

Patient Information

Name: _____ Appt Date: _____

Date of Birth: _____ SSN of patient: _____ Insurance Co. Name: _____

Ins. Subscriber Name _____ Ins. Subscriber SSN: _____

*** Indicate if YOU or any immediate family member (father/mother, brother/sister, son/daughter) have been diagnosed with any of the following:**

- Rheumatoid Arthritis-whom? _____
 Diabetes-whom? _____
 Lupus-whom? _____
 Heart Problems-whom? _____
 Cancer-whom? _____
 ALS-whom? _____

Do you have any of the following?
 Pacemaker
 Defibrillator
 Cochlear Implant
 None of these

What is your preferred method of contact for the following? (Circle One)

Bills or statements: **EMAIL** **MAIL**

Appointment Reminders: **EMAIL** **PHONE CALL** **TEXT MESSAGE**

Telephone Communication: **HOME** **CELLULAR** **WORK**

Primary/Preferred Phone Number: _____ HOME (Landline) CELLULAR

Secondary Phone Number: _____ HOME (Landline) CELLULAR

Email Address: _____

Mailing Address: _____

Employer _____

Employer Address _____

Who is your Primary Care Physician? _____

In an Emergency who should we contact (name/relationship/phone number)?

Medications:

(please list any blood thinners, pain medications, anti-inflammatory, or steroids used short or long term.)

Check Here if not Taking Any Medications _____	

PATIENT HISTORY FORM

Patient Name: _____ Date: _____ Ins: _____

DOB: _____ Height _____ Weight _____ Blood Pressure L _____ R _____ MD _____

1. Is today's visit the direct result of: Auto Accident Workers Compensation Incident Neither

2. Please list your complaints and their location Rate the intensity of your complaint on a scale of 1-10

1. _____ 1 2 3 4 5 6 7 8 9 10

2. _____ 1 2 3 4 5 6 7 8 9 10

3. _____ 1 2 3 4 5 6 7 8 9 10

4. _____ 1 2 3 4 5 6 7 8 9 10

3. Do you consider these problems to be severe?

- Yes Yes at times No

4. How long have you had these problems? _____

5. How did these problems begin? _____

6. What things relieve your problems? _____

7. What things make your problems worse? _____

8. How often do you experience your symptoms?

- Constantly (76-100% of the time) Frequently (51-75% of the time)
 Occasionally (26-50% of the time) Intermittently (1-25% of the time)

9. How would you describe your pain?

- Achy Electric like Stabbing
 Burning Numb Stiff
 Diffuse Sharp Tingly
 Dull Shooting Other _____

5. How are your symptoms changing with time? Getting Worse Staying the Same Getting Better

6. What is your occupation? _____

7. What activities do you do at work? _____

8. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

9. What activities do you do outside of work? _____

10. How much has the problem interfered with your social and day to day activities?

- Not at all A little bit Moderately Quite a bit Extremely

11. What concerns you about your problem/What does it prevent you from doing?

12. Have you seen a Chiropractor in the past? _____ When? _____

13. Who else have you seen for your problem?

- Primary Physician Massage Therapist ER Physician No one
- Orthopedist Neurologist Physical Therapist Other: _____

14. Have you had X-rays, or an MRI/CT performed for THESE PROBLEMS? _____

WHEN and at WHAT FACILITY? _____

15. How would you rate your overall health? Excellent Very Good Good Fair Poor

16. What type of exercise do you do? Strenuous Moderate Light None

17. Do you have any of the following? Pacemaker Defibrillator Cochlear Implant None of these

18. Are you currently taking any of the following:

- Blood Thinners Steroids (current or long term) Prescription pain medication

19. Please list any surgical procedures you have had:

20. Have you had significant past trauma or accidents? No Yes`

Please describe _____

Have those problems or complaints resolved? No Yes

21. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present			
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Mid/Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbance
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Wrist/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	UTI/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bowel/Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type ___)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

FOR FEMALES:

22. Are you presently pregnant or trying to become pregnant?

- No
- Yes (If Yes- Date LMP _____ and/or Due Date _____)

23. Anything else pertinent to your visit today? _____

24. How did you hear about our office? _____

Patient Signature _____ **Date:** _____

NECK DISABILITY INDEX

Name: _____ Date: _____ Height: _____ Weight: _____ BP (L): _____

Score _____/50 Score % _____

BP (R): _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day with most aspects of self-care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 –Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 5 – Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6—Concentration

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I cannot concentrate at all.

SECTION 7—Sleeping

- I have no trouble sleeping.
- My sleep is disturbed for less than 1 hour.
- My sleep is disturbed for up to 1-2 hours.
- My sleep is disturbed for up to 2-3 hours.
- My sleep is disturbed for up to 3-5 hours.
- My sleep is disturbed for up to 5-7 hours.

SECTION 8—Driving

- I can drive my car without neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.

SECTION 9—Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all due to neck pain.

SECTION 10—Recreation

- I have no neck pain during all recreational activities.
- I have some neck pain during all recreational activities.
- I have some neck pain during a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

REVISED OSWESTRY INDEX (Low Back)

Name: _____ Date: _____ Height: _____ Weight: _____ BP (L): _____

Score _____/50 Score % _____

BP (R): _____

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderately increasing.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 – Walking

- I have no pain from walking.
- I have some pain from walking, but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6—Standing

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7—Sleeping

- I get no pain while lying in bed or sleeping.
- I get pain while lying in bed, but it doesn't prevent me from sleeping well.
- Because of pain my normal nights sleep is reduced by less than ¼.
- Because of pain my normal nights sleep is reduced by less than ½.
- Because of pain my normal nights sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8—Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9—Travel

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10—Changing degree of pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is getting better.
- My pain seems to be getting better, but slowly.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.