Mann Mobile Chiropractic,Inc
3992 Anderson Hwy
Hartwell, GA 30643
Phone: 706-376-8686
Fax: 706-376-3933
Email: mannchiropractic@outlook.com
Website: www.mannfamilychiropractic.com

Demographic & Contact Information

First Name:
Last Name:
Birth Date:
Gender
Address
Primary Phone
Cell Phone
Address 2
Work Phone
Home Phone
City
State/Province
Postal Code
E-Mail
Preferred Communication
Preferred Reminder Format
Preferred Language
Smoking Status

Insurance Information

Insured First Name:
Insured Last Name:
Insured ID Number:
Insured Address:
City:
State/Province:
Postal Code:
Insured Phone:
Insured Gender:
Male
Insurance Carrier:
Insured Policy:
Insurance Group No:
Insurance Plan/Program:
Insured Birth Date:
Insured Relationship To Patient:
Self

Current Medications

Medication
Reason
Start Date
Medication
Reason
Start Date
Medication
Reason
Start Date
Medication
Reason
Start Date
Medication
Reason
Start Date

Medication Allergies

Medication	Reason	Symptom

Allergies (Check all that apply)

- [ ] Animals
- [ ] Aspirin/Pain Medicine
- [ ] Bee Stings
- [ ] Chocolates/Sweets
- [ ] Dairy Products (milk, cheese)
- [ ] Dust
- [ ] Eggs
- [ ] Latex
- [ ] Molds
- [ ] Penicillin
- [ ] Ragweed/Pollen
- [ ] Rubber
- [ ] Seasonal Allergies
- [ ] Shellfish
- [ ] Soaps
- [ ] Wheat
- [ ] X-ray Dye
- [ ] None

Surgeries (Check all that apply)

- [ ] Appendix
- [ ] Back
- [ ] Brain/Tumor
- [ ] Carpal tunnel
- [ ] Cervical Disc
- [ ] Chest
- [ ] Disc
- [ ] EENT
- [ ] Elbow
- [ ] Elbow
- [ ] Foot
- [ ] Gallbladder
- [ ] Gastrointestinal
- [ ] Gynecological
- [ ] Heart
- [ ] Heart Bypass
- [ ] Hernia
- [ ] Hip
- [ ] Hip Replacement
- [ ] Knee
- [ ] Knee
- [ ] Knee Replacement
- [ ] Lumbar Disc
- [ ] Neck
- [ ] Neurological
- [ ] Obstetrical
- [ ] Other
- [ ] Podiatric
- [ ] Shoulder
- [ ] Thoracic Disc
- [ ] Wrist
- [ ] Wrist/Hand

Medical History (Check all that apply)

- [ ] Ankle Pain
- [ ] Arm Pain
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Broken Bones
- [ ] Cancer
- [ ] Chest Pain
- [ ] Depression/Other disorder
- [ ] Diabetes
- [ ] Dizziness
- [ ] Elbow Pain
- [ ] Epilepsy
- [ ] Eye/Vision Problems
- [ ] Fainting
- [ ] Fatigue
- [ ] Foot Pain
- [ ] Genetic Spinal Disorder
- [ ] Hand Pain
- [ ] Headaches
- [ ] Hearing Problems
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Hip Pain
- [ ] Jaw Pain
- [ ] Joint Stiffness
- [ ] Knee Pain
- [ ] Leg Pain
- [ ] Low Back Pain
- [ ] Menstrual Problems
- [ ] Mid Back Pain
- [ ] Minor Heart Trouble
- [ ] Multiple Sclerosis
- [ ] Neck Pain
- [ ] Neurological Disorder
- [ ] Pacemaker
- [ ] Parkinson's Disease
- [ ] Polio
- [ ] Prostate Problems

Medical History - Continued (Check all that apply)

- [ ] Shoulder Pain
- [ ] Significant weight change
- [ ] Spinal Cord Injury
- [ ] Sprain/Strain
- [ ] Stomach Problems
- [ ] Stroke/Heart Attack
- [ ] Tumor
- [ ] Ulcer/s
- [ ] Wrist Pain

Social History (Check all that apply)

- [ ] Alcohol use
- [ ] Being in college
- [ ] Being in high school
- [ ] Being married
- [ ] Being single
- [ ] Caffeine use
- [ ] Disability
- [ ] Drug abuse
- [ ] Employment status
- [ ] Exercising regularly
- [ ] Good sleep habits
- [ ] Health status
- [ ] Home stress
- [ ] Normal family environment
- [ ] Other stress
- [ ] Poor diet habits
- [ ] Sexual history
- [ ] Smoking/tobacco use
- [ ] STD history
- [ ] Work stress
- [ ] Working

Custom (Check all that apply)

- [ ] test

Family History

Family Member	Condition

Accidents

Accident Type	Details

Tell us about your symptom(s) today. Symptom #1

Symptom

Symptom Start Date

☐ Experienced before?

On what side are you experiencing the pain?

◯ Left ◯ Right ◯ Bilateral ◯ Central ◯ None

What is the level of pain?

◯ None ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

What is the intensity of the pain?

◯ None ◯ Minimum ◯ Mild ◯ Moderate ◯ Severe ◯ Unbearable

What is the nature of pain?

☐ Burning ☐ Dull ache ☐ Numb ☐ Radiating pain ☐ Sharp
☐ Shooting ☐ Stabbing pain ☐ Throbbing ☐ Tightness ☐ Tingling

What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Intermittently (0 - 25% of the day) ◯ Occasionally (26 - 50% of the day)

What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice
☐ Massage Therapy ☐ Nothing works ☐ Other ☐ Pain Medicines
☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy

What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending
☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs
☐ Concentrating ☐ Cooking/Cleaning ☐ Crouching/Squatting
☐ Doctor’s visits ☐ Doing Hobbies ☐ Doing things on time
☐ Dressing ☐ Driving ☐ Eating
☐ Exercise/Sports ☐ Financial Management ☐ Gardening
☐ General Mobility ☐ Getting Places ☐ Hearing

- [ ] Holding onto objects
- [ ] Housework
- [ ] Jogging
- [ ] Keeping balance
- [ ] Knitting
- [ ] Leaning
- [ ] Lifting
- [ ] Light/Sound
- [ ] Lying down
- [ ] Making decisions
- [ ] Moving Joint/s
- [ ] Mowing
- [ ] Personal hygiene/Grooming
- [ ] Pushing/Pulling with feet
- [ ] Pushing/Pulling with hands
- [ ] Reaching out/up/down
- [ ] Reading
- [ ] Running
- [ ] Seeing
- [ ] Sewing
- [ ] Sexual Activity
- [ ] Shopping
- [ ] Sitting
- [ ] Speaking
- [ ] Standing
- [ ] Turning
- [ ] Twisting
- [ ] Using the phone
- [ ] Walking
- [ ] Watching TV
- [ ] Working
- [ ] Yard work

What are your expectations regarding this symptom?

- [ ] Become Pain Free
- [ ] Explanation of my Condition
- [ ] Learn how to care for this condition on my own
- [ ] Reduce Symptoms
- [ ] Resume Normal Activity

Tell us about your symptom(s) today. Symptom #2

Symptom

Symptom Start Date

- [ ] Experienced before?

On what side are you experiencing the pain?

- ◯ Left
- ◯ Right
- ◯ Bilateral
- ◯ Central
- ◯ None

What is the level of pain?

- ◯ None
- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

What is the intensity of the pain?

- ◯ None
- ◯ Minimum
- ◯ Mild
- ◯ Moderate
- ◯ Severe
- ◯ Unbearable

What is the nature of pain?

- [ ] Burning
- [ ] Dull ache
- [ ] Numb
- [ ] Radiating pain
- [ ] Sharp
- [ ] Shooting
- [ ] Stabbing pain
- [ ] Throbbing
- [ ] Tightness
- [ ] Tingling

What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Intermittently (0 - 25% of the day) ◯ Occasionally (26 - 50% of the day)

What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice
☐ Massage Therapy ☐ Nothing works ☐ Other ☐ Pain Medicines
☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy

What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending
☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs
☐ Concentrating ☐ Cooking/Cleaning ☐ Crouching/Squatting
☐ Doctor’s visits ☐ Doing Hobbies ☐ Doing things on time
☐ Dressing ☐ Driving ☐ Eating
☐ Exercise/Sports ☐ Financial Management ☐ Gardening
☐ General Mobility ☐ Getting Places ☐ Hearing
☐ Holding onto objects ☐ Housework ☐ Jogging
☐ Keeping balance ☐ Knitting ☐ Leaning
☐ Lifting ☐ Light/Sound ☐ Lying down
☐ Making decisions ☐ Moving Joint/s ☐ Mowing
☐ Personal hygiene/Grooming ☐ Pushing/Pulling with feet ☐ Pushing/Pulling with hands
☐ Reaching out/up/down ☐ Reading ☐ Running
☐ Seeing ☐ Sewing ☐ Sexual Activity
☐ Shopping ☐ Sitting ☐ Speaking
☐ Standing ☐ Turning ☐ Twisting
☐ Using the phone ☐ Walking ☐ Watching TV
☐ Working ☐ Yard work

What are your expectations regarding this symptom?

☐ Become Pain Free ☐ Explanation of my Condition ☐ Learn how to care for this condition on my own
☐ Reduce Symptoms ☐ Resume Normal Activity

Tell us about your symptom(s) today. Symptom #3

Symptom

Symptom Start Date

☐ Experienced before?

On what side are you experiencing the pain?

◯ Left ◯ Right ◯ Bilateral ◯ Central ◯ None

What is the intensity of the pain?

◯ None ◯ Minimum ◯ Mild ◯ Moderate ◯ Severe ◯ Unbearable

What is the nature of pain?

☐ Burning ☐ Dull ache ☐ Numb ☐ Radiating pain ☐ Sharp
☐ Shooting ☐ Stabbing pain ☐ Throbbing ☐ Tightness ☐ Tingling

What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Intermittently (0 - 25% of the day) ◯ Occasionally (26 - 50% of the day)

What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice
☐ Massage Therapy ☐ Nothing works ☐ Other ☐ Pain Medicines
☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy

What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending
☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs
☐ Concentrating ☐ Cooking/Cleaning ☐ Crouching/Squatting
☐ Doctor’s visits ☐ Doing Hobbies ☐ Doing things on time
☐ Dressing ☐ Driving ☐ Eating
☐ Exercise/Sports ☐ Financial Management ☐ Gardening
☐ General Mobility ☐ Getting Places ☐ Hearing
☐ Holding onto objects ☐ Housework ☐ Jogging
☐ Keeping balance ☐ Knitting ☐ Leaning
☐ Lifting ☐ Light/Sound ☐ Lying down
☐ Making decisions ☐ Moving Joint/s ☐ Mowing
☐ Personal hygiene/Grooming ☐ Pushing/Pulling with feet ☐ Pushing/Pulling with hands
☐ Reaching out/up/down ☐ Reading ☐ Running
☐ Seeing ☐ Sewing ☐ Sexual Activity
☐ Shopping ☐ Sitting ☐ Speaking
☐ Standing ☐ Turning ☐ Twisting
☐ Using the phone ☐ Walking ☐ Watching TV
☐ Working ☐ Yard work

What are your expectations regarding this symptom?

☐ Become Pain Free ☐ Explanation of my Condition ☐ Learn how to care for this condition on my own
☐ Reduce Symptoms ☐ Resume Normal Activity

Tell us about your symptom(s) today. Symptom #4

Symptom

Symptom Start Date

☐ Experienced before?

On what side are you experiencing the pain?

◯ Left ◯ Right ◯ Bilateral ◯ Central ◯ None

What is the level of pain?

◯ None ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

What is the intensity of the pain?

◯ None ◯ Minimum ◯ Mild ◯ Moderate ◯ Severe ◯ Unbearable

What is the nature of pain?

☐ Burning ☐ Dull ache ☐ Numb ☐ Radiating pain ☐ Sharp
☐ Shooting ☐ Stabbing pain ☐ Throbbing ☐ Tightness ☐ Tingling

What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Intermittently (0 - 25% of the day) ◯ Occasionally (26 - 50% of the day)

What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice
☐ Massage Therapy ☐ Nothing works ☐ Other ☐ Pain Medicines
☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy

What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending
☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs
☐ Concentrating ☐ Cooking/Cleaning ☐ Crouching/Squatting

- [ ] Doctor's visits
- [ ] Doing Hobbies
- [ ] Doing things on time
- [ ] Dressing
- [ ] Driving
- [ ] Eating
- [ ] Exercise/Sports
- [ ] Financial Management
- [ ] Gardening
- [ ] General Mobility
- [ ] Getting Places
- [ ] Hearing
- [ ] Holding onto objects
- [ ] Housework
- [ ] Jogging
- [ ] Keeping balance
- [ ] Knitting
- [ ] Leaning
- [ ] Lifting
- [ ] Light/Sound
- [ ] Lying down
- [ ] Making decisions
- [ ] Moving Joint/s
- [ ] Mowing
- [ ] Personal hygiene/Grooming
- [ ] Pushing/Pulling with feet
- [ ] Pushing/Pulling with hands
- [ ] Reaching out/up/down
- [ ] Reading
- [ ] Running
- [ ] Seeing
- [ ] Sewing
- [ ] Sexual Activity
- [ ] Shopping
- [ ] Sitting
- [ ] Speaking
- [ ] Standing
- [ ] Turning
- [ ] Twisting
- [ ] Using the phone
- [ ] Walking
- [ ] Watching TV
- [ ] Working
- [ ] Yard work

What are your expectations regarding this symptom?

- [ ] Become Pain Free
- [ ] Explanation of my Condition
- [ ] Learn how to care for this condition on my own
- [ ] Reduce Symptoms
- [ ] Resume Normal Activity

Tell us about your symptom(s) today. Symptom #5

Symptom

Symptom Start Date

- [ ] Experienced before?

On what side are you experiencing the pain?

- ◯ Left
- ◯ Right
- ◯ Bilateral
- ◯ Central
- ◯ None

What is the level of pain?

- ◯ None
- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

What is the intensity of the pain?

- ◯ None
- ◯ Minimum
- ◯ Mild
- ◯ Moderate
- ◯ Severe
- ◯ Unbearable

What is the nature of pain?

- [ ] Burning
- [ ] Dull ache
- [ ] Numb
- [ ] Radiating pain
- [ ] Sharp

☐ Shooting ☐ Stabbing pain ☐ Throbbing ☐ Tightness ☐ Tingling

What is the frequency of pain?

◯ None ◯ Constantly (76 - 100% of the day) ◯ Frequently (51 - 75% of the day)
◯ Intermittently (0 - 25% of the day) ◯ Occasionally (26 - 50% of the day)

What makes the pain better?

☐ Acupuncture ☐ Chiropractic Therapy ☐ Heat ☐ Ice
☐ Massage Therapy ☐ Nothing works ☐ Other ☐ Pain Medicines
☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching ☐ Therapy

What makes the pain worse?

☐ Baking ☐ Bathing ☐ Bending
☐ Bending Arm ☐ Bending Leg ☐ Care of others/Pets
☐ Caring for Children ☐ Carrying Objects ☐ Climbing Stairs
☐ Concentrating ☐ Cooking/Cleaning ☐ Crouching/Squatting
☐ Doctor’s visits ☐ Doing Hobbies ☐ Doing things on time
☐ Dressing ☐ Driving ☐ Eating
☐ Exercise/Sports ☐ Financial Management ☐ Gardening
☐ General Mobility ☐ Getting Places ☐ Hearing
☐ Holding onto objects ☐ Housework ☐ Jogging
☐ Keeping balance ☐ Knitting ☐ Leaning
☐ Lifting ☐ Light/Sound ☐ Lying down
☐ Making decisions ☐ Moving Joint/s ☐ Mowing
☐ Personal hygiene/Grooming ☐ Pushing/Pulling with feet ☐ Pushing/Pulling with hands
☐ Reaching out/up/down ☐ Reading ☐ Running
☐ Seeing ☐ Sewing ☐ Sexual Activity
☐ Shopping ☐ Sitting ☐ Speaking
☐ Standing ☐ Turning ☐ Twisting
☐ Using the phone ☐ Walking ☐ Watching TV
☐ Working ☐ Yard work

What are your expectations regarding this symptom?

☐ Become Pain Free ☐ Explanation of my Condition ☐ Learn how to care for this condition on my own
☐ Reduce Symptoms ☐ Resume Normal Activity