Sorbera 4 Health

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Patient Name _____ Date: _____
(Last) (First) (Middle)

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell: (_____)_____

SSN: _____ Email: _____ Sex: ☐M ☐F Age: _____ Birthdate: _____

☐Married ☐Widowed ☐Single ☐Separated ☐Divorced ☐Minor *(Under18)*

Children Names/Ages _____

Patient Employer/School_____

Spouse's Name: _____ Spouse's Birthdate: _____

Women Only: Are you pregnant? ☐ Yes ☐ No

Hobbies/Interests: _____

How did you hear about us? ☐ Newspaper ☐ TV ☐ Online Referral: _____

Do you have health insurance? ☐ Yes ☐ No Name of Insurance Company: _____

Please provide a copy of photo ID

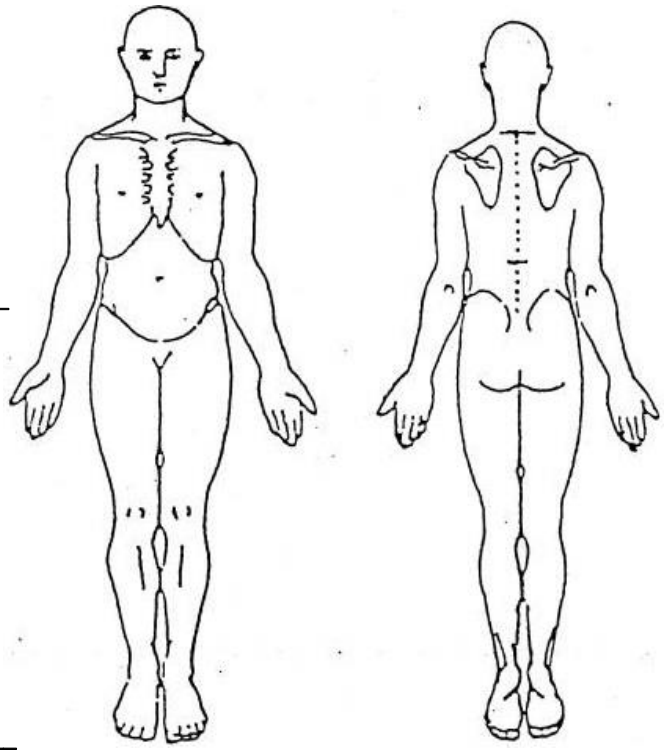
PATIENT CONDITION

Reason for visit: _____

When did this condition appear? _____

Is this condition progressively worse? ☐Yes ☐No

Mark an X on the picture where you experience any pain, numbness or tingling



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe) _____

Types of pain: ☐Sharp ☐Dull ☐Throbbing ☐Burning ☐Numbness ☐Aching
☐Shooting ☐Tingling ☐Cramps ☐Swelling ☐Stiffness

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your? ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Painful activities or movements: ☐Sitting ☐Standing ☐Walking ☐Bending
☐Lying Down

Is this the result of an accident or injury? ☐Yes ☐ No If yes, when? _____

What have you done for this condition in the past? ☐Chiropractic ☐Medication
☐ Physical Therapy ☐ None ☐ Other

Name and address of other doctor(s) who have treated you for this condition_____ FLIP PAGE

EXERCISE		WORK ACTIVITY	HABITS
☐None	Types of exercise	☐ Sitting	☐Smoking Packs/Day_____
☐Moderate	_____	☐ Standing	☐Alcohol Drinks/Week _____
☐Daily	_____	☐ Light Labor	☐Coffee/Caffeine Cups/Day _____
☐Heavy		☐ Heavy Labor	☐High Stress Level Reason _____

INJURIES/SURGERIES You have had throughout your life

	Description	Dates
Auto Accidents	_____	_____
Head Injuries	_____	_____
Surgeries	_____	_____

MEDICATIONS

Name	
_____	_____
_____	_____

The above information is true and accurate to the best of my knowledge. I clearly understand and agree that all services rendered to me are charged directly to me and that I am directly responsible for payment.

Patient or Guardian Signature: _____ Date: _____

Activity of Daily Living

Pain Intensity
- ☐ No Pain
- ☐ Mild Pain
- ☐ Severe Pain
- ☐ Worst Possible

Recreation
- ☐ Can do all activities
- ☐ Can do most activities
- ☐ Can do some activities
- ☐ Can do a few activities
- ☐ Cannot do any activities

Sleeping
- ☐ Perfect Sleep
- ☐ Mildly Disturbed Sleep
- ☐ Moderately Disturbed Sleep
- ☐ Greatly Disturbed Sleep
- ☐ Totally Disturbed Sleep

Frequency of Pain
- ☐ No Pain
- ☐ Occasional Pain; 25% of the day
- ☐ Intermittent Pain; 50% of the day
- ☐ Frequent Pain; 75% of the day
- ☐ Constant Pain; 100% of the day

Personal Care
- ☐ No Pain; no restrictions
- ☐ Mild Pain; no restrictions
- ☐ Moderate Pain; need to go slowly
- ☐ Severe Pain; need 100% assistance

Lifting
- ☐ No pain with heavy weight
- ☐ Increased pain with heavy weight
- ☐ Increased pain with moderate weight
- ☐ Increased pain with light weight
- ☐ Increased pain with any weight

Travel (driving, etc.)
- ☐ No pain on long trips
- ☐ Mild pain on long trips
- ☐ Moderate pain on long trips
- ☐ Moderate pain on short trips
- ☐ Severe pain on short trips

Walking
- ☐ No pain; any distance
- ☐ Increased pain after several hours
- ☐ Increased pain after ½ mile
- ☐ Increased pain after ¼ mile
- ☐ Increased pain with any standing

Work
- ☐ Can do usual work unlimited extra work
- ☐ Can do usual work; no extra work
- ☐ Can do 50% work of usual work
- ☐ Can do 25% of usual work
- ☐ Cannot work

Standing
- ☐ No pain after several hours
- ☐ Increased pain after several hours
- ☐ Increased pain after 1 hour
- ☐ Increased pain after ½ hour
- ☐ Increased pain after any standing