Welcome to

GENESIS CHIROPRACTIC CLINIC


Dr. Gene Fish, D.C

Rest assured that you will be provided the most appropriate and professional healthcare possible.

At **Genesis Chiropractic Clinic,** our Purpose and Passion is to provide solutions to empower true health. We specialize in helping restore functional movement to those suffering from low back pain, neck pain, auto accident injuries, and headaches. Our guarantee is we will put every effort to find out the cause of your problem and treat it naturally.

Our introduction to you begins with gathering as much information as we can about your condition and your goals. Although paper-work isn't fun, sometimes little details that we pick up can go a long way towards diagnosis and treatment. We have carefully designed our questionnaires to learn as much as possible so that we can custom tailor treatment plans for you. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health.

On your first visit with us, please bring along any relevant medical history, x-rays & MRIs (we prefer the actual disc or film, but a report might help), etc. Anything you think might help. On the day of your visit we ask that you wear clothing that you are comfortable moving in for the physical portion of the examination. The initial assessment will take between 30-45 minutes.

If you'd like us to have this before you come in for your initial evaluation, you can email these to us **genesischiropractic@gmail.com** or you can fax these in at **215-343-3223.**

Location:
Our clinic is conveniently located on the corner of Route 611 (Easton Road) and County Line Road in Horsham, PA. We are in a red brick building on the same corner as the Navy Base.

GENESIS
CHIROPRACTIC

CONFIDENTIAL PATIENT RECORD (LEVEL III - IV)

APPLICATION FOR CARE

GENESIS CHIROPRACTIC

First Name: | M.I. | Last Name:

Address:

City: | State: | Zip:

Cell Phone: | Home Phone: | Email:

Birthdate: | Sex: ☐ Male ☐ Female | Marial Status: ☐ Single ☐ Married

Whom may we thank for referring you to our office?

☐ Website ☐ Facebook ☐ Friend / Family _____ ☐ Other _____

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, when?

Current Employer: | Occupation:

Does Your Job Involve:

☐ Standing How Long? _____ ☐ Sitting How Long? _____

☐ Driving How Long? _____ ☐ Lifting How Much? _____

☐ Walking How Long? _____ ☐ Repetitive Motion

HISTORY of COMPLAINT(s)

List in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office:

Primary complaint	
2nd	
3rd	
4th	

	When did it begin?	Number of times you have experienced?	When was the Last Episode?	Constant or Intermittent?
Primary complaint				
2nd				
3rd				
4th				

HISTORY of COMPLAINT(s)

	What relieves your symptom(s)?	What makes them feel worse?	On a scale of 1-10 (10 = worst) rate how you feel today.
Primary complaint			
2nd			
3rd			
4th			

Do your symptoms cause you to feel worse

in the ☐ AM ☐ PM ☐ mid-day ☐ late PM

Have these Problems ever been treated by anyone in the past?

☐ No ☐ Yes ➔ If yes Who provided: _____

How long ago? _____What type of treatment did you receive?

_____

_____

What were the results? ☐ Favorable ☐ Unfavorable

➔ If unfavorable please explain: _____

_____

List any medications taken to treat these conditions:_____

_____

_____

Did they help? ☐ No ☐ Yes

If you still take them, how often? _____

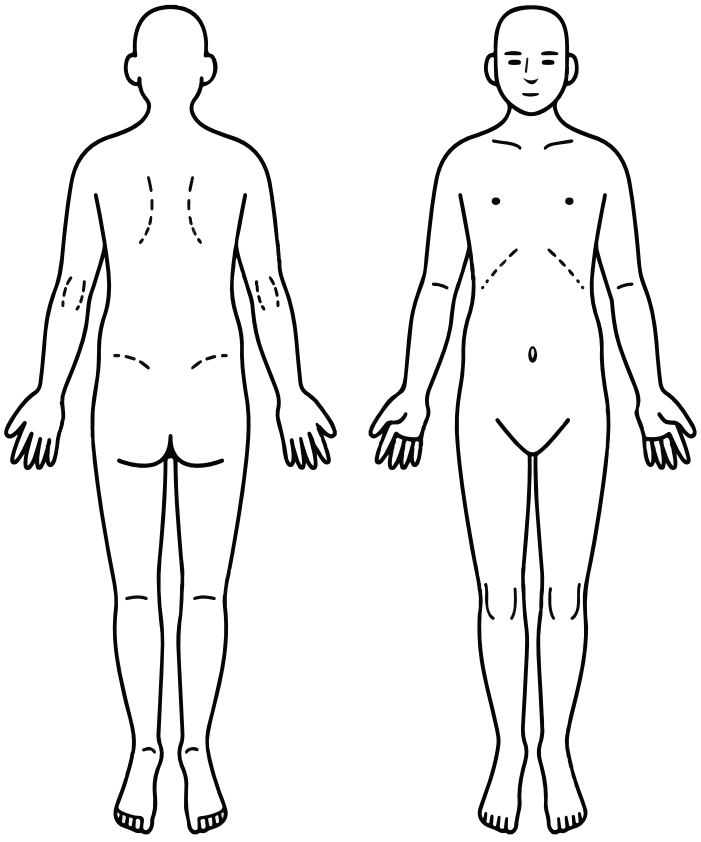
Are any of your problem(s) today the result of ANY recent

accident? ☐ No ☐ Yes If yes, How long ago? _____

Please explain what type of accident: _____

_____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching
N = **N**umbness **S** = **S**harp/ Stabbing **T**= **T**ingling



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Genesis Chiropractic Clinic
801 County Line Road, #6
Horsham PA 19044 **Ph. 215.343.3223**

REVIEW OF SYSTEMS

Please rate each of the symptoms on this page according to your health status over the **past 30 days**: **Leave Blank** if you never have this symptom, Mark with an **"O"** if you occasionally have this symptom, Mark with an **"F"** if you frequently have this symptom

Head:
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TMJD / Jaw Pain
_____ Loss of Balance
_____ Ringing / Buzzing in Ears

Energy/Activity:
_____ Fatigue/Sluggishness
_____ Sleep Problems
_____ Restlessness

Lungs:
_____ Chest Congestion
_____ Asthma, Bronchitis
_____ Shortness of Breath
_____ Difficulty Breathing

Ears:
_____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage From Ear
_____ Ringing In Ears, Hearing Loss

Weight:
_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Water Retention
_____ Underweight

Nose:
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation

Skin:
_____ Acne
_____ Hives, Rashes, Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating

Mouth & Throat:
_____ Chronic Coughing
_____ Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness
_____ Swollen or Discolored Tongue

Eyes:
___ Watery or Itchy Eyes
___ Swollen, Red or Sticky Eyelids
___ Bags or Dark Circles Under Eyes
___ Blurred or Tunnel Vision
(not including near or far sightedness)
___ Light Sensitivity

Joints/Muscles:
_____ Pain or Aches in Joints
_____ Arthritis
_____ Stiffness or Limited Movement
_____ Pain or Aches in Muscles
_____ Weakness or Fatigued Muscles

Emotions:
_____ Mood Swings
_____ Anxiety/Fear/Nervousness
_____ Anger/Irritability
_____ Depression

Heart:
_____ Irregular or Skipped Heartbeat
_____ Rapid or Pounding Heartbeat
_____ Chest Pain

Mind:
_____ Poor Memory
_____ Confusion, Poor Comprehension
_____ Poor Concentration
_____ Poor Physical Condition
_____ Difficulty Making Decisions
_____ Stuttering or Stammering
_____ Slurred speech

Digestive Tract:
_____ Nausea, Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching, Passing Gas
_____ Heartburn
_____ Intestinal/Stomach Pain

Nervous System:
_____ Pins and Needles in arms
_____ Numbness in fingers
_____ Pins and Needles in legs
_____ Numbness in toes
_____ Neck Stiffness
_____ Back pain
_____ Cold hands
_____ Cold feet

Have you ever been diagnosed with any of the following conditions?

Leave Blank for: **Never have had** , Mark with a "**P**" for: **In the Past** , Mark with a "**C**" for: **Currently**

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Fracture

___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis

___ Osteo Arthritis ___ Seizure ___ Diabetes ___ Other Serious Conditions _____

PLEASE, identify ALL PAST and or any unrelated current **conditions you feel may be contributing your present problem:**

	How Long Ago?	Type of Care Received?	By Whom?
Previous Accidents:			
Adult Diseases:			
Surgeries:			
Childhood Diseases:			
Hospitalizations:			

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes If yes whom: _____

☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sisters ☐ Brothers ☐ Son(s) ☐ Daughter(s)

2. Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

3. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes _____

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SOCIAL HISTORY

1. Smoking: ☐ cigars ☐ pipe ☐ cigarettes ➔ How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ➔ ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. How many years of school did you complete? ☐ 1-8 ☐ 8-12 ☐ 12-14 ☐ 14-16 ☐ 16+

ACTIVITIES OF DAILY LIVING

Please provide a Measurement on a Scale of **1 to 10** for activities that cause Pain.
Also Mark with an "**X**" the effect your condition is having on your ability to perform the activity.

	Pain Scale Measurement (1 - 10) ↓				
Bending Neck Forward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending Neck Backward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Turning Neck Right		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Turning Neck Left		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Twisting From The Waist		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending Side To Side		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending Backward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Bending Forward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Going From Standing To Sitting		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Going From Sitting To Standing		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing Over 10 Minutes		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Going From Sitting To Lying Down		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lying Down		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Going From Lying To Sitting Up		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over When Lying Down		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Extending Arms Overhead		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Extending Arms Forward		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pulling		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking Or Running		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing Uphill (Stairs, Ladders)		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking Downhill		☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Signature:_____ Date Completed: / / Doctors Signature: _____

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