



DEDICATED  
TO QUALITY  
CHIROPRACTIC  
CARE

FAST RELIEF OF NECK  
& BACK PAIN

"ON AVERAGE 9 OUT OF 10  
PATIENTS ARE 90% IMPROVED  
IN 6 TREATMENTS OR LESS!"

# Thomas P. Yankush, DC, FACO

Board Certified in Chiropractic Orthopedics  
and Quality Assurance/Utilization Review

## PATIENT INFORMATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_

Mobile: \_\_\_\_\_

Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_  Full Time  Part Time  Retired

Referred to Our Office by: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

## INSURANCE INFORMATION

Do you need a referral for treatment?  Yes  No

Primary Insurance Company: \_\_\_\_\_

Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_

### **If injured during the course of work:**

Reported to employer?  Yes  No Witness to injury: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ M.C.O. Name: \_\_\_\_\_



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**PATIENT HEALTH HISTORY:** Please check all the following that apply to you:

YES	NO	CONDITION	YES	NO	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	History of Recent Infection	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Currently Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes			# of Weeks: _____
<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid Use	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills			Gain <input type="checkbox"/> Loss <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Stroke Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Low/Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in Groin/Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	History of Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	History of Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Nocturnal Pain (Night)
<input type="checkbox"/>	<input type="checkbox"/>	Recent Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries: _____

**FAMILY HISTORY OF:** Please check all the following that apply to you:

Cancer   
  Diabetes   
  High Blood Pressure   
  Cardiovascular Problems  
 Stroke   
  Other: \_\_\_\_\_

## CONSENT FOR TREATMENT

I hereby consent to Chiropractic evaluation and treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## AUTHORIZATION

I authorize Dr. Thomas P. Yankush to bill for services to my insurance carrier. I understand that my insurance or combination of insurances, may only recognize, accept or pay a portion of the total amount which I will then owe or shall owe and be personally responsible for the balance on my account. Should the account be referred to a collection agency, I shall be responsible for the fees and collection expense. (all delinquent accounts bear the interest of the prime rate charged by Sky Bank which is in effect at the time the charges are incurred).

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I have reviewed and understand Dr. Thomas P. Yankush's notice of protected health information practices. I understand and consent to the uses and disclosures of my health information according to the articles outlined in the notice of protected health information practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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www.thomasyankush.com

## SYMPTOM INFORMATION SHEET

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

1. Is your pain constant or intermittent? \_\_\_\_\_
2. What activities/positions **intensify** your pain?  Sitting  Standing  Bending  Walking  Laying  
 Other \_\_\_\_\_
3. What activities/positions **decrease** or **relieve** your pain?  Laying  Sitting  Standing  
 Other \_\_\_\_\_
4. Are you able to sleep comfortably?  Yes  No
5. How does your affected part feel in the morning?  Stiff  Sore  Fine
6. How does your pain progress throughout the day?  Better  Worse  Same  
 Other \_\_\_\_\_
7. Have you experienced any signs of weakness?  Yes  No  
If yes, where? \_\_\_\_\_
8. Does coughing increase your symptoms?  Yes  No  N/A
9. Are you having any bowel or bladder changes?  Yes  No  N/A
10. Overall do you feel your symptoms are:  Improving  Worsening  Same
11. Have you had any changes in equipment, footwear, etc. that may have contributed to your present symptoms?  
 Yes  No  
If yes, what type of changes were made? \_\_\_\_\_
12. Are there any other facts that you might add to explain the cause or aggravation of your symptoms?  
 Yes  No  
If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature



Name: \_\_\_\_\_

Date: \_\_\_\_\_

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**WHAT POSITION / ACTIVITY MAKES THE PAIN WORSE / BETTER?**

ACTIVITY	WORSE	BETTER	COMMENTS
Bending			
Bowel Movement			
Coughing			
General Activity			
Home Remedies			
Lying Down			
Sitting			
Standing			
Walking			

Do you wear a neck or back brace?  Yes  No What kind of brace? \_\_\_\_\_

How long can you stand with little or no pain? \_\_\_\_\_

How far can you walk with little or no pain? \_\_\_\_\_

Do you need support to help you walk?  Yes  No What kind of support? \_\_\_\_\_

**HAVE YOU HAD:**

Spinal X-Rays  Yes  No Date Taken: \_\_\_\_\_ Area Taken: \_\_\_\_\_

MRI  Yes  No Date Taken: \_\_\_\_\_ Area Taken: \_\_\_\_\_

CT Scan  Yes  No Date Taken: \_\_\_\_\_ Area Taken: \_\_\_\_\_

Other Tests? \_\_\_\_\_ Date Taken: \_\_\_\_\_

**PLEASE LIST THE PREVIOUS DOCTOR'S (MD, DO, CHIROPRACTORS) YOU HAVE SEEN FOR THIS PROBLEM**

PHYSICIANS NAME	SPECIALTY	TYPE OF TREATMENT

**PLEASE LIST MEDICATIONS BEING USED**

NAME OF MEDICATION	DOSAGE	TAKEN FOR HOW LONG



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## CLIENT SYMPTOM BODY CHART

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

### **INSTRUCTIONS**

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition. **REMEMBER** - Identify your pain at this exact minute.

### **KEY**

<b>/// - Stabbing</b>	<b>XXX - Burning</b>	<b>OOO - Pins &amp; Needles</b>	<b>=== - Numbness</b>
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### **DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

Date Problem Began: \_\_\_\_\_

How Problem Began: \_\_\_\_\_

- Headache    Neck Pain    Mid Back Pain  
 Low Back Pain    Other: \_\_\_\_\_

### **IS THIS?**

- Work Related    Auto Related  
 Other Accident    N/A

### **ARE YOU?**

- Right Handed    Left Handed

### **WHAT PERCENT OF NECK PAIN IS:**

Neck %: \_\_\_\_\_ Arm %: \_\_\_\_\_ (Total 100%)

### **WHAT PERCENT OF BACK PAIN IS:**

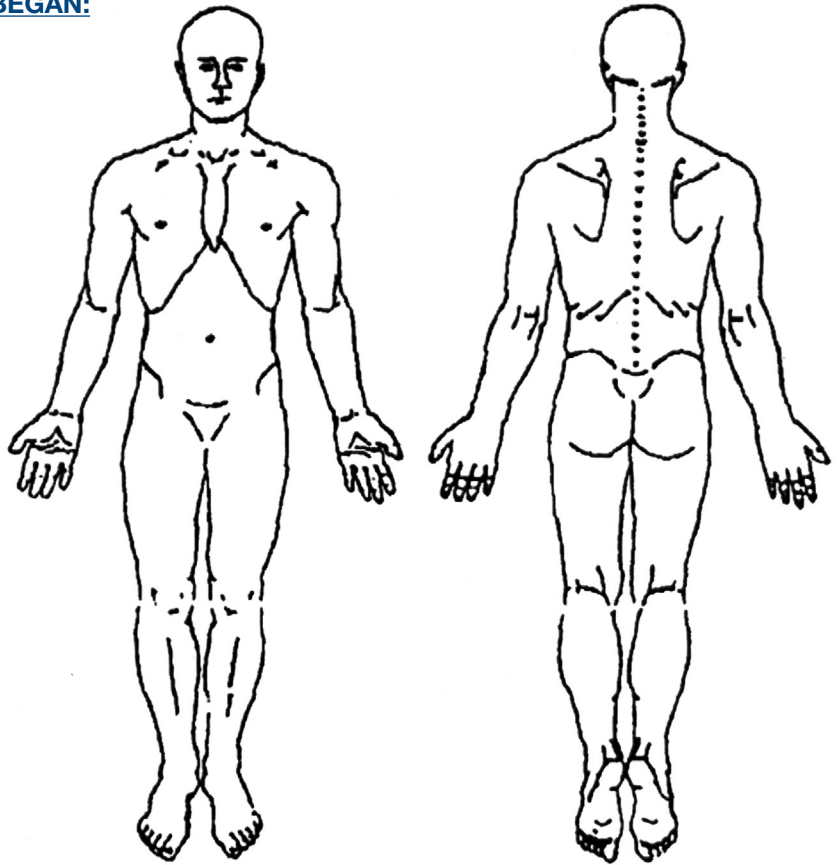
Back %: \_\_\_\_\_ Leg %: \_\_\_\_\_ (Total 100%)

### **HOW OFTEN ARE YOUR SYMPTOMS PRESENT?**

- 0-25%    26-50%    51-75%    76-100%

### **CAN YOU PERFORM YOUR DAILY ACTIVITIES?**

- Yes    No



**DESCRIBE LIMITATIONS:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Mark an (X) on the line indicating the usual degree of pain.    0 - No Pain    10 - Excruciating Pain

- 0    1    2    3    4    5    6    7    8    9    10  
 No Pain Excruciating Pain

\_\_\_\_\_  
 Signature