PATIENT INFORMATION SHEET **Date:** ____________________

Name: ____ **Date of Birth (m/d/y):** _____________ **Sex: M__ F__**

Full Address: ____

(town/city) (postal code)

Home Phone: _________________ **Work Phone:** _________________ **Cell Phone:** ____________________

Employer: _________________________________ **Email Address**___________________________________

Insurance Company:________________________ **Policy #:** __________________ **I. D#:** _______________

Dr's Name: ____ **Location:**_________________________

NB Medicare No: ______________________________

I, _____________________________, do hereby authorize my chiropractor, **Dr. Jeff Sheppard**, to report to my family physician results of the chiropractic assessment findings and progress on my condition.

Signature:_____________________________________

Patients who do not provide 24 hour notice of cancellations may be subject to a full appointment charge

Current Health Habits	Yes	No	Patients Comments	Doctor's Comments
Did/do you smoke?				
Did/do you drink any alcohol?				
Are you concerned about your diet?				
Have you been in accidents?				
Current medications? How Long?				
Allergies?				
Exercise regularly?				
Females; Are you pregnant?				

Sleeping posture: ☐ side ☐ stomach ☐ back

Is there a family history of: Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other _________

Present Complaint: ____

Pain or problem started on ___________________________________

Pains are: Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐

What activities aggravate your condition/pain? ____

What activities lessen your condition/pain? ____

Is condition worse during certain times of the day? ____

Is this condition interfering with your work? ____ Sleep? ____Daily Routine? ____ Other? ____

Is condition getting progressively worse? ____

Have you seen any other Doctors for this condition? _____________________________________

Any effective treatments? ____

Have you experienced any side effects from the drugs and surgeries? ___________________________

Other Symptoms:

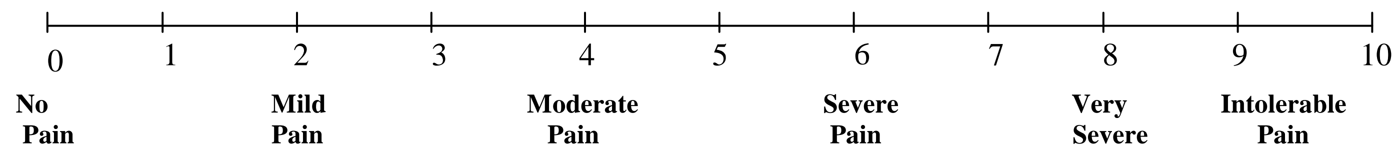
☐	Headaches	☐	Pins and Needles in legs	☐	Fainting
☐	Neck Pain	☐	Pins and Needles in Arms	☐	Loss of Smell
☐	Sleeping Problems	☐	Numbness in Fingers	☐	Loss of Taste
☐	Back Pain	☐	Numbness in Toes	☐	Diarrhea
☐	Nervousness	☐	Shortness of Breath	☐	Feet Cold
☐	Tension	☐	Fatigue	☐	Hands Cold
☐	Irritability	☐	Depression	☐	Stomach Upset
☐	Chest Pains	☐	Lights Bothers Eyes	☐	Constipation
☐	Dizziness	☐	Loss of Memory	☐	Cold Sweats
☐	Face Flushed	☐	Ears Ring	☐	Loss of Balance
☐	Neck Stiff	☐	Fever	☐	Buzzing in Ears

Patient Pain Assessment

Name:

Last **First** **Date**

0-10 Numeric Pain Intensity Scale (1)



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1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain ... Intolerable Pain

2) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain ... Intolerable Pain

3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10
No Pain ... Intolerable Pain

4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10
No Pain ... Intolerable Pain

5) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere ... Completely Interferes

B. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere ... Completely Interferes

C. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere ... Completely Interferes

D. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere ... Completely Interferes

E. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere ... Completely Interferes