Boesky Chiropractic PLC **HPI-New symptom or returning Patients**
4204 S. Westnedge Ave
Kalamazoo, MI 49008 (269)342-9090 Fax (269)342-9054 **Dr. Andrew Boesky DC, CACCP**

Office Use Only: Quick Update

___ Address ___ E-Mail ___ Phone ___ Insurance Info ___ ABN/HIPPA Verified by: _____

Please inform us of your current e mail, address and insurance information

Today's Date: _____ **Legal Name:** _____ **Last adjustment date**_____

Address _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

e-mail address _____ SSN_____

Preferred Method of Contact Home Phone Cell Phone Work Phone E-mail

Are you currently pregnant? Y N Approximate Due date _____ Is the baby breech? Y N

Previous Surgeries and dates _____

Previous auto accidents and dates _____ _____

Current Medications _____ _____ _____ _____ _____

Allergies: List Here _____ _____ _____ _____ _____

Do You Currently Smoke? Y N Have You Ever Smoked? Y N

Race/Ethnicity: ____ African-American ____ Caucasian ____ Asian ____ Latino-Hispanic

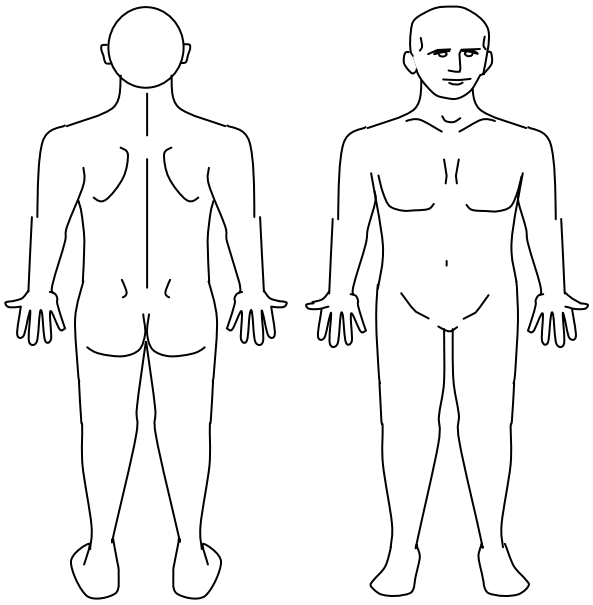
____Native American ____ Other_____

Preferred Language _____

Height _____ Weight _____

Are you currently pregnant? Y N Approximate Due date _____ Is the baby breech? Y N

Please complete diagram section below



Darken the figures to the right where you have pain or numbness or other symptoms

BP _____/_____ P _____

Please check other health complaints you have or have had below

Circle C=Current I=Intermittent P=Past (over 1 year)

- ____**Neck pain** C I P _____
- ____**Upper Back Pain** C I P _____
- ____**Lower Back Pain** C I P _____
- ____**Sacroiliac Pain** C I P _____
- ____**Tailbone Pain** C I P _____
- ____**Sciatica** C I P _____
- ____**Arm/Hand Numbing** C I P ___Left ___Right ___Both What area? _____
- ____**Leg/Foot Numbing** C I P ___Left ___Right ___Both What area? _____
- ____**Migraines with nausea** C I P How Often? ___Weekly ___Monthly ___Other_____
- ____Migraines-no nausea C I P _____
- ____Arm pain C I P ___Left ___Right ___Both _____
- ____Leg pain C I P ___Left ___Right ___Both _____
- ____Headaches C I P _____
- ____Muscle Spasms C I P ___Upper ___Mid Back ___Low Back _____
- ____Muscle Pain/stiffness C I P _____
- ____Dizziness C I P _____
- ____Irritability C I P _____
- ____Jaw problems/TMJ C I P _____
- ____Forgetfulness C I P _____
- ____Blurred vision C I P _____
- ____Fatigue C I P _____
- ____Ringing ears C I P _____
- ____Memory loss C I P _____
- ____Light sensitivity C I P _____
- ____Disturbed sleep C I P _____
- ____Muscle Pain (Mid-Upper) C I P _____
- ____Shoulder pain C I P _____
- ____Rib pain C I P _____
- ____Chest pain C I P _____
- ____Digestive Problems C I P _____
- ____Shortness of breath C I P _____
- ____Back stiffness C I P _____
- ____Hip Pain C I P _____
- ____Impotence C I P _____
- ____Menstrual problems C I P _____

- Other symptoms not listed _____

_____

_____

Please Complete…Put ONLY ONE symptom or complaint in EACH BOX.

Name your worst symptom here ______________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 1=Best **1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? ________________________

What makes it Better? ___________________________________

What makes it Worse? ___________________________________

When is it Better? ___ AM ___ PM ___ No special time

When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ______________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 1=Best **1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? ________________________

What makes it Better? ___________________________________

What makes it Worse? ___________________________________

When is it Better? ___ AM ___ PM ___ No special time

When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ______________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 1=Best **1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? ________________________

What makes it Better? ___________________________________

What makes it Worse? ___________________________________

When is it Better? ___ AM ___ PM ___ No special time

When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ______________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

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When is it Better? ___ AM ___ PM ___ No special time

When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ______________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

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How bad is it? 1=Best **1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? ________________________

What makes it Better? ___________________________________

What makes it Worse? ___________________________________

When is it Better? ___ AM ___ PM ___ No special time

When is it Worse? ___ AM ___ PM ___ No special time

ACTIVITIES DISCOMFORT SCALE

NAME: _____ DATE: _____

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt	Hurts a Little	Hurts Very Much	Almost Unbearable	Unbearable
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Exercise					
8. Climbing Stairs					
9. Carrying					
10. Household Chores					
11. Driving					
12. Dressing					
13. Job Duties					

Are there any activites you are not able to do because of your current complains? Please list them here

_____

_____

_____