PATIENT INITIAL HEALTH STATUS

PATIENT INFORMATION/患者情報

Name:_____ **Birthdate:**_____ **Sex** 性別**:** M / F

Home address:_____ City_____ State____ Zip _____

Phone: (____) _____ **E-mail:** _____ **Work Phone:** (____) _____

Occupation ご職業**:**_____ **Employer** 勤務先**:**_____

Emergency contact person 緊急連絡者**:** _____ **Relationship** ご関係**:**_____

Emergency phone: (____) _____ **Referred by** (How did you find us?) ご紹介者 _____

CURRENT CONDITION/現在の症状

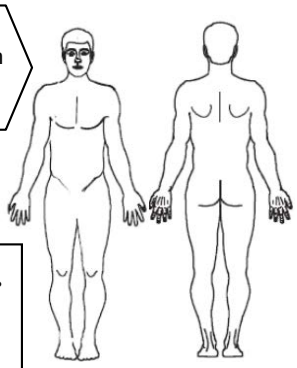
◆ **Your current problem**

☐ Headache 頭痛 ☐ Neck Pain 首痛 ☐ Mid Back Pain 背部痛
☐ Low Back Pain 腰痛 ☐ Other その他 _____

◆ **Is this?** ☐ Work Related ☐ Auto Related ☐ N/A

◆ **Date Problem Began:**_____ ◆ **How Problem Began:**_____

Please mark an X on the picture where you have pain or other symptoms.
痛みのある箇所に印をつけて下さい



Current Complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain 痛みなし — Unbearable pain 耐えられない痛み

How often are your symptoms present? その症状（痛み）が起こる頻度は？

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
Occasional 断続的 — Constant 絶えず続く

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)? この１週間、その症状（痛み）で、仕事や日常生活にどのくらい支障がありましたか？

0 1 2 3 4 5 6 7 8 9 10
No interference 支障なし — Unable to carry on any activities あらゆる活動で支障あり

◆ **Have you had spinal X-ray, MRI, CT Scan for your area(s) of complaint?**
その症状のために、レントゲン、MRI、CTスキャンを撮りましたか？

☐ No
☐ Yes Date taken/いつ？: _____
What areas were taken?/どの部位？ _____

◆ **In general would you say your overall health right now is:**
現在のあなたの全体的な健康状態は？

☐ Excellent 極めて良好 ☐ Very good とても良好 ☐ Good 良好 ☐ Fair 悪い ☐ Poor 非常に悪い

MEDICAL RECORD/医療記録

◆ **Please check all the following that apply to you** 該当する箇所に全てチェックして下さい**:**

☐ Recent Fever 急な発熱
☐ Menstrual Problems 生理不順
☐ Urinary Problems 泌尿器系疾患
☐ Currently Pregnant 妊娠中, weeks 週 ____
☐ Corticosteroid Use (Cortisone, prednisone, etc) コルチコステロイド使用（コルチゾン、プレドニゾン等）_____
☐ Taking Birth Control Pills 経口避妊薬服用
☐ Pain Unrelieved by Position or Rest 体位や安静による軽減しない痛み
☐ Cancer/ Tumor (explain) ガン/腫瘍 _____
☐ Visual Disturbances 視覚障害
☐ Alcohol/Drug Dependence アルコール/薬物依存
☐ Medication 薬剤 _____
☐ Surgeries 手術 _____
☐ Prostate Problems 前立腺疾患
☐ High Blood Pressure 高血圧
☐ Lungs Disease 肺疾患
☐ Marked Morning Pain/Stiffness 著しい朝方の痛み/こわばり
☐ Dizziness/Fainting めまい/失神
☐ Epilepsy/Seizures てんかん/発作
☐ Numbness in Groin/Buttocks 鼠蹊部/臀部のしびれ
☐ Other Health Problems (explain) その他健康問題 _____
☐ Diabetes 糖尿病
☐ Heart Disease 心疾患
☐ Stroke 脳卒中 (date)_____
☐ Abnormal Weight 異常体重
☐ Gain 増加 ☐ Loss 減少
☐ Osteoporosis 骨粗しょう症
☐ Pain at Night 夜間の痛み
☐ Tobacco Use-Type 喫煙
Frequency 頻度 _____ /Day

Family History: ☐ Cancer ガン ☐ Diabetes 糖尿病 ☐ High Blood Pressure 高血圧
☐ Heart Problems/Stroke 心疾患/脳卒中 ☐ Rheumatoid Arthritis 関節リウマチ

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit though this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____