CORDIMA CHIROPRACTIC CENTER

Dr. Christopher Cordima
707 Broadway
Somerville, MA 02144
(617) 629-2600
www.somervillechiropractor.com

1. **Please enter your information.**

First Name: ____ Middle Initials: ____ Last Name: ____

Is This Your Legal Name
○ Yes ○ No

Date of Birth: ____

Gender:
○ Female ○ Male

Spouse Name ____

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: ____ Apt./Unit #: ____ City: ____ State: ____ Zip Code: ____

Home Phone: ____ Mobile Phone: ____ Email: ____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Occupation ____ Employer ____

2. **Chose clinic because / Referred to clinic by:**

☐ Dr. Referral
☐ Family/Friend
☐ Emergency Room
☐ Other
☐ Internet
☐ Mailer
☐ Facebook
☐ TV
☐ Radio
☐ Email

If other, please specify:

____

3. **Type of Insurance**

○ None
○ Medicare
○ Aetna
○ Tufts
○ Car Accident Insurance
○ Mass Health
○ BCBS
○ Cigna
○ HCHP
○ Other

If other, please specifiy:

____

4. **Are your complaints from an accident?**

- ○ No
- ○ Work Accident
- ○ Car Accident
- ○ Another Type of New Injury

5. **If your condition is the result of an Automobile Accident please fill out the following:**

Date of Accident ________

Name of the Car Insurance? ________

Do you have a claim number? ________

Have you reported this accident to the insurance company?
○ Yes ○ No

Did the police come to the scene?
○ Yes ○ No

Did the ambulance come to the scene?
○ Yes ○ No

Did you go to the hospital?
○ Yes ○ No

Name of the Hospital ________

Did you have x-rays?
○ Yes ○ No

Please describe any other medical treatment for this injury

____

Do you have an attorney for this accident?
○ Yes ○ No

If so, what is your attorney's name and phone number?

____

Have you missed work due to this accident
○ Yes ○ No

How many days have you missed? ________

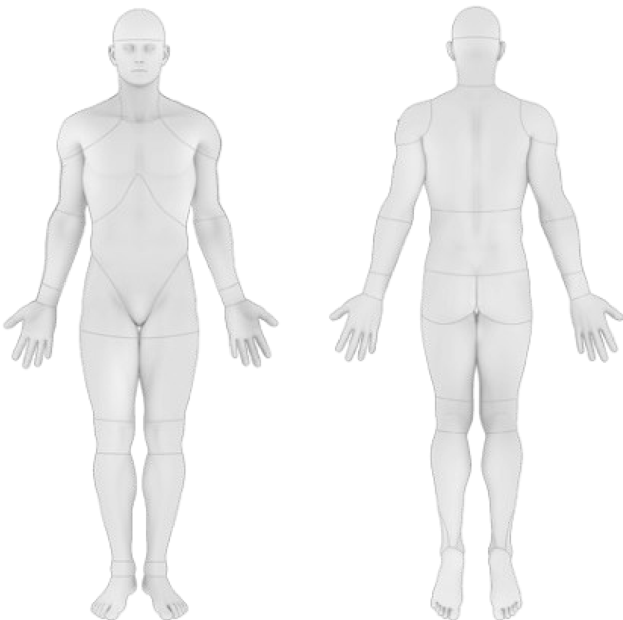
Are you back to work now?
○ Yes ○ No

Please Describe The Accident (How did the accident happen)

____

____

6. **Indicate on the body where you are currently having symptoms**



Other

____

7. **What is your major complaint?**

Please check the areas where you presently have complaints

☐ Headaches ☐ Neck Pain ☐ Upper Back Pain ☐ Mid Back Pain ☐ Lower Back Pain
☐ Leg Pain, Buttock pain or Sciatica ☐ Hip Pain - Left ☐ Hip Pain - Right ☐ Shoulder Pain - Left
☐ Shoulder Pain - Right ☐ Knee Pain - Left ☐ Knee Pain - Right

If you have multiple complaints, what is the main reason you came to see us for?

____

____

8. **How long have you had this problem?**

____

____

9. **Please describe the quality of the pain**

☐ Aching Pain ☐ Numbness ☐ Hot Sensation
☐ Cramping ☐ Stabbing Pain ☐ Tingling
☐ Throbbing Pain ☐ Swelling ☐ Sharp Pain
☐ Pins & Needles Pain ☐ Dead Feeling ☐ Burning
☐ Tiredness ☐ Heavy Feeling ☐ Cold Hands/Feet
☐ Electric Shocks

Other

____

10. **How would you rate your average pain over the past week for this problem?**

0 No Pain - 10 Worst Possible Pain

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

11. **What time of the day is the condition the worst?**

○ Morning ○ Afternoon ○ Evening ○ Night - Sleep Time

12. **Is this condition interfering with any of the following (check all boxes that apply)**

☐ Work ________ ☐ Sleep ________ ☐ Daily Routine ________
☐ Household tasks/chores ________ ☐ Walking ________ ☐ Standing ________
☐ Shopping ________ ☐ Family Time ________ ☐ Sitting ________
☐ Recreational Activities ________ ☐ Leisure/Social Activities ________

List any other activities or loss here

____

13. Have your symptoms?

- ○ Improved ○ Worsened ○ Stayed the same

14. Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about?

- ○ Yes ○ No

15. What exactly do you think brought this problem about and when did it happen

____
____
____
____

16. What kind of treatments have you received?

- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage
- ☐ Surgery
- ☐ Nerve Block/Injection
- ☐ Stem Cell
- ☐ Pain Medications
- ☐ Tylenol
- ☐ Gabapentin
- ☐ Neurontin
- ☐ Ibuprofen
- ☐ Cymbalta
- ☐ Lyrica
- ☐ Aleve
- ☐ Creams
- ☐ Orthotics

Other:

____

17. Did any of these treatments work? If so, which one(s)?

- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage
- ☐ Surgery
- ☐ Nerve Block/Injection
- ☐ Stem Cell
- ☐ Pain Medications
- ☐ Tylenol
- ☐ Gabapentin
- ☐ Neurontin
- ☐ Ibuprofen
- ☐ Cymbalta
- ☐ Lyrica
- ☐ Aleve
- ☐ Creams
- ☐ Orthotics

Is there anything that you currently do that makes it feel better?

____

18. Are there any activities that make it worse?

- ○ Yes ○ No

If So What

____

19. What concerns you the most about your symptoms / condition?

____
____

20. **How serious do you feel the problem is?**

- ☐ Minimal (annoying but causing no significant limitation)
- ☐ Slight (tolerable and causing minimal limitation)
- ☐ Moderate (sometimes tolerable, sometimes causing definite limitation) Severe (causing significant limitation)
- ☐ Extreme (causing nearly constant limitation)

21. **Have you seen a M.D., P.T., or a D.C. for this problem?**

○ Yes ○ No

22. **Are you currently under the care of a family physician or any other health professional? If yes, please indicate:**

	Health Professional's Name	Specialty	For What Condition	Year(s) Seen
1				
2				

23. **Height & Weight**

Height: feet ______________________

Height: inches ______________________

Weight: pounds ______________________

24. **Health History**

General:
- ☐ Fatigue, Tiredness
- ☐ Weakness
- ☐ Sedentary Lifestyle
- ☐ Generalized Pain
- ☐ Poor wound healing

Neurological:
- ☐ Poor Balance
- ☐ Numbness of Face / Arm / Leg
- ☐ Peripheral Neuropathy
- ☐ Stroke or Mini-Stroke
- ☐ Burning Pain
- ☐ Restless Leg
- ☐ Prickling/Tingling Feeling
- ☐ Muscle Cramping

Psychiatric:
- ☐ Alzheimer's
- ☐ Confusion (Abnormal)

Respiratory:
- ☐ TB
- ☐ Chronic Obstructive Disease
- ☐ Wheezing
- ☐ Chronic Cough Asthma

Cardiac:
- ☐ Angina (Chest Pain)
- ☐ Past heart attacks
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Pacemaker
- ☐ Defibrillator

Vascular:
- ☐ Blood Clots in Legs (Deep or Superficial)
- ☐ Amputation of Toes
- ☐ Amputation of Feet or Legs
- ☐ Peripheral Vascular Disease
- ☐ Ulcers of Lower Legs

Gastrointestinal:
- ☐ Ulcer
- ☐ Stool Changes
- ☐ Indigestion
- ☐ Colon Polyps
- ☐ Diverticulitis

Genitourinary:
- ☐ Current Dialysis
- ☐ Urgency of Urine
- ☐ Renal Transplant
- ☐ Erectile Dysfunction

Blood & Lymph System:
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Blood Disease
- ☐ Transfusions
- ☐ Leukemia
- ☐ Bone Marrow Test
- ☐ Long Term Coumadin Use
- ☐ Blood Clotting Problems/Blood Clots
- ☐ Multiple Myeloma

Eyes, Ears, Nose & Throat:
- ☐ Vertigo

Musculoskeletal:
- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Degenerative Disc
- ☐ Bulging Disc
- ☐ Herniated Disc
- ☐ Pinched Nerve
- ☐ Spinal Stenosis
- ☐ Sciatica ☐ Leg Pain ☐
- ☐ Joint Replacement

Skin:
- ☐ Malignant Melanoma
- ☐ Squamous Cell Carcinoma
- ☐ Basal Cell Carcinoma
- ☐ Fungal infections
- ☐ Non-healing Sores

Endocrine:
- ☐ Thyroid problems
- ☐ Diabetes – Type
- ☐ Diabetes – Type 2
- ☐ Excessive Thirst or Urination

Abnormal Organs:
- ☐ Hepatitis
- ☐ Cirrhosis(Liver)
- ☐ Gallbladder Disease

Hands
- ☐ Hand Pain
- ☐ Arthritis in Hands
- ☐ Hand/Wrist Surgery
- ☐ Hand Numbness
- ☐ Carpal Tunnel Syndrome

Feet
- ☐ Foot Pain
- ☐ Arthritis in Feet
- ☐ Foot Surgery
- ☐ Foot Numbness
- ☐ Morton's Neuroma
- ☐ Plantar Fasciitis

Check Areas you have experienced Pain, Numbness, Tingling, or Stiffness in the last 6 months

☐ Left Knee ☐ Right Knee ☐ Feet ☐ Hands ☐ Back ☐ Neck ☐ Shoulder ☐ Hip

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25. Please list all surgeries you have had:

	Surgery	When?
1		
2		
3		

26. Have you had any cancers?

○ Yes ○ No

If yes, for how long?

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27. STATIN: Are you currently taking a Statin medication? (Cholesterol Med)

○ Yes ○ No

If yes, for how long

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28. List the prescription drugs you are currently taking

	Medication	Since When? or For How Long?	Effective?
1			

2			
3			

29. List ALL allergies/sensitivities to medication, food, and other items here:

30. Your Family History: (does anyone in your immediate family have any issues with their heart, high blood pressure, high cholesterol, liver, kidney, diabetes, cancer or other health concern)

	Age	Health Issue
Mother		
Father		
Brothers		
Sisters		
Children		

Extra information

31. Habits and Lifestyle

Do you smoke?
☐ Yes ☐ No

If 'yes', what?

How much per day?

Since when?

Do you drink alcohol?
☐ Yes ☐ No

If 'yes', what?

How much?

How often?

Do you exercise regularly?
☐ Yes ☐ No

How often?

If 'yes', please describe what kind of exercise you do.

32. In spite of the fact that you're not a back pain specialist, you are in fact the person who knows more about your condition than anyone else. In your own words, what do you think the problem is?

33. If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

34. Is there anything else that you would like to tell the doctor before your visit?

35. On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

    ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

36. If you would like us to help verify your insurance before your appointment you can upload a copy of your License or I.D. and your Insurance Card? We can also assist you with this upon your arrival.