> Business Owner	<input type="checkbox"/> Daycare/Childcare	<input type="checkbox"/> Heavy Equipment	<input type="checkbox"/> Retail Worker	<input type="checkbox"/> Teacher
<input type="checkbox"/> Clerical/Secretarial	<input type="checkbox"/> Executive/Legal	<input type="checkbox"/> Heavy Manual Labor	<input type="checkbox"/> Retired	<input type="checkbox"/> Truck Driver
<input type="checkbox"/> Computer User	<input type="checkbox"/> Food Service Industry			
RECREATIONAL ACTIVITIES				
<input type="checkbox"/> Backpacking/Hiking	<input type="checkbox"/> Dance/Ballet	<input type="checkbox"/> Gymnastics	<input type="checkbox"/> Skiing/Snowboarding	<input type="checkbox"/> Track and Field
<input type="checkbox"/> Baseball/Softball	<input type="checkbox"/> Equestrian Riding	<input type="checkbox"/> Martial Arts	<input type="checkbox"/> Skiing-Cross country	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Basketball	<input type="checkbox"/> Field Hockey/Lacrosse	<input type="checkbox"/> Racketball	<input type="checkbox"/> Soccer	<input type="checkbox"/> Walking
<input type="checkbox"/> Biking	<input type="checkbox"/> Football/Rugby	<input type="checkbox"/> Rowing/Paddling Sports	<input type="checkbox"/> Swimming	<input type="checkbox"/> Weightlifting
<input type="checkbox"/> Boating	<input type="checkbox"/> Golf	<input type="checkbox"/> Running	<input type="checkbox"/> Tennis	<input type="checkbox"/> Wrestling
				<input type="checkbox"/> Yoga



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Sports Injuries Clinic, LLC

Patient Health Questionnaire

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE.

Please complete both sides of this health questionnaire.

The information you provide helps your doctor provide you with the highest level of care.

Patient Name: _____ **Date:** _____

Height: _____ **Weight:** _____ **Handedness** (circle one): Right / Left / Ambi

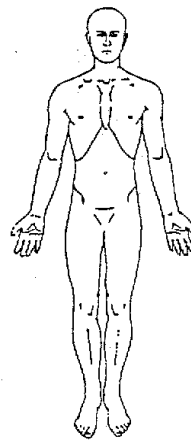
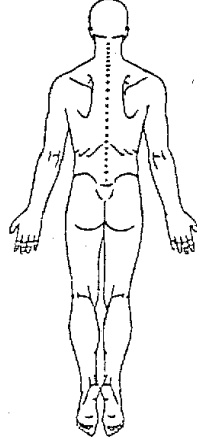
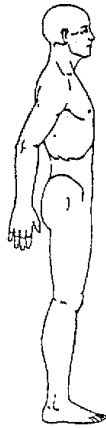
Present Complaint: (Location and symptoms): _____

When did your problem begin? (Specific date): _____

What caused your symptoms? _____

Circle the area(s) of complaint and put the number(s) that describe your pain in the appropriate area(s).

1. Headache
2. Pain
3. Radiating pain
4. Dull ache
5. Pain on movement
6. Numbness
7. Tingling
8. Redness
9. Inflammation
10. Weakness
11. Burning
12. Stiffness
13. Throbbing
14. Sharp/shooting



1) How often do you experience symptoms?

- Intermittent (0-26%)
 Occasional (26-50%)
 Frequent (51-75%)
 Constant (76-100%)

2) Describe the nature of your symptoms:

- Sharp/Shooting
 Dull Ache
 Numbness
 Burning
 Tingling
 Headache
 Radiating Pain
 Inflammation
 Throbbing
 Pain on Movement
 Other _____

3) Since your problem began, is the pain:

- Getting Better
 Not Changing
 Getting Worse

4) What makes your symptoms worse (check all that apply)?

- Sitting
 Standing
 Walking
 Bending
 Lifting
 Sleeping
 Reaching
 Lying Down
 Movement
 Stretching/Exercise
 Nothing
 Other _____

5) What makes your symptoms better (check all that apply)?

- Sitting
 Standing
 Lying Down
 NO movement
 Movement
 Heat
 Medication
 Rest
 Stretching/Exercise
 Adjustments
 No Relief
 Other _____

6) During the past 4 weeks indicate the average intensity of your symptoms:

- 0 (no pain)
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 (worst pain)

7) During the past four weeks, how much has your pain interfered with your normal work (including housework)?

- Not at all
 A little bit
 Moderately
 Quite a bit
 Extremely

8) During the past four weeks, how much time has your condition interfered with your social activities?

- All of the time
 Most of the time
 Some of the time
 A little of the time
 None of the time

9) In general, would you say your overall health right now is:

Excellent Very good Good Fair Poor

10) What treatment have you received for your *current* symptoms? (If none, please skip to question 15)

Chiropractic Massage Physical therapy Surgery Acupuncture Exercise/Stretching Medication
 Bracing/Support/Taping/Orthotics Injection ER/Ambulance/EMT Naturopathy/Nutritional Supplements/Herbs

11) Who have you seen for your *current* symptoms?

No one Other Chiropractor Medical Doctor Physical Therapist Massage Therapist Other _____

12) When did you receive this treatment?

In the last month 2-3 months ago 3-6 months ago 6-12 months ago 1-2 years ago 2-5 yrs ago 5-10 yrs ago

13) What tests have you had for your *current* symptoms?

X-rays MRI CT Scan Lab work (blood, urine, etc.) Other: _____

14) When were these tests done?

In the last month 2-3 months ago 3-6 months ago 6-12 months ago 1-2 years ago 2-5 yrs ago 5-10 yrs ago

15) Have you had similar symptoms *in the past*?

Yes No

16) If you have received treatment *in the past* for the same or similar symptoms, who did you see?

This Office Other Chiropractor Medical Doctor Physical Therapist Massage Therapist Other _____

17) What are your treatment goals?

Reduce Pain Optimize Athletic Performance Symptom Control/Palliative Care Injury Prevention
 Compete In Future Event Wellness

18) What is your occupation?

Professional/Executive White collar/Secretarial Tradesperson Laborer Homemaker FT student PT student
 Retired Other _____

19) If you are not retired, a homemaker, or a student, what is your work status?

Full-time Part-time Self-employed Unemployed Off Work Other _____



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Review of Systems

Patient Name: _____ Date: _____

CARDIOVASCULAR	Present	Past	No	ALLERGY/IMMUNOLOGIC	Present	Past	No
Poor Circulation	_____	_____	_____	Hives	_____	_____	_____
High Blood Pressure	_____	_____	_____	Immune Disorder	_____	_____	_____
Aortic Aneurysm	_____	_____	_____	HIV/AIDS	_____	_____	_____
Heart Disease	_____	_____	_____	Allergy Shots	_____	_____	_____
Vascular Disease	_____	_____	_____	Cortisone Use	_____	_____	_____
Heart Attack	_____	_____	_____				
Chest Pain	_____	_____	_____	GASTROINTESTINAL	Present	Past	No
High Cholesterol	_____	_____	_____	Gallbladder Problems	_____	_____	_____
Pace Maker	_____	_____	_____	Bowel Problems	_____	_____	_____
Jaw Pain	_____	_____	_____	Constipation	_____	_____	_____
Irregular Heart Beat	_____	_____	_____	Liver Problems	_____	_____	_____
Swelling of Legs	_____	_____	_____	Ulcers	_____	_____	_____
				Diarrhea	_____	_____	_____
GENITOURINARY	Present	Past	No	Nausea/Vomiting	_____	_____	_____
Kidney Disease	_____	_____	_____	Bloody Stools	_____	_____	_____
Lower Side Pain	_____	_____	_____	Poor Appetite	_____	_____	_____
Burning with Urination	_____	_____	_____				
Frequent Urination	_____	_____	_____	MUSCULOSKELETAL	Present	Past	No
Blood in Urine	_____	_____	_____	Gout	_____	_____	_____
Kidney Stone	_____	_____	_____	Arthritis	_____	_____	_____
				Joint Stiffness	_____	_____	_____
HEMATOLOGIC/LYMPHATIC	Present	Past	No	Muscle Weakness	_____	_____	_____
Hepatitis	_____	_____	_____	Osteoporosis	_____	_____	_____
Blood Clots	_____	_____	_____	Broken Bones	_____	_____	_____
Cancer	_____	_____	_____	Joints Replaced	_____	_____	_____
Easy Bruising	_____	_____	_____				
Easy Bleeding	_____	_____	_____	NEUROLOGICAL	Present	Past	No
Fevers/Chills/Sweats	_____	_____	_____	Stroke	_____	_____	_____
				Seizures	_____	_____	_____
RESPIRATORY	Present	Past	No	Head Injuries	_____	_____	_____
Asthma	_____	_____	_____	Brain Aneurysm	_____	_____	_____
Tuberculosis	_____	_____	_____	Numbness	_____	_____	_____
Shortness of Breath	_____	_____	_____	Severe Headaches	_____	_____	_____
Emphysema	_____	_____	_____	Pinched Nerves	_____	_____	_____
Cold/Flu	_____	_____	_____	Parkinson's Disease	_____	_____	_____
Cough/Wheezing	_____	_____	_____	Carpal Tunnel	_____	_____	_____
				Spinning/Balance	_____	_____	_____
EARS/NOSE/THROAT	Present	Past	No				
Dizziness	_____	_____	_____	ENDOCRINE	Present	Past	No
Hearing Loss	_____	_____	_____	Thyroid Disease	_____	_____	_____
Sinus Infection	_____	_____	_____	Diabetes	_____	_____	_____
Nosebleed	_____	_____	_____	Hair Loss	_____	_____	_____
Sore Throat	_____	_____	_____	Menopausal	_____	_____	_____
Difficulty Swallowing	_____	_____	_____	Menstrual Problems	_____	_____	_____
Bleeding Gums	_____	_____	_____				
				PSYCHIATRIC	Present	Past	No
EYES	Present	Past	No	Depression	_____	_____	_____
Glaucoma	_____	_____	_____	Anxiety Disorder	_____	_____	_____
Double Vision	_____	_____	_____	Unusual Stress	_____	_____	_____
Blurred Vision	_____	_____	_____				
				CONSTITUTIONAL	Present	Past	No
INTEGUMENTARY	Present	Past	No	Weight Loss/Gain	_____	_____	_____
Skin Ulcers	_____	_____	_____	Energy Level Problem	_____	_____	_____
Skin Disease	_____	_____	_____	Difficulty Sleeping	_____	_____	_____
Eczema	_____	_____	_____				
Psoriasis	_____	_____	_____				
Rashes	_____	_____	_____				