

# Pro Active Chiropractic Center

Dr. Scott Stiffey \* Email: [DrScottStiffey@gmail.com](mailto:DrScottStiffey@gmail.com)

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[www.DrScottStiffey.com](http://www.DrScottStiffey.com)

219 South Main

Palmyra, MO 63461

## \*New Patient Information Worksheet\*

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ E-mail: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Right handed: \_\_\_\_\_ Left Handed: \_\_\_\_\_

Employed By: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Marital Status: M S W D Spouse's Birth Date: \_\_\_\_\_ Spouse's SS#: \_\_\_\_\_

Referred By: (Friend) (Relative) (Newspaper Ad) (Yellow Pages) (Sign) (Other: \_\_\_\_\_)

Which one of our patient's should we thank for referring you? \_\_\_\_\_

Please circle your current symptoms:

(Headache) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper-Back Pain)

(Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain)

(Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other: \_\_\_\_\_)

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

List all surgeries in the past five years: \_\_\_\_\_

Have you ever had spinal surgery? (No) (Yes: \_\_\_\_\_)

List any serious condition the doctor should be aware of: \_\_\_\_\_

\*Females: Are you pregnant at this time? (No) (Yes) Due Date: \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_ Located: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Have you been treated for any health condition by MD in last year? (YES) (NO)

If yes, describe: \_\_\_\_\_

Medications you are currently taking: \_\_\_\_\_

May we have your permission to update your MD regarding your care at this office? (YES) (NO)

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Please circle the number which most closely describes your chief complaint(s) today:

## 1. Pain Intensity

------(0)------(1)------(2)------(3)------(4)  
No Pain      Mild Pain      Moderate Pain      Severe Pain      Worse Possible Pain

## 2. Frequency Of Pain

------(0)------(1)------(2)------(3)------(4)  
No Pain      Occasional Pain      Intermittent Pain      Frequent Pain      Constant Pain  
                    25% Of The Day      50% Of The Day      75% Of The Day      100% Of The Day

## 3. Personal Care (Washing, Dressing, etc.)

------(0)------(1)------(2)------(3)------(4)  
No Pain      Mild Pain      Moderate Pain      Moderate Pain      Severe Pain  
No Restrictions      No Restrictions      Need to go slowly      Need some assistance      Need 100% Assistance

## 4. Travel (Driving, Riding, etc.)

------(0)------(1)------(2)------(3)------(4)  
No Pain      Mild Pain      Moderate Pain      Moderate Pain      Severe Pain  
On Long Trips      On Long Trips      On Long Trips      On Short Trips      On Short Trips

## 5. Work

------(0)------(1)------(2)------(3)------(4)  
Can Do Usual Work      Can Do Usual Work      Can Do 50%      Can Do 25 %      Cannot Work  
Plus Extra Work      No Extra Work      Of Usual Work      Of Usual Work

## 6. Recreation

------(0)------(1)------(2)------(3)------(4)  
Can Do All      Can Do Most      Can Do Some      Can Do A Few      Cannot Do Any  
Activities      Activities      Activities      Activities      Activities

## 7. Sleeping

------(0)------(1)------(2)------(3)------(4)  
Perfect      Mildly      Moderately      Greatly      Totally  
Sleep      Disturbed      Disturbed      Disturbed      Disturbed

## 8. Lifting

------(0)------(1)------(2)------(3)------(4)  
No Pain      Increased Pain      Increased Pain      Increased Pain      Increased Pain  
With Heavy Weight      With Heavy Weight      With Moderate Weight      With Light Weight      With Any Weight

## 9. Walking

------(0)------(1)------(2)------(3)------(4)  
No Pain      Increased Pain      Increased Pain      Increased Pain      Increased Pain  
Any distance      After One Mile      After Half Mile      After Quarter Mile      With All walking

## 10. Standing

------(0)------(1)------(2)------(3)------(4)  
No Pain      Increased Pain      Increased Pain      Increased Pain      Increased Pain  
After Several Hours      After Several Hour      After One Hour      After Half Hour      With Any Standing

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Significant Past Health History

Have you ever been hospitalized?

- a) No
- b) Yes: (Year: \_\_\_\_\_) (Reason: \_\_\_\_\_)

Have you had any surgeries?

- a) No
- b) Yes: (Year: \_\_\_\_\_) (Reason: \_\_\_\_\_)

Do you have any significant health problems?

- a) No
- b) Yes: (\_\_\_\_\_)

## Significant Past Medical History

Have you seen another doctor for this condition?

- a) No
- b) Yes: (Name: \_\_\_\_\_)

Did this doctor recommend any treatment?

- a) No
- b) Yes: (\_\_\_\_\_)

Are you taking any medication?

- a) No
- b) Yes: (\_\_\_\_\_)

## Significant Past Social History

Do you play any sports or exercise?

- a) No
- b) Yes: (\_\_\_\_\_)

How many hours do you sleep a night? (\_\_\_\_\_)

How many hours a week do you work? (\_\_\_\_\_)

## Significant Family Medical History

Did your father have any health problems?

- a) No
- b) Yes: (\_\_\_\_\_)

Did your mother have any health problems?

- a) No
- b) Yes: (\_\_\_\_\_)

Did your brother(s) have any health problems?

- a) No
- b) Yes: (\_\_\_\_\_)

Did your sister(s) have any health problems?

- a) No
- b) Yes: (\_\_\_\_\_)

Did your grandpa have any health problems?

- a) No
- b) Yes: (\_\_\_\_\_)

Did your grandma have any health problems?

- a) No
- b) Yes: (\_\_\_\_\_)

## Health Risk Factors

Do you drink alcohol?

- a) No
- b) Yes: (\_\_\_\_\_)

Do you smoke?

- a) No
- b) Yes: (\_\_\_\_\_)

Anything else the doctor should know about?

- a) No
- b) Yes: (\_\_\_\_\_)

**People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause and others to prevent future ailments. Your doctor will weigh your needs & desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes.**

( ) Relief    ( ) Correction of the cause    ( ) Prevention    ( ) Let the Doctor choose for me

**List Your Pains/Complaints from Most Severe (1) to Least (4)**

Today, you have the following physical complaints:

List First Problem Area

List Second Problem Area

List Third Problem Area

List Fourth Problem Area

Is this complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting or Other (Explain)?

- Sharp
- Dull
- Achy
- Numb
- Electric/Shooting

- Sharp
- Dull
- Achy
- Numb
- Electric/Shooting

- Sharp
- Dull
- Achy
- Numb
- Electric/Shooting

- Sharp
- Dull
- Achy
- Numb
- Electric/Shooting

How often do you feel this complaint? Constant, Daily, "Off & On", or Weekly?

- Constant
- Daily
- Off & On
- Weekly
- Monthly
- Other \_\_\_\_\_

- Constant
- Daily
- Off & On
- Weekly
- Monthly
- Other \_\_\_\_\_

- Constant
- Daily
- Off & On
- Weekly
- Monthly
- Other \_\_\_\_\_

- Constant
- Daily
- Off & On
- Weekly
- Monthly
- Other \_\_\_\_\_

How long have you had this?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is it getting better, worse or staying the same?

- Better
- Worse
- Same

- Better
- Worse
- Same

- Better
- Worse
- Same

- Better
- Worse
- Same

What makes it better?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What makes it worse?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

On a scale of 1 – 10 Rate your discomfort:

Circle one  
10 9 8 7 6 5 4 3 2 1 0

Circle one  
10 9 8 7 6 5 4 3 2 1 0

Circle one  
10 9 8 7 6 5 4 3 2 1 0

Circle one  
10 9 8 7 6 5 4 3 2 1 0

10 = Excruciating  
0 = No Discomfort

10 = Excruciating  
0 = No Discomfort

10 = Excruciating  
0 = No Discomfort

10 = Excruciating  
0 = No Discomfort

How long have you taken care of this in the past? How has it worked for you?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This issue is affecting my: (Please circle)

Job            Childcare  
Marriage    Sex  
Golf          Finances  
Bowels      Urine  
Playing with kids

Job            Childcare  
Marriage    Sex  
Golf          Finances  
Bowels      Urine  
Playing with kids

Job            Childcare  
Marriage    Sex  
Golf          Finances  
Bowels      Urine  
Playing with kids

Job            Childcare  
Marriage    Sex  
Golf          Finances  
Bowels      Urine  
Playing with kids

Helping this issue would increase my Quality of Life by: (Please circle)

10 - 20%    30 - 40%  
50 - 60%    70 - 80%  
90%

10 - 20%    30 - 40%  
50 - 60%    70 - 80%  
90%          100%

10 - 20%    30 - 40%  
50 - 60%    70 - 80%  
90%          100%

10 - 20%    30 - 40%  
50 - 60%    70 - 80%  
90%          100%

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Present Health History

### When did your present condition begin?

- a) Gradual Onset (on specific date)
- b) Date: \_\_\_\_\_

### What caused your present condition?

- a) No specific injury
- b) Home accident
- c) Work Accident
- d) Auto Accident

### What happened to cause your present pain?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Have you ever had these symptoms before?

- a) No
- b) Yes: (Date: \_\_\_\_\_)

### What time of day are your symptoms better?

- a) Morning
- b) Afternoon
- c) Evening
- d) All of the above (constant pain)

### Have you missed any work?

- a) No
- b) Yes: (Date: \_\_\_\_\_)

### What makes your pain better?

- a) Rest
- b) Ice packs/Heating pads
- c) Prescription medication
- d) Drug store medications (Ibuprofen, Advil)
- e) Other: \_\_\_\_\_

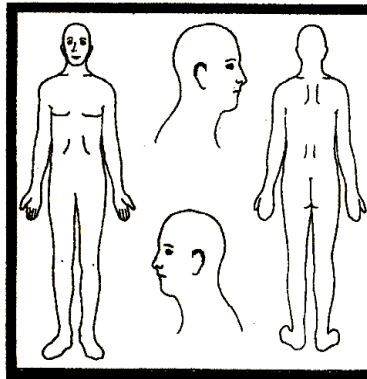
### What makes your pain worse?

- a) Activity (work, repetitive motions)
- b) Ice packs/Heating pads
- c) Driving (or riding) in car
- e) Other: \_\_\_\_\_

### What home remedies have you tried?

- a) Ice packs
- b) Heating pads/Hot Tubs
- c) Exercise
- d) Other: \_\_\_\_\_

### Please Label the Area(s) of Today's Pain



NOTES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*PRO ACTIVE CHIROPRACTIC CENTER FINANCIAL POLICY\***

**Financial Obligation**

In considering the amount of medial expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Pro Active Chiropractic Center located at 219 South Main, Palmyra, MO 63461, medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies.

I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, choice in action, or other right.

I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, choice in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, choice in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Patient: \_\_\_\_\_

Parent, if minor child, or guardian: \_\_\_\_\_  
(If patient unable to sign, Representative name and relationship)

Date: \_\_\_\_\_