

# BUELT CHIROPRACTIC REGISTRATION

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

## PATIENT INFORMATION

### Patient Name

Last: \_\_\_\_\_

First \_\_\_\_\_

Middle Initial \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

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

Email Address \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: M F

Patient Social Security Number \_\_\_\_\_

Marital Status: single married widowed separated divorced

Spouse's Name \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

## EMERGENCY CONTACT

Name \_\_\_\_\_

Relationship \_\_\_\_\_ home(\_\_\_\_\_) \_\_\_\_\_

work(\_\_\_\_\_) cell (\_\_\_\_\_) \_\_\_\_\_

Office Use Only  
Chart Number

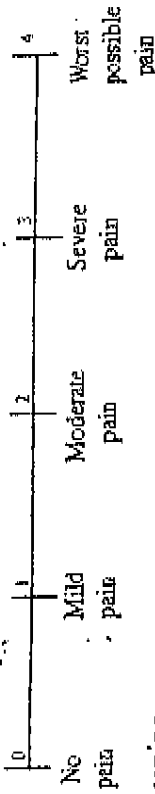
Insurance

# Functional Rating Index

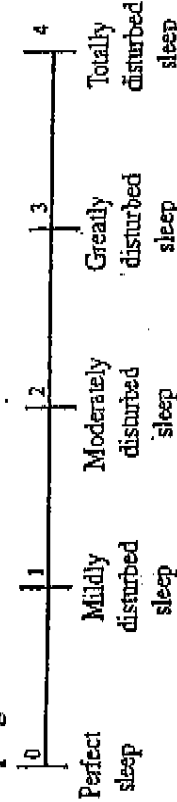
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

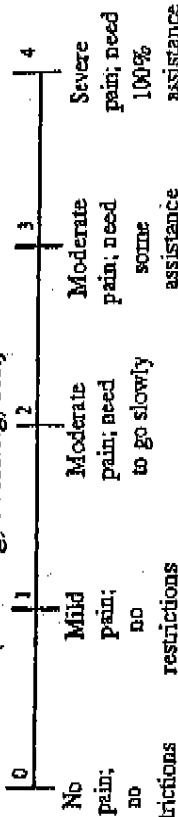
## 1. Pain Intensity:



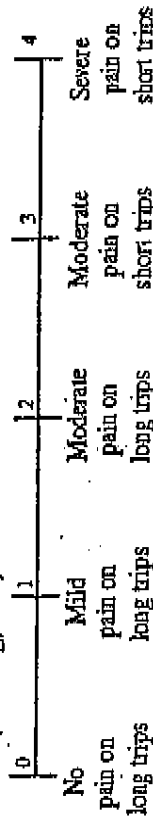
## 2. Sleeping



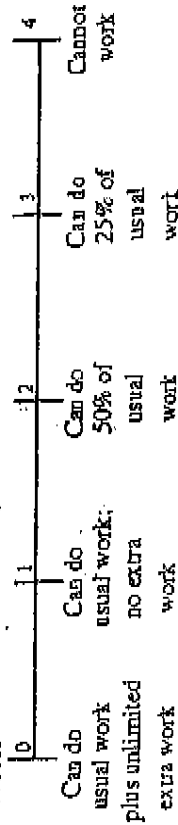
## 3. Personal Care (washing, dressing, etc.)



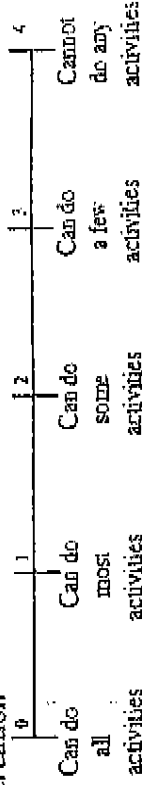
## 4. Travel (driving, etc.)



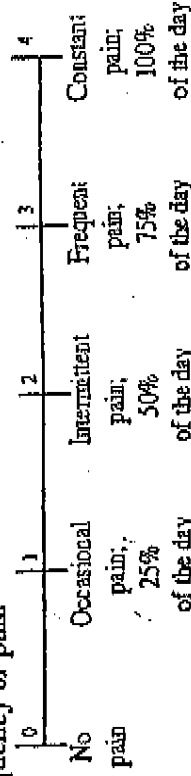
## 5. Work



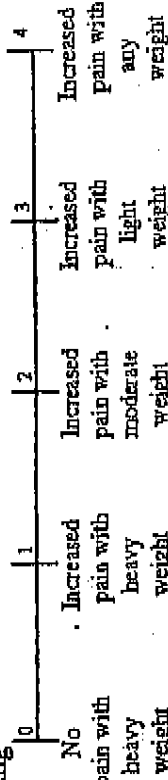
## 6. Recreation



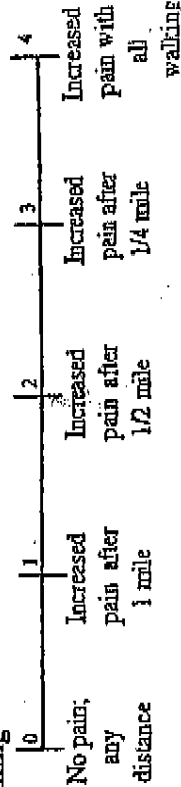
## 7. Frequency of pain



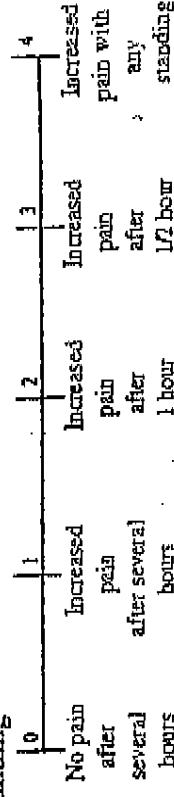
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

PRINTED \_\_\_\_\_

ID# \_\_\_\_\_

Plan ID \_\_\_\_\_

Total Score \_\_\_\_\_

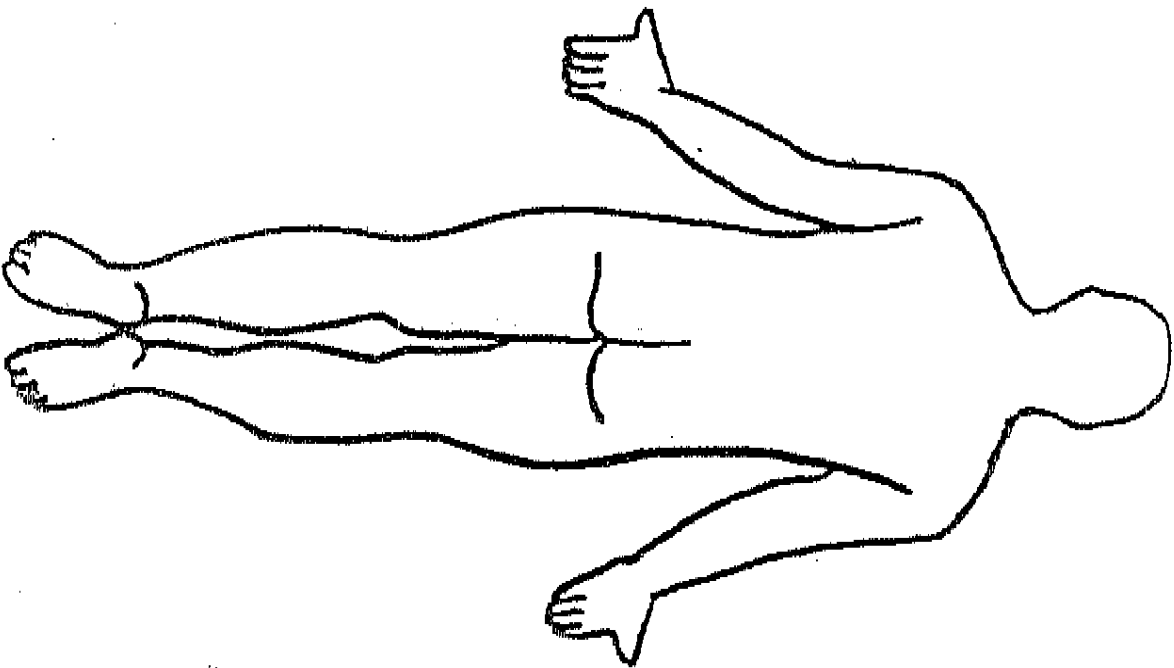
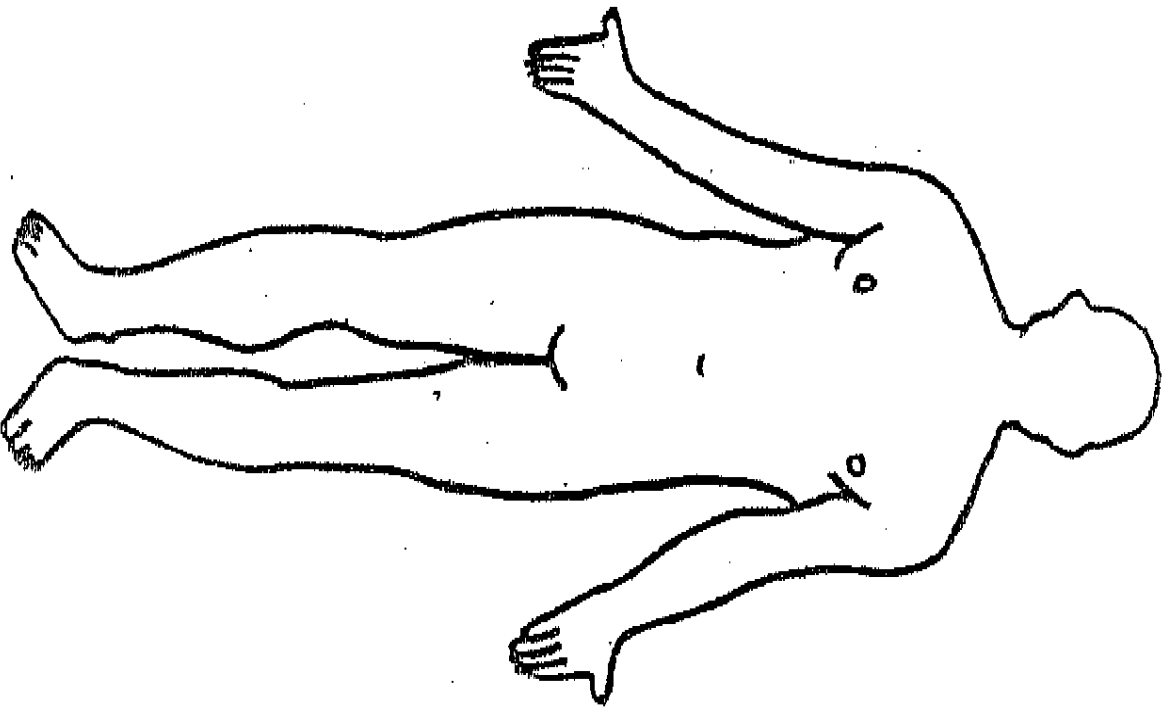
Revised 10/07

Signature \_\_\_\_\_

Date \_\_\_\_\_

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**Please mark the areas with an X where you are hurting  
and wish the Doctor to exam and treat.**



**Name:****Review of Systems**

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Please circle any symptoms you are having so the doctor may review with you during your examination

**Constitutional Symptoms:**

**NONE** / fever / chills / weight loss / night sweats / fatigue / poor appetite

**Sleep:**

**NONE** / snoring / gasping / insomnia / restless legs / difficulty sleeping

**Ears**

**NONE** / hearing loss / ringing / ear pain

**Eyes**

**NONE** / change in vision / blurry vision / double vision / eye pain

**Nose, Mouth and Throat:**

**NONE** / change in sense of smell / runny nose / nose bleeding / sores in the mouth / sore throat / difficulty or pain swallowing

**Cardiovascular:**

**NONE** / chest pain / palpitations / swollen legs / fainting / shortness of breath

**Respiratory:**

**NONE** / cough / coughing up blood / coughing up phlegm / wheezing

**Gastrointestinal:**

**NONE** / abdominal pain / nausea / vomiting / diarrhea / constipation / heartburn

**Musculoskeletal:**

**NONE** / muscle pain / bone pain / joint pain / swollen or red joints / broken bones

**Genitourinary:**

**NONE** / difficulty urinating / vaginal or penile discharge / kidney stones

**Skin:**

**NONE** / rash / ulcers that will not heal / moles that are changing

**Endocrine:**

**NONE** / heat or cold intolerance / frequent urination / unusually thirsty / high or low blood sugar

**Neurological:**

**NONE** / headache / weakness / seizure / dizziness / tremor / TIA's / Stroke

**Lymph and Heme:**

**NONE** / easy bleeding / swollen lymph nodes

**Psychiatric:**

**NONE** / Depression / anxiety / hallucinations