

Patient Name _____

Date _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit

Are you in pain: Yes No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: Work Sports/ play Auto Accident Routine/ Household activity

When did your condition/ accident occur? ____/____/____ Where did your injury occur? _____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes

Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

Has this or something similar happened in the past?

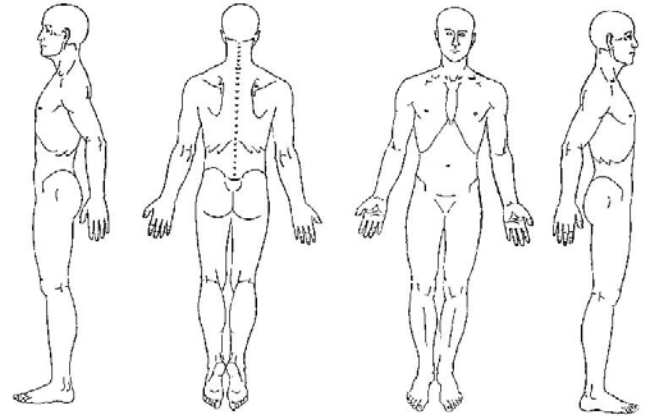
Yes No Explain: _____

Using the adjacent body charts, please circle all affected Areas.

Have you been treated by a medical physician for this Pain? Yes No If so, where? _____

Have you ever been treated by a chiropractor? Yes No
Clinic or Dr's Name: _____

Clinic Phone#: _____



Left

Back

Front

Right

Are you taking any of the following medications? Nerve Pills Pain killers (including aspirin) Muscle relaxes Blood thinners

Tranquilizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|------------------------------|----------------------------------|-------------------------|--|---------------------------|
| Y N Heart Attack/ Stroke | Y N Heart/ Surg./ Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol/ Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N Anemia/ Diabetes |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Kidney Problems |
| Y N High/ Low Blood Pressure | Y N Psychiatric problems | Y N Rheumatic Fever | Y N Severe/ Frequent Headaches | Y N Tuberculosis |
| Y N Ulcers/ Colitis | Y N Fainting/ Seizures/ Epilepsy | Y N Sinus Problems | Y N Emphysema/ Asthma | Y N Arthritis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/ Joints/ Implants | |

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above:

List any past serious accidents with dates:

Please list anything that you may be allergic to:

NECK PAIN AND DISABILITY INDEX (VERNON-MIOR)

Patient Name: _____

Date: ____/____/____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely describes your problem.

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 worse than 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 in 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 objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can lift very light objects.
- I cannot lift or carry anything at all.

SECTION 4 - READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with light pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

SECTION 5 - HEADACHES

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

SECTION 6 - CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7 - WORK

- I can do as much work as I want.
- I can do only 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 work at all.
- I can't do any work at all.

SECTION 8 - DRIVING

- I can drive without any 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 hardly drive at all because of severe neck pain.
- I can't drive at all.

SECTION 9 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

- I am able to engage in all my recreational activities with no neck pain.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- I am able to engage in a few of my usual recreational activities because of neck pain.
- I can hardly do any recreational activities because of neck pain.
- I can't do any recreational activities at all.

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absence |-----| **Extreme**

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____

Date: ____/____/____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

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

SECTION 2 - PERSONAL CARE

- I do 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 increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases 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 or dressing without help.

SECTION 3 - LIFTING

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

SECTION 4 - WALKING

- I have no pain on walking.
- I have some pain but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 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.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than half an hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain.

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 1/2 hour without increasing pain.
- I cannot stand longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Pain reduces my normal sleep by 1/4 each night.
- Pain reduces my normal sleep by 1/2 each night.
- Pain reduces my normal sleep by 3/4 each night.
- 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 pain.
- My social life is unaffected by pain apart from limiting more energetic interests.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- 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 alternate forms of travel.
- I get extra pain while traveling which compels me to seek alternate 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 definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence |-----| **Extreme**

Patient Name _____

Date _____

Family Health History:

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes How much? _____ How Long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since ____/____/____

For Women: Are you taking Birth Control? Yes No

Are you nursing? Yes No Are you pregnant? Yes No If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

Adult patient Parent or Guardian Spouse

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ a.m. p.m.

Were you the: Driver Front Passenger Rear passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? Yes No

Was a police report filed? Yes No

Were there any witnesses? Yes No

Were you wearing a seat belt? Yes No

Was this vehicle equipped with airbags? Yes No

If yes, did it/ they inflate? Yes No

In relation to the base of your skull, where was the headrest? Above Below At base of skull

What did your vehicle impact? Another vehicle Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? Yes No

If yes, please describe: _____

Make and model of the vehicle you were occupying? _____

Name of the location/ street on which you were traveling? _____

In which direction were you headed? N S E W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the : Front Rear Right Side Left Side Other

During impact, were you facing: Right Left Forward

Were you aware or surprised by the impact?

If accident vehicle made impact with another vehicle...

Direction other vehicle was headed? N S E W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

After Injury

Did accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other Doctor? Yes No

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance Private transportation

Name of hospital and/ or attending doctor: _____

Was he/she a: D.C. M.D. D.O. D.D.S

Describe any treatment you received: _____

Were X-Rays taken? Yes No

Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury? Yes No

Indicate the symptoms that are a result of this accident:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Arms/ shoulder pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numb hands/ fingers | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Back stiffness |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Stomach upset | |

Other _____

Is your condition getting worse? Yes No Constant Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney: Yes No

If yes, whom? _____

His/ Her phone #: _____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

<input type="checkbox"/> Standing	<input type="checkbox"/> Driving	<input type="checkbox"/> Operating equipment
<input type="checkbox"/> Sitting	<input type="checkbox"/> Twisting	<input type="checkbox"/> Work with arms above
<input type="checkbox"/> Walking	<input type="checkbox"/> Crawling	head
<input type="checkbox"/> Lifting	<input type="checkbox"/> Bending	<input type="checkbox"/> Typing
		<input type="checkbox"/> Stooping

Other _____

Patient Name _____

Date _____

What positions can you work in with minimum physical effort and for how long?

_____ N/A

Prior to the injury were you capable of working on an equal basis with others your age? Yes No N/A

Do you work with others who can help you with any heavy lifting? Yes No N/A

While in recovery, is there any light duty work you could request? Yes No N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____

Date ____/____/____

Adult patient Parent or Guardian Spouse

