SoftWave Therapy
— of Monmouth —

280 US Highway 9, Morganville, NJ 07751
www.SoftWaveNJ.com
(732) 617-9355

Confidential Health Record

Welcome To Our Office! Today's Date M/D/Y ___/___/___

Whom may we thank for referring you to our office? ______________________

Personal Information

Name LAST ______________ FIRST ______________ MIDDLE ______________

Birth Date M/D/Y ___/___/___ Age ______ Sex PLEASE CHECK ○ Male ○ Female Social Security # ____-____-____

Address ______________ Apt # ______ City ______________ State ______ Zip ______

Phone # HOME ______________ CELL ______________ WORK ______________

Email Address ______________ Occupation ______________

Marital Status PLEASE CHECK ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated

Spouses Name LAST ______________ FIRST ______________ # of Children ______

Emergency Contact

Name LAST ______________ FIRST ______________ Relationship ○ Spouse ○ Relative ○ Friend

Phone # HOME ______________ CELL ______________ WORK ______________

Present Health Challenge

IF YOU HAVE NO SYMPTOMS OR COMPLAINTS, AND ARE HERE FOR **CHIROPRACTIC WELLNESS SERVICES**, CHECK HERE ○

Unwanted Health Challenge

Explain why you are here today ______________________

____

____

____

____

Has it ever occurred before? ○ Yes ○ No

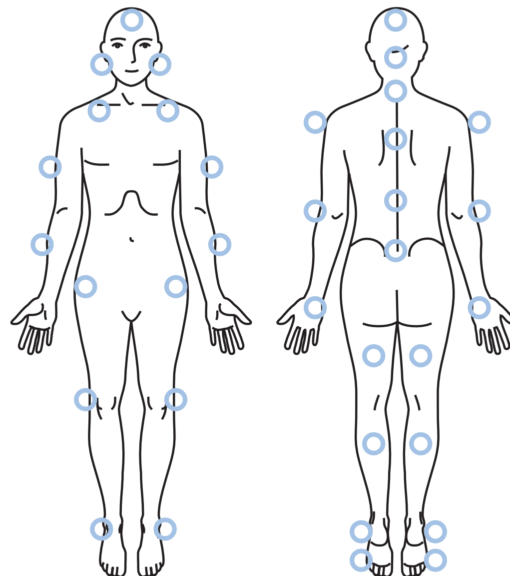
When do you think these problems originally started? ______________________

____

____

Date of Auto Crash or Work Related Injury M/D/Y ___/___/___

PLEASE CHECK ON THE DIAGRAM THE AREA OF DISCOMFORT



PLEASE CHECK THE APPROPRIATE CIRCLE & COMPLETE BLANKS.

Body Area(s) Involved ○ Neck ○ Back ○ Head ○ Other ______________
○ Shoulder ○ Elbow ○ Wrist ○ Hip ○ Knee ○ Ankle ○ Foot

Current Symptoms ○ Pain ○ Numbness ○ Stiffness ○ Weakness ○ Other ______________

Quality ○ Burning ○ Diffuse ○ Dull/Aching ○ Localized ○ Radiating ○ Sharp ○ Shooting
○ Stabbing ○ Throbbing ○ Tightness ○ Tingling ○ Other ______________

Timing ○ Morning ○ Afternoon ○ Night ○ With Activity ○ Constant ○ Intermittent

What Makes it Worse? ______________________

What Makes it Better? ______________________

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Level of Impairment Due to Symptoms CHECK THE APPROPRIATE LEVEL WITH **0 = NONE / 10 = EXTREME**

While Resting	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
With Activity	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

Headaches							
	Location	○ Occipital	○ Frontal	○ Left Temporal	○ Right Temporal	○ Parietal	○ Sinus
	Quality	○ Dull	○ Sharp	○ Throbbing	○ Stabbing	○ Aura	○ No Aura
	Types	○ Hat Band	○ Cluster	○ Migraine	○ Tension		

Employment – Occupation/Job Title ______________________________ Work # ________ hours per day

Conditions Effect on Job Performance ○ No Effect ○ Mild Pain ○ Moderate Pain ○ Unable to Perform

Daily Activities – Effects of Current Condition on Performance

Bending	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Change Position (Sit-Stand)	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Climb Stairs	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Driving	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Extended Computer Use	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Household Chores / Yard Work	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Lifting	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Reading/Concentration	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Self Care (Bathe/Dress)	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Sleep	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Prolonged Sitting	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Prolonged Standing	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Walking	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)

Recreational Activities – PLEASE LIST ANY CURRENT RECREATIONAL ACTIVITIES AND CHECK THE EFFECTS OF CURRENT CONDITION ON PERFORMANCE

______________________ ○ No Effect ○ Mild (Can do) ○ Moderate (Limited) ○ Severe (Unable to Perform)

REVIEW OF SYSTEMS

PLEASE CHECK THE ITEMS BELOW THAT APPLY TO YOU.

Nervous System

○ Dizziness	○ Seizures	○ Loss of Memory	○ Slurred Speech	○ Loss of Consciousness
○ Strokes	○ Tremor	○ Limb Weakness	○ Fatigue	○ Sleep Disturbance
○ Stress	○ Numbness	○ Headache	○ Loss of Balance	○ Tinnitus/Ringing in Ears

Respiration

○ Asthma	○ Cough	○ Wheezing	○ Sputum Production	○ Shortness of Breath

Cardiovascular

○ I DENY Any Symptoms	○ Chest Pain	○ Swelling Of Legs	○ Low Blood Pressure	○ Claudication (Leg Pain/Ache)
○ Palpitations	○ Varicose Veins	○ High Blood Pressure	○ Shortness Of Breath	

Gastrointestinal

○ Diarrhea	○ Indigestion	○ Abnormal Stool	○ Vomiting Blood	○ Weight Changes
○ Belching	○ Vomiting	○ Abdominal Pain	○ Constipation	○ Difficulty Swallowing
○ Nausea	○ Heartburn	○ Ulcers		

Psychologic

○ Irritability	○ Insomnia	○ Memory Loss	○ Behavioral Change	○ Bi-Polar Disorder
○ Anxiety	○ Depression	○ Mood Change	○ Loss or Change in Appetite	

Immune

○ Itching	○ Anaphalaxis	○ Food Intolerance	○ Nasal Congestion	○ Rash

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LIFESTYLE REVIEW

1. On a scale of Poor, Good, Excellent please describe your lifestyle MARK **POOR, GOOD** OR **EXCELLENT**.

   Diet ____________ Exercise ____________ Sleep ____________ General Health ____________

2. What Wellness services/products do you currently incorporate into your lifestyle? ____________

3. What Supplements are you currently taking? ____________

4. On a scale of 1-10 describe your stress level **1 = NONE / 10 = EXTREME** Occupational ____________ Personal ____________

5. **What are your top two health goals? 1.** ____________ **2.** ____________ **or** ○ **I do not have any**

6. **Are you pregnant?** ○ Yes ○ No

HEALTH HISTORY

FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

Previous Chiropractic Care: ○ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name ____________ Date of Last Visit M/D/Y ___/___/___

Current Medication(s) LIST **ANY/ALL** MEDICATIONS YOU ARE **CURRENTLY** TAKING. BE SPECIFIC. ____________

Doctor's Name ____________

Illness(es) **LIST** ALL HEALTH CONDITIONS. ____________

Surgery(ies) **LIST** ALL SURGICAL PROCEDURES. WRITE THE **DATE** OF THE PROCEDURE IMMEDIATELY AFTERWARD. ____________

Injury(ies) MARK OR LIST ALL INJURIES. WRITE THE **DATE** OF THE INJURY IMMEDIATELY AFTERWARD.

○ Fall (Severe) M/D/Y ___/___/___ ○ Broken Bones M/D/Y ___/___/___ ○ Loss of Consciousness M/D/Y ___/___/___

○ Head Injury M/D/Y ___/___/___ ○ Back/Neck Injury M/D/Y ___/___/___ ○ Motor Vehicular Crash M/D/Y ___/___/___

SOCIAL HISTORY

Tobacco ○ Do not use tobacco ○ Smoke/Chew: # ________ per Day ○ Live with a smoker ○ Quit smoking

Alcohol ○ Do not use alcohol ○ # ________ Drinks per Week ○ # ________ Drinks per Month

An evaluation will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation and radiological examination (x-rays).

The statements made on this form are accurate to the best of my recollection and I knowingly allow our doctors to examine me for further evaluation/treatment, and understand that I am responsible for all charges incurred.

Signature ____________ **Date** M/D/Y ___/___/___

THANK YOU FOR ALLOWING US TO SERVE YOU!