The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do. Respond to each category by indicating the overall impact of the pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Completely able to function — Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, dishes, errands, favors for other family members, driving children to school, etc.) _____

2. RECREATION: hobbies, sports, and other similar leisure time activities. _____

3. SOCIAL ACTIVITIES: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____

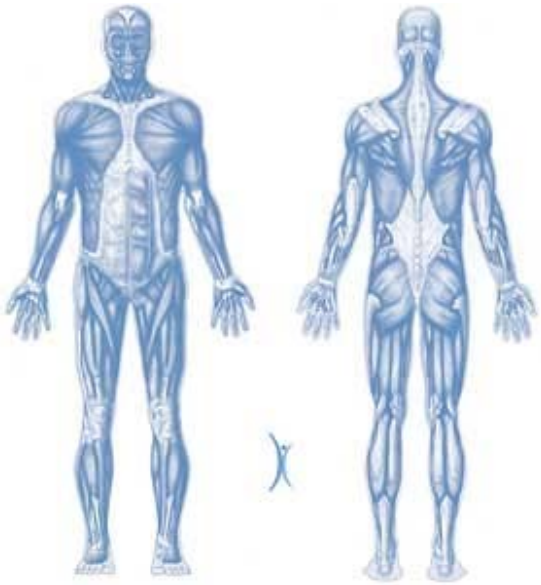
4. OCCUPATION: activities that are a part of or directly related to ones job, including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, breathing. _____

If you are experiencing any health problems, *please mark the exact location* of your pain on the diagram below. Also describe the type and frequency of your pain, For example, dull, sharp, constant, off and on, when standing, sitting, walking, etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: __**Cash** __**Check** __**Credit Card** __**Other:**_____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE AND LENGTH OF CARE.

Patient's Signature_____ **Date**_____

ACTIVE BODY CHIRO-CARE

5400 ROSECRANS AVE., HAWTHORNE, CA 90250

Name: _____ Address: _____

City:_____ State_____ Zip_____ Home Phone_____ Cell_____

Pager _____E-Mail Home_____ E-Mail Work_____

SSN_____-_____-_____ Date of birth_____-_____-_____ Age_____ Height_____ Weight_____

Male __ Female__ Single__ Married__ Divorced__ # of children____ Name of spouse or parent_____

How were you referred to our office? _____

Employer: _____Address:_____

City_____ State_____ Zip_____ Wk ph:_____ Occupation:_____

Have you ever had chiropractic care before? _____If yes, when? _____

If you are experiencing any health problems, please list your chief complaints in order of severity.

1. _____ For how long? _____

2._____ For how long? _____

3._____ For how long? _____

List other doctors consulted for these conditions._____

Name of family physician_____

Do you ever experience any of these complaints while working? _____ If yes, describe what activities at work may be causing you to experience these complaints: _____

_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____

If yes, please explain: _____

_____

If this is due to an injury or accident, what is the date of the injury or accident? _____

Has this problem been improving, getting worse, or staying the same? _____

What activities make your condition worse? _____

Have you ever had any surgeries or hospitalizations? Please list: _____

Please list any other injuries or illnesses not listed above: _____

Please indicate medications you are currently taking: ____Aspirin/Tylenol ____Pain Killers ____Muscle Relaxers ____Insulin ____ Tranquilizers ____ Birth Control Pills ____ Others_____

Have you been involved in an auto accident in the last 12 months? If yes, when? _____

Health Insurance_____Policy Holder_____

Claims Address_____Policy Number_____

Spouse's Health Insurance_____Policy Holder_____

Claims Address_____Policy Number_____