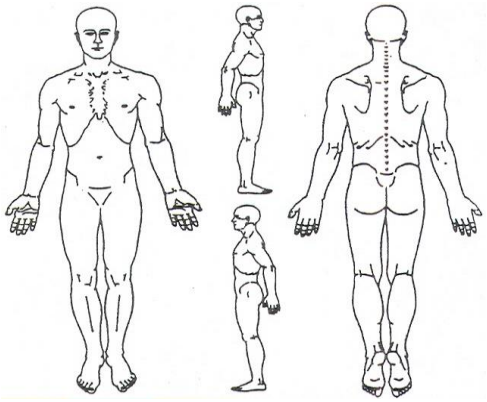
SUBJECTIVE DAILY



Please shade problems areas

New Injury or symptom(s)? □ Yes □ No
Any changes in symptoms since last visit? □ Yes □ No
□ Improved □ Unchanged □ Regressed
Pain Scale 0-10 (10=worse) Today is _____
Percentage time bothersome 0-100 (100 =Constant) _____

Initials: _____

□ W/C □ MVA □ S/F □ Sports □ Other DOI: _____

How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Slightly Better □ Much better

Description of Pain & Symptoms:

□ Sharp □ Dull □ Diffuse □ Achy □ Burning □ Shooting □ Squeezing □ Cramping □ Numbness □ Tingling
□ Tightness □ Stiffness □ Loss of Strength □ Weakness □ Loss of Motion □ Feels Asleep
□ Sharp with Motion □ Stabbing with Motion □ Shooting with Motion □ Electric Like with Motion

Activities Affected:

□ Bending □ Squatting □ Stooping □ Kneeling □ Leaning □ Twisting □ Turning □ Rotating □ Nodding □ Balance
□ Reaching □ Pushing □ Pulling □ Elevating □ Lifting □ Carrying □ Standing □ Walking □ Climbing □ Crawling
□ Sitting □ Getting Up □ Getting Down □ Lying □ Sleeping □ Riding □ Driving □ Opening Things
□ Loss or Decreased Grip Strength □ Loss or Decreased Motion □ Loss or Decreased Fine Motion □ Fatigue □ Nausea

How much is the problem interfering with your **house work / home activities**?
□ Not at all □ Little bit □ Moderately □ Quite a bit □ Extremely

How much is the problem interfering with you **leisure / social activities**?
□ Not at all □ Little bit □ Moderately □ Quite a bit □ Extremely

How much is the problem interfering with your **work or school**?
□ Not at all □ Little bit □ Moderately □ Quite a bit □ Extremely

Working: □No □ Yes □ Full Time □ Part Time □ Full Duties □ Limited Duties

Home Treatment: □ Rest □ Heating pad □ Hot showers/Hot baths □ Cold pack □ Cold showers/baths
□ Hot tub, Jacuzzi, Sauna □ Massage □ Stretches/Yoga □ Exercise
□ Creams □ Icy Hot □ Ben Gay □ Bio-Freeze □ Skinner's Salve
□ Aspirin □ Tylenol □ Ibuprofen (Advil) □ Naproxen (Aleve) □ Medication(s

How often do you experience your symptoms? □ Constantly (76-100% of the time) □ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

Severity of Symptoms

□ **Minimal –** When the symptoms or signs constitute an annoyance but cause ***no impairment*** in the performance of a particular activity.
□ **Slight –** When the symptoms or signs can be tolerated but would cause ***some impairment*** in the performance of an activity that precipitates the symptoms or signs.
□ **Moderate** - When the symptoms and signs would cause ***marked impairment*** in the performance of an activity that precipitates the symptoms or signs.
□ **Marked –** When the symptom or signs ***preclude any activity*** that precipitates the symptoms or signs

Name: _____ Date: _____

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

HM Phone: _____ Mobile Phone: _____ Work: _____

Email: _____ Preferred method of contact: □ Phone □ Email □ Text

Age: _____ Date of Birth: _____ Gender: □ Female □ Male **Social Security No**: _____

Race: □ White □ Hispanic □ Black/African American □ American Indian/Alaskan Native □ Asian □ Pacific Islander □ Multi-racial

Ethnicity: □Hispanic or Latino □ NON-Hispanic or Latino □ Cuban □ Unknown or declined to disclose

Marital Status: □ Married □ Single □ Single with Partner □ Widowed □ Separated □ Divorced

Spouse / Partner Name: _____ Phone: _____

Emergency Contact Info: Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Next of Kin: Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Mothers Maiden Name: _____ **(For electronic access of records)**

CURRENT SYMPTOMS or ACCIDENT or INJURY

Type of Care Requested today: □New accident/injury □Gradual Onset □Old Problem □Re-Activation of Old Problem □Maintenance

Date of accident / injury or date symptoms began: _____

Please describe your Accident or Injury: **What happen to cause your Injury?** _____

What was injured: **Where do you hurt?** _____

Prior treatment for this condition / Injury: □ No □Yes If yes Where:_____

Is the current pain from: □new accident □old Injury Date symptom(s) began: □ _____ or □ Gradual Onset

What makes the pain better?: _____

What makes it worse?: _____

Does the pain radiate, travel or shoot anywhere?: □ No □ Yes If yes where: _____

MEDICATIONS / OTHER TREATMENTS

Allergies: □**NONE** □Food □Stinging Insects .□Medications □Pollen/grasses □Environmental □Latex □Cat /Dog Dander □Chemicals □ Other

Medication(s) / Conditions: □ **NONE** □Cancers/tumors □Diabetes □Kidney/Liver □Hepatitis □Auto-Immun □HIV □Blood Pressure □Stroke □Heart problems □Meningitis □ Mental disorders □Seizures □GU/GI □ Respiratory □Spinal problems □Arthritis □Bone □Soft Tissue □Birth Control □Muscle relaxers □Pain Killers □Anti-Inflammatory □Anti-Depressants □Antibiotics □Hormones □Thyroid Meds □Inhaler □ Allergy Meds □Steroid's □other(s) _____

O-T-C Medications: □ **NONE** □ Aspirin □ Tylenol □ Ibuprofen(Advil, Motrin) □ Naproxen(Aleve) □ Creams(Icy Hot, Ben Gay)

CURRENT MEDICATIONS: (Please list all medications taken within the past 30 days)

Vitamins / Nutritional Supplements: □ **NONE** □ Multi-vitamin □Vit. A □ Vit. B □ Vit. B Vit. D □ Vit. E □ Vit. K □ Pre-natal □ Calcium □ Herbs □ Naturalpathic Remedies □ Other: _____

OTHER TREATMENTS FOR CURRENT CONDITION(s): □**NONE** □ ER □ MD/DO/NP □ Chiropractor/Acupuncture □ Pain Management □ Physical Therapist □ Psychologist □ Counselor □ Massage □ TENS unit □ Medication □ Home Treatment □ Rest

OCCUPATION INFORMATION

Occupation: _____ Supervisor: _____:

Employer: _____ Supervisor Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

How long employed: _____ Work Hours: _____ Missed any work? □ No □ Yes How Much: _____

Describe your normal work duties: _____

PREVIOUS HEALTH HISTORY

Illness: □ **NONE** □ Mumps □ Measles □ Rubella □ Chicken Pox □ Whooping Cough □ TB □ HIV □ Communicable Disease

Vaccinations: □ Measles □ Rubella □ Chicken Pox □ Whooping Cough □ Hepatitis □ Meningitis □ Pneumonia □ Flu

Prior: □ **NONE** □ Automobile Accident □ Work Comp injury(s) □ Sports Injury

Prior Treatments: □ ER □ MD/DO □ Chiropractor/Acupuncture □ Physical Therapist □ Psychologist □ Counselor □ Massage

Prior History: □ **NONE** □ Pregnancy □ Hospitalization □ Surgery □ Serious Conditions □ Accidents □ Fractures

Have you had any changes in your health? (ie. new diagnosis, accident(s), injury(s) surgery, therapy, cancer, tumors, diabetes, heart problem, blood pressure, stroke, seizures, , thyroid. or **other problems** since you were last examination at this office ? Yes No

Other Current Conditions (which may affect outcome): □**NONE** □Obesity □ Poor Physical Condition □Sedentary Lifestyle □Disability □Age □Occupation □Diabetes □High Blood Pressure □Smoker □Coffee/tea drinker □Alcohol Drinker □Soda Drink □Arthritis □Other(s)

PERSONAL & SOCIAL HISTORY

Children: □ No □ Yes Names/ages: _____

Religious Affiliation: □ **NONE** □ Catholic □ Protestant □ Jewish □ Muslim □ Hindu □ Buddhist □ Other

Hobbies / Leisure Activities: _____

(Gardening, Playing with children/grand children, cards/games, walking, hiking, swimming, sewing, softball, dancing, social events, sitting at theater, etc.)

Addictions: _____

(i.e. Smoking, alcohol, drugs, coffee, tea, soda, sugar, carbohydrates, fat's, exercise, TV, computer, , video games, gambling, sex etc.)

Stressors: **What cause you stress:** _____

(i.e. School, Work, Inability to work, Money problems, Bills, Car damage, Children, Spouse, Neighbors, Driving, Pain, etc)

How is your condition affecting your activities:_____

(Unable to work, unable to garden, unable to run, unable to work out, unable to play with children, unable to do housework. etc).

Exercise: □ Walk/Run/Jog □ Aerobic □ Workout/Gym □ Weights/Bands/Machines □ Stretching/Yoga □ Bike □ Swim □ Sports

Diet: □ Regular American Diet □ Vegetarian Diet □ Diabetic Diet □ Gluten Free □ Low Calorie Diet □ Junk Food □none □some

Appetite Good: □ Yes □No Do you skip meals: □ Yes □ No Do you sleep well? □ Yes □ No How many hours: _____

Drink: □ Water mostly or some □ Fruit Drinks □ Coffee □Tea □ Soda □ Alcohol How many/ How often: _____
Smoking: □ No one smokes at home □ Never Smoked □ Quit When_____ □ Trying to quit □ Smokes: _____
Sex: □ Not sexually active □ Sexually active: □ Birth Control Method: _____

Name: _____ Date: _____

FAMILY HISTORY

Condition	Self	Family Member	Condition	Self	Family Member	Condition	Self	Family Member
Cancer/Tumors	□	□	Heart Disease	□	□	Spinal Problems	□	□
Diabetes	□	□	High Blood Pressure	□	□	Arthritis	□	□
Kidney/Liver	□	□	Stroke	□	□	Asthma	□	□
GU/GI	□	□	Seizures	□	□	Addiction(s)	□	□
Auto-Immun	□	□	Mental Disorder(s)	□	□	Headaches	□	□
Hepatitis	□	□	Meningitis	□	□	Bone	□	□
NONE	□	□	Respiratory	□	□	Soft Tissue	□	□

FINIANCAL RESPONSIBILIY

Insurance: □ Major Medical / Health □ Work Comp □ (Slip and Fall) Liability □ Automobile □ Attorney □ Cash

Insurance Company Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim / Policy Number: _____ Attorney Name: _____

Please note we will make a photocopy of your Picture ID, Divers License, Insurance Card, Attorney Card, and Police Report.

All fees are due and payable at the time of service, unless other arrangement has been made in advance. I understand that I am personally responsible for the total amount of remaining charges on my account. I understand that if this account payment balance is due within 30 days of service. After 30 days interest charges of (1.5% / month or 18% annually) for unpaid balance and $5.00 billing charge for each time you are billed. If sent to collection all collection fees, attorney fees, court fees and other related fees will also apply. X-rays remain the property of this clinic. Thank You.

I, undersigned, herby give permission for treatment and.

(X) 12. PATIENTS AUTHORIZED PERSON'S SIGNATURE: I Authorize the release of any medial or other information necessary to process this claim. I also request payment of benefits to the party who accepts assignment below.
(X) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described on itemized statement or claim form..
(X) Benefits have been assigned to the doctor please pay the doctor direct.
(X) The Insurance company or attorney is authorized and directed to make check out and mail settlement check of the claim to Joseph H. Lones III
(X) I hereby authorize the doctor who treats me to designate his assistants to administer treatment as he so deems necessary.

X_____ Date: _____

REVIEW OF SYSTEMS

CONSTITUTIONAL: □ Generally Healthy □ No changes □ No Problems
□ changes in appetite/weight □ change in strength or exercise tolerance □ changes in temperature or blood pressure
□ night sweats □ changes sleeping pattern □ fatigue/malaise/lethargy □ itch/rash □ lumps/bumps/masses

EYES: □ Normal vision
□ diplopia □ tearing □ visual changes □ eye pain □ double vision □ scotomas (blind spots) □ floaters
□ "feeling like a curtain got pulled down" (retinal hemorrhage vs amaurosis fugax).

ENT: □ No Problems
□ Runny nose □ frequent nose bleeds (epistaxis) □ sinus pain □ stuffy ears □ ear pain □ ringing in ears (tinnitus) □ gingival bleeding □ toothache □ sore throat □ pain with swallowing (odynophagia) □ obstruction □ discharge. □ change in hearing □ vertigo □ redness □ difficulty swallowing

INTEGUMENTARY (SKIN) /BREAST: □ No Problems
□ Breast pain □ soreness □ lumps □ swelling □ discharge □ dryness and/or discoloration □ rashes □ pruritus (itching) □ jaundice □ stria □ lesions □ wounds □ incisions □ nodules □ tumors □ eczema □ pigmentation changes □ hair changes, □ nail changes.

CARDIOVASCULAR: □ No Problems
□ high blood pressure □ heart attack □ irregular heartbeat □ chest pain □ shortness of breath □ exercise intolerance □ orthopnea, □ edema □ palpitations □ faintness □ loss of consciousness □ murmurs or valvular disease □ heart surgeries □ congestive heart failure

RESPIRATORY: □ No Problems
□ shortness of breath □ prolonged cough □ wheezing □ sputum production □ prior tuberculosis □pleurisy □ oxygen at home □coughing up blood □ asthma □ emphysema □abnormal chest x-ray

GASTRO-INTESTINAL: □ No Problems
□ heartburn □ constipation □ intolerance to certain foods □ diarrhea □ abdominal pain □ nausea □ vomiting □ blood in stools □ unexplained change in bowel habits □ pancreatic disease □ irritable bowel/colitis □ hepatitis or liver

GENITO-URINARY: □ No Problems
□ painful urination □ frequent urination □ urgency □ prostate problems □ bladder problems □ impotence □ Renal calculi/stones □ hematuria (blood in the urine) □ incontinence (can't control) □ bladder infections □ kidney disease □ dialysis □

MUSCULOSKELETAL: □ No Problems other than the chief complaints
□ the patient reports no other joint pain □ aching muscles □ swelling of joints □ joint deformities □ rheumatoid arthritis □ gout □ osteoarthritis □ broken bones □ spinal fracture □ spinal surgery □ joint surgery □ arthritis (unknown type) □ scoliosis

NEUROLOGICAL: □ No Problems other than the chief complaints □ uncontrolled motions
□ headaches □ weakness □ change in sensation □ problems with walking or balance □ dizziness, tremor, loss of consciousness

PSYCHIATRIC: □ No Problems
□ insomnia □ irritability □ depression □ anxiety □ recurrent bad thoughts□ mood swings □ hallucinations □ compulsions.

ENDOCRINE: □ No Problems □ thyroid problem □hormonal replacement therapy □ diabetes
□ intolerance to heat or cold □ menstrual irregularities □ frequent/urination/thirst □ changes in sex drive

HEMATOLOGIC/LYMPHATIC: □ No Problems □ easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, swelling

ALLERGIES/ IMMUNOLOGIC: □ No problems □ seasonal allergies □ hay fever symptoms □ itching □ frequent infections □ HIV

Name: _____ Date: _____

Check any condition or symptoms you have.
Circule sintomas que tenga

( ) **Post-Tramatic Headache** G44.311
( ) **Headache /** Dolor de Cabeza R51
( ) **Concussion** / Concusion S06.0X9A
( ) **Lightheaded** / Borracheras de cabeza R42
( ) **Fainting /** Desmayos R55
( ) **Ringing in ears /** Zumbido en oidos H93.1
( ) **Tinnitus** / Zumbido H93.1
( ) **Visual Discomfort/** H53.149
dolor en los ojos por la luz
( ) **Loss of smell-taste/** Perdida de olor-sabor R438/9
( ) **Loss of appetite**/ Perdida de Apetito F50.80
( ) **Dizziness /** Mareos R42
( ) **Vertigo /** Vertigo R42
( ) **Mental Diorder**/confusion mental F06.8
( ) **Mild cognitive impairment** G31.84
( ) **Altered mental status**/Alertada mental 780.91
( ) **Memory Loss** / Perdida de memoria R41.3
( ) **Anxiety** / Ansiedad F49.1
( ) **Depression /** Deprecion F32.9
( ) **Nervous /** Nervioso(a) R45.0
( ) **Malaise /Fatigue** / Flojera R53.53
( ) **Lethargy/tiredness /** Cansancio R53.83
( ) **Generalized muscle weakness** / Debil M62.81
( ) **Lack of coordination**/Perdida de coordinacion R27.8
( ) **Difficulty walking**/dificultidad de caminar R26.2
( ) **Numbness-tingling**/Adormecidos R20.1
( ) **Chest pain** / Dolor de pecho R07.89
( ) **Chest pain with breathing**/
Problemas de Respiracion R07.1
( ) **Abdominal Pain**/Dolores de abdominal R10.84
( ) **Nausea** / Nausias, Bomito R11.0
( ) **Constipation** / Constipacion K59.00
( ) **Fever** / Fiebre R50.9
( ) **Sleepig problms**/Problemas dormiendo F51.8
( ) **Swelling/Edema** / Hinchazon/edema R60.9
( ) **Swelling in limb**/Hinchazon de miembro R60.0
( ) **Muscle soreness/Myalgia**/dolor musculo M79.1
( ) **Muscle Cramps**/calambres de musculo R25.2
( ) **Muscle Spasms**/Espasms de musculo M62.0830
( ) **Neck pain** / Dolor de Cuello M54.2
( ) **Mid Back pain /** Dolor en espalda M54.6
( ) **Lower Back pain /** Dolor en espalda M54.9
( ) **Abnormal Posture** R29.3
( ) **Joint pains** / Dolor de coyuntura o empalme R52

Swelling/Effusion of joint / Hinchazon de coyuntura o empalme **Rt. Lt.**
( ) Shoulder R L /Hombro De Es M25.411 412
( ) Elbow R L / Codo De Es M25.421 422
( ) Wrist R L / Muneca De Es M25.431 432
( ) Hand R L / Mano Ds Es M25.441 442
( ) Hip R L / Cadera De Es M25.452 452
( ) Knee R L / Rodilla De Es M25.461 462
( ) Ankle/foot R L/Tobillo/pieDE M25.471 472
( ) Foot R L/ Pie Ds Es M25.474 475

Joint Pain/ Dolor de coyuntura o empalme Rt. Lt
( ) Shoulder R L / Hombro De Es M25.511 12
( ) Upper arm R L /Brazo De Es M79.602 601
( ) Elbow R L / Codo De Es M25.521 22
( ) Forearm R L/Antebrazo De Es M79.632 631
( ) Wrist R L / Muneca De Es M25.531 32
( ) Hand R L / Mano Ds Es M79.642 642
( ) Fingers R L / Dedos Ds Es M79.644 645
( ) Hip R L / Cadera De Es M25.551 52
( ) Thigh R L / Muslo De Es M79.651 652
( ) Knee R L / Rodilla De Es M25.561 62
( ) Lower legR L/ Pierna bajaDeEs M79.661 662
( ) Ankle/foot R L/Tobillo/pie DE M25.571 72
( ) Foot R L/ Pie Ds Es M79.671 671
( ) Toe(s) R L/ Dedos Ds Es M79.674 675

Stiffness/Tiesedad de coyuntura o empalme **Rt. Lt.**
( ) Shoulder R L /Hombro De Es M25.611 612
( ) Elbow R L / Codo De Es M25.621 622
( ) Wrist R L/ Muneca De Es M25.631 632
( ) Hand R L / Mano Ds Es M25.641 642
( ) Hip R L /Cadera De Es M25.651 652
( ) Knee R L / Rodilla De Es M25.661 662
( ) Ankle/ R L/TobilloDe Es M25.671 672
( ) Foot R L/ Pie Ds Es M25.674 675

Contusion(Bruising)/Moreton
( ) Head S00.93XA
( ) Neck S10.93XA
( ) Head S00.93XA
( ) Breast R L/ Pecho De Es S20.01XA 2XA
( ) Back Chest wall R L S20.221A 2A
( ) Front Thorax wall R L S20.211A 2A
( ) Abdominal Wall/ Pared Abd S30.1XXA
( ) Lower Back / o espalda S30.0XXA
( ) Buttock / Nalga S30.0XXA
( ) Interscapular S20.229A
( ) Shoulder R L /Hombro De Es S40.011A 2A
( ) Upper arm R L /Brazo De Es S40.021A 2A
( ) Hip R L / Cadera De Es S70.01XA 2XA
( ) Thigh R L / Muslo De Es S70.11XA 2XA

NAME: _____ **DATE:** _____