Beautiful Gate Chiropractic LLC 15814 East U.S. Highway 24 Independence, MO 64050

Terms to Know: SUBLUXATION: a misalignment and/or restriction of a bone/joint causing interference or pressure on nerves resulting in decreased health.
ADJUSTMENT: a specific, scientific force applied to a joint in a precise direction to assist the body in bringing correction of subluxation.

Personal Information

Name (First, MI, Last): _____ Nickname _____

Gender: M / F Birthday: _____/_____/_____ Phone: _____ Email: _____

Street Address: _____ City, State, Zip: _____

Marital Status: S M W D Spouse's Name: _____ Medicare Subscribe? Y / N Occupation: _____

Emergency Contact Name/Relation/Phone: _____ Any Children? _____ Ages? _____

S

History & Purpose of Visit

Do you smoke? Y / N If smoke, how long? _____ How much? _____

Ever had Chiropractic before? Y / N If yes, when? _____ Where? _____ *FEMALE*: pregnant?___ Due date: ____

Reason(s) you are here: _____ ***When*** did symptoms start? _____

How did symptoms start?_____ Anything make it ***Better***?_____ or ***Worse***? _____

Time when it's Worse? _____ ***Radiate*** into Arms or Legs? _____ ***Feels***: Numb/Tingling Achy Sharp Dull Stiff/Sore

Health Review – place X	Self	Spouse	Children	Family	
Heart/Vascular Problems					
ADHD/ADD/Behavior Issues					
Allergies/Asthma/Lung Issues					
Nervousness/Anxiety					
Arthritis/Osteoporosis					
Diabetes					
High Blood Press/Cholesterol					
Kidney/Bladder Dysfunction					
Cancer					

	Self	Spouse	Children	Family	
Digestion/Bowel Problems					
Dizziness/Fainting					
Neck/Back Problems					
Shldr/Elbow/Wrist/Hand Issue					
Hip/Knee/Ankle/Foot Issue					
Headaches/Migraines					
Stroke/Neurological History					
Hormone /Thyroid Issue					
Skin Problems					

Previous ***SURGERIES*** (w/years): _____ **Hardware in body**? Y / N

Taking medications? Type/Reason taking: _____

Under the care of another Doctor? Y / N If Yes, why?: _____ **Had spine x-rays taken before**? Y / N When? _____

ANY other HEALTH DETAIL(S) or ACCIDENTS to share?: _____

***Infant/Child patient:** Induced/Early Birth? _____ C-sec? _____ Irritable infant? _____ Traumas? _____ All shots? _____ Other: _____

Patient/Guardian Signed Name _____ **Date** _____

(Office Use Only)

****Circles/remarks made ONLY on completed exam procedures. If NO circles/remarks present or if sections crossed-off then procedure was NOT completed.**

CspROM: Flx/Ext Rot LatB **Csp Comp**: Neg Pos (Radicular _____) Pain R L **Csp Foraminal Comp (Bilat)**: Neg Pos (Radicular _____) Pain R L
Pain **CspROM**: Y / N **Csp Distrct**: Neg Pos (Relieves) Pain R L **Modified Slump**: _____ Pain R L

T/Lsp ROM: Flx/Ext Rot LatB **Lsp Sit SLR**: Neg Pos (Radicular R L B) Pain R L **Other**: _Upper Csp Temp Test:_____
Pain **T/Lsp ROM**: Y / N **Valslva**: Neg Pos (Radicular R L B) Pain R L Posture changes:_____

Rflx: **Rt**: All 2/2 C5____ C6____ C7____ All 2/2 L4___ S1___ **Motor**: **Rt**: All 5/5 C5___ C6___ C7___ All 5/5 L4___ L5___ S1___ **Sensory**: no changes
Lft: All 2/2 C5____ C6____ C7____ All 2/2 L4___ S1___ **Lft**: All 5/5 C5___ C6___ C7___ All 5/5 L4___ L5___ S1___ Other: _____

Other: __Temp___Scan___X-ray___Index___Extremity ROM/Check_____

O

A

Assym: **Csp** 0 1 2 3 4 5 6 7 **Tsp R1** 1 2 3 4 5 6 7 8 9 10 11 12 **Lsp** 1 2 3 4 5 **Sac LI RI**
CO UCsp MCsp LCsp C/T UTsp MTsp LTsp T/L MLsp LLsp L/S Sac lium

Tone Chnge: Subocc C p/s LScap/Trap Rhomb Tp/s L p/s Glut/Piriform Leander focus: FS Csp / Tsp / Lsp / Pelv

POP: Csp Tsp Lsp Sac/Pelvis **ISD**: Rt UE Shldr/Elbow/Wrist-Hand Rt LE Hip/Knee/Ankle-Foot Charette _____

Short Leg: R L _____ inch Lft UE Shldr/Elbow/Wrist-Hand Lft LE Hip/Knee/Ankle-Foot PNF or Tggr pts_____

Techniques: Various 1.MPI 2.Diversified 3.Leander 4.Drops 5. Instrument 6.Y-Axis 7. Extremity 8. Infrared _____

DX: VSC (minimum circle one) M99.01 (Csp) M99.02 (Tsp) M99.03 (Lsp) M99.04 (Sac) M99.05 (Pelv) M99.07 (UE) M99.06 (LE) M99.00 (0cc) M99.08 (rib)
Other: M62.838 (other) _____ **TX** (adjust): _____; 98940; 98941; 98943; S8990; 97026; 97012; _____

P

___ Adjust FS per clinical findings ___ Rec ICE or HEAT ___ Rec Medical Visit ____ Rec other: Daily ROM, Diet changes, Quit smoke, Pharm review

Rec: 10x/4-6 wks 4-6x/2wks 4x/2wks 3x/2wks 2x/2wks 1x/2wks 1x/wk for ____ wks ___/wk for ____wks

Other: See Suggested care form No care suggested

_____ Tim Sullivan DC _____ Date

Functional Goals Survey

Date: _____

Please give details for each question so we can better understand your health challenge(s).

What health challenge(s) brings you in today? _____

How many doctors have you seen for this condition(s)? _____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

_____

_____

_____

Has what you've done to date for your condition helped?

☐ **Yes, a lot** ☐ **Yes, some** ☐ **No, not at all** ☐ **Indifferent**

What are 2– 3 activities you can no longer do or are struggling to do because of this condition? *Please be specific.*

1._____

2._____

3._____

What is your honest vision of your life in the next few years if this problem continues to progress?

_____

_____

What would be different &/or better in your life without this problem? Please be specific.

_____

_____

What is your biggest fear if this condition continues to progress? _____

_____

_____

What would success mean to you in our office? _____

_____

_____

On a scale of 0-10, knowing that to achieve results it takes consistency & time, how serious and committed are you about fixing your condition? Please be honest with your answer.

Not Serious 1 2 3 4 5 6 7 8 9 10 Totally Committed

Patient Name: _____

DOB: _____