FOR OFFICE USE ONLY	IN OFFICE APPOINTMENT
SURVEY DATE________________ TIME________________	DAY________________
STAFF___________ LOCATION________________________	DATE________________
	TIME________________

PITTSBURGH CHIROPRACTIC
& REHABILITATION CENTER, LLC

Joel M. Lopacinski, D.C. ▪ Michele Lopacinski, DPT
470 Home Drive ▪ Pittsburgh, PA 15275 ▪ 412.787.7400
Fax 412.787.7407 ▪ pghchiro@drjoel.us

HEALTH AND STRESS SURVEY

NAME ____ PLACE OF WORK ________________________________
ADDRESS ____ CITY __________________________ ZIP ____________
HOME PHONE ___________________________ BUSINESS PHONE ____________________________ EXT ___________
SOCIAL SECURITY # ___________________________________ AGE __________ BIRTHDAY ____________________

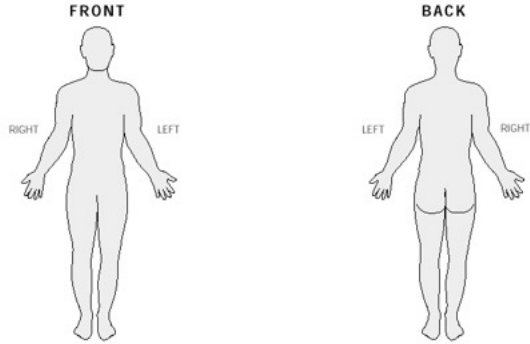
1. CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED IN THE LAST 12 MONTHS:

☐ Headaches ☐ Chronic Pain ☐ Whiplash ☐ Pain with activity
☐ Upper Backaches ☐ Fibromyalgia ☐ Numbness / Tingling ☐ Shoulder Pain
☐ Lower Back Pain ☐ Osteoarthritis ☐ Wrist Pain ☐ Sciatica
☐ Migraine Headaches ☐ Mid Back Pain ☐ Stiff Neck ☐ Leg / Hip Pain

Which of the above is worst? ____________________________________
How long have you had it? ____________________________________
How often do you get it? ____________________________________
How does it feel at its worst? ____________________________________

How does it affect you at its worst?

☐ Moody ☐ Hinders recreational activity
☐ Irritable ☐ Decreases productivity at work
☐ Interrupts Sleep ☐ It has no effect on me
☐ Lose patience with spouse/children ☐ Other _______________________
☐ Restricts daily activities ☐ Other _______________________



**Please circle your areas of pain in the figures above*

How important is it to you to eliminate this pain? (circle below)
Not important. . .0 1 2 3 4 5 6 7 8 9 10. . .Very Important

Are you Pregnant? ☐ YES ☐ NO

2. HAVE YOU EVER HAD ANY ACCIDENTS?

☐ Auto (mo. /yr.) ________________ ☐ Work (mo. / yr.) ________________ ☐ Other (mo. / yr.) ________________

3. WHAT TYPE OF DOCTORS ARE YOU CURRENTLY SEEING?

	☐ Medical Doctor	☐ Chiropractor	☐ Physical Therapist	☐ Hospital
Date of Last Visit	______________	______________	______________	______________

4. HEALTH INSURANCE SURVEY – PLEASE HELP US KEEP UP WITH CHANGES IN HEALTH CARE

Do you have health insurance? ☐ YES ☐ NO If yes, name of insurance company___________________________________
Group # ________________________ Policy # ____________________ Insured's name _______________________________
SS# ______-_____-________ Type of insurance ☐ HMO ☐ PPO ☐ MEDICARE ☐ MEDICAID ☐ OTHER _________________

5. LIST NAMES FOR ADDITIONAL HEALTH PASSES FOR FAMILY AND FRIENDS:

1. ______________________________ 2. ______________________________ 3. ______________________________