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

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

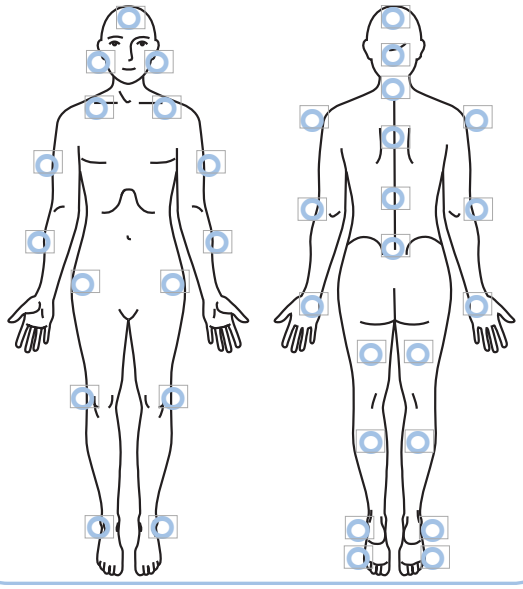
When do you think these problems originally started? _____

_____

_____

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!