

## Chiropractic Patient Information Form

PATIENT NAME		HOME PHONE		WORK PHONE	
STREET ADDRESS		CITY		STATE ZIP	
EMAIL		CELL PHONE		BY WHOM WERE YOU REFERRED?	
BIRTHDATE	AGE	SOCIAL SECURITY #	DRIVER'S LICENSE #	HEIGHT	WEIGHT
OCCUPATION		EMPLOYER	EMPLOYER'S ADDRESS		
SPOUSE'S NAME		SPOUSE'S BIRTHDATE	SPOUSE'S SOCIAL SECURITY #	SPOUSE'S WORK PHONE	
SPOUSE'S OCCUPATION		SPOUSE'S EMPLOYER	SPOUSE'S EMPLOYER'S ADDRESS		

Is illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Do you have other insurance that might cover this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list other insurance company name	
Please list your reason(s) for this visit or your condition(s) in order of importance: 1 _____ 2 _____ 3 _____ 4 _____	Date you first noticed: _____ _____ _____ _____	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), circle the number that best reflects your condition: ↓ none . . . . . to . . . . . severe ↓ 0 1 2 3 4 5 6 7 8 9 10	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason: <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% <input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
		0 1 2 3 4 5 6 7 8 9 10	
		0 1 2 3 4 5 6 7 8 9 10	
		0 1 2 3 4 5 6 7 8 9 10	

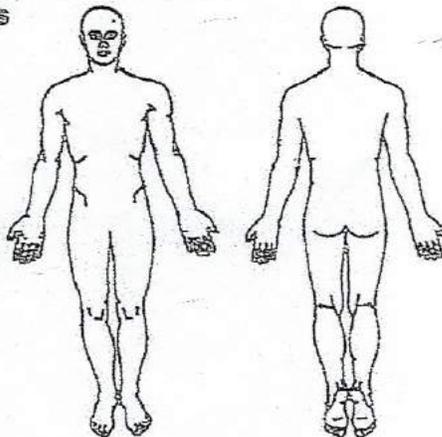
For each of the reasons or conditions listed above, please mark how it happened:

- Developed over time  Illness  Injury  Auto accident  Other \_\_\_\_\_  I don't know
- Developed over time  Illness  Injury  Auto accident  Other \_\_\_\_\_  I don't know
- Developed over time  Illness  Injury  Auto accident  Other \_\_\_\_\_  I don't know
- Developed over time  Illness  Injury  Auto accident  Other \_\_\_\_\_  I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	<input type="checkbox"/>	<input type="checkbox"/>								
Reason 2	<input type="checkbox"/>	<input type="checkbox"/>								
Reason 3	<input type="checkbox"/>	<input type="checkbox"/>								
Reason 4	<input type="checkbox"/>	<input type="checkbox"/>								

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:



- +++ Sharp or stabbing
- ooo Pins and needles
- vvv Dull or aching
- /// Numbness

Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer work/typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Chiropractic Patient Information Form

Please continue ...

- a. During what time of the day do you feel worse? \_\_\_\_\_
- b. Do you sleep well?  Yes  No What are your normal sleeping hours? \_\_\_\_\_ to \_\_\_\_\_
- c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?  
 No  Yes → For what condition? \_\_\_\_\_  
 Name of doctor/provider \_\_\_\_\_ Phone number \_\_\_\_\_
- d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?  
 No  Yes If yes, please describe each event below:  
 Event \_\_\_\_\_ Year \_\_\_\_\_  
 Event \_\_\_\_\_ Year \_\_\_\_\_
- e. Do you exercise?  Yes  No If yes, please describe activity \_\_\_\_\_  
 How many days a week? \_\_\_\_\_ How many minutes per session? \_\_\_\_\_

## Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

- Pain in body**
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Neck pain with difficulty swallowing   | <input type="checkbox"/> Recent progressive muscle weakness or shaking  | <input type="checkbox"/> Severe degenerative arthritis   |
| <input type="checkbox"/> Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck | <input type="checkbox"/> Recent or current fever over 102°F   | <input type="checkbox"/> History of compression fracture   |
| <input type="checkbox"/> Leg pain that worsens with exercise but is relieved by resting                       | <input type="checkbox"/> Loss of bowel or bladder control   | <input type="checkbox"/> History of heart attack   |
| <input type="checkbox"/> Loss of feeling in inner thighs  | <input type="checkbox"/> Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions | <input type="checkbox"/> History of stroke or aneurysm   |
| <input type="checkbox"/> Back pain with urinary problems  | <input type="checkbox"/> Recent major accident such as a fall from height, whiplash or blow to the head             | <input type="checkbox"/> Past history of cancer or currently diagnosed with cancer                         |
| <b>Types of pain</b>  | <input type="checkbox"/> Memory loss after injury   | <input type="checkbox"/> Diabetes with cold, burning or numb feet  |
| <input type="checkbox"/> Severe pain interrupts sleep   | <b>Previously diagnosed condition/ medical history</b>  | <input type="checkbox"/> Gout  |
| <input type="checkbox"/> Constant pain that doesn't improve by changing positions or lying down               | <input type="checkbox"/> Congenital bone or joint disorder  | <input type="checkbox"/> Lupus   |
| <b>Current conditions</b>   | <input type="checkbox"/> Rheumatoid arthritis   | <input type="checkbox"/> Ankylosing spondylitis  |
| <input type="checkbox"/> Unable to balance when walking   |   | <input type="checkbox"/> Immune suppression such as from chemotherapy, organ transplant, etc.              |
| <input type="checkbox"/> Recent unexplained weight loss   |   | <input type="checkbox"/> 3 or more months use of steroid medications or intravenous drugs (past or recent) |

## Family history

- |   |                                   |   |   |
|---|-----------------------------------|---|---|
| <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Mental illness   |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizure disorder |

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature \_\_\_\_\_ Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

## Please list medications if any:

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

# Symptoms

Patient \_\_\_\_\_ Date \_\_\_\_\_ Date of Injury \_\_\_\_\_

Please fill in all symptoms you currently have that you did not have before the accident.

## Orthopedic & Musculoskeletal Symptoms

- "Clunk" Sound with Neck Movements
- Neck Pain
- Upper Back Pain
- Low Back Pain
- Shoulder Pain       Left    Right
- Upper Arm Pain       Left    Right
- Elbow Pain             Left    Right
- Forearm Pain           Left    Right
- Wrist Pain              Left    Right
- Hand Pain               Left    Right
- Hip Pain                 Left    Right
- Upper Leg Pain         Left    Right
- Knee Pain               Left    Right
- Lower Leg Pain         Left    Right
- Ankle Pain              Left    Right
- Foot Pain               Left    Right
- Jaw Pain
- Clicking in Jaw
- Pain when Chewing
- Face Pain
- Chest Pain
- Stomach Pain
- Bruise/Contusion to \_\_\_\_\_
- Abrasion/Scrape to \_\_\_\_\_
- Other Symptom \_\_\_\_\_
- Other Symptom \_\_\_\_\_

## Neurological Symptoms

- Numb/Tingling Arm / Hand    L    R
- Numb/Tingling Leg / Foot    L    R
- Weakness Arm / Hand        L    R
- Weakness Leg / Foot         L    R

## Symptoms Associated with Injuries

- Range of Motion Problems
- Headaches
- Muscle Spasms
- Dizziness
- Visual Disturbances
- Sleep Disruption
- Radiating Pain
- Anxiety
- Depression
- I am taking over-the-counter pain meds

## Brain/Neuropsych/MTBI Symptoms

- Wanting to be Alone
- Sleepiness
- Nausea/vomiting
- Difficulty Concentrating
- Day Dreaming/Staring Mindless Staring
- Mood Swings
- Agitation
- Sadness or tearful
- Blurry Vision
- Double Vision
- Disoriented
- Confused
- Difficulty Speaking
- Feelings of Isolation from Others
- Attention Problems
- Appetite Change
- Pupils Different Sizes
- Room Spins/ Woozy Feeling
- Balance Problems
- Difficulty Walking
- Difficulty Focusing/Easily Distracted
- Very Tired
- Dozing During The Day
- Personality Change
- Can't Remember Numbers
- Reading Problems
- Writing Problems
- Difficulty with Adding/Subtracting
- Poor Attention
- Difficulty Learning New Things
- Difficulty Understanding
- Difficulty Remembering Things
- Re-reading Things to Understand It
- Anger
- Difficulty Making Decisions
- Change in Sexual Functioning
- Reduced Confidence
- Helplessness
- Apathy (Don't Care)
- Irritable
- Change in Sense of Taste or Smell
- Flashbacks to Accident
- Impatience
- Frustration
- Hearing Problems
- Difficulty Planning or Organizing

↓

## REVISED NECK DISABILITY INDEX QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

### Section 1—Pain Intensity

- A I have no pain at the moment
- B The pain is very mild at the moment
- C The pain is moderate at the moment
- D The pain is fairly severe at the moment
- E The pain is very severe at the moment
- F The pain is the worst imaginable at the moment

### Section 2—Personal Care

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

### Section 3—Lifting

- A I can lift heavy weights, without extra pain
- B I can lift heavy weights, but it gives extra pain
- C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (ex: on a table)
- D Pain prevents me from lifting heavy weight, but I can manage light to medium weights if they are conveniently positioned
- E I can lift very light weights
- F I cannot lift or carry anything at all

### Section 4—Reading

- A I can read as much as I want to with no pain in my neck
- B I can read as much as I want to with slight pain in my neck
- C I can read as much as I want with moderate pain in my neck
- D I cannot read as much as I want because of moderate pain in my neck
- E I cannot read as much as I want because of severe pain in my neck
- F I cannot read at all

### Section 5—Headaches

- A I have no headaches at all
- B I have slight headaches which come infrequently
- C I have moderate headaches which come infrequently
- D I have moderate headaches which come frequently
- E I have severe headaches which come frequently
- F I have headaches almost all the time

### Section 6—Concentration

- A I can concentrate fully when I want to with no difficulty
- B I can concentrate fully when I want to with slight difficulty
- C I have a fair degree of difficulty in concentrating when I want to
- D I have a lot of difficulty in concentrating when I want to
- E I have a great deal of difficulty in concentrating when I want to
- F I cannot concentrate at all

### Section 7—Work

- A I can work as much work as I want to
- B I can only do my usual work, but no more
- C I can do most of my usual work, but no more
- D I cannot do my usual work
- E I can hardly do any work at all
- F I cannot do any work at all

### Section 8—Driving

- A I can drive my car without any neck pain
- B I can drive my car as long as I want with slight pain in my neck
- C I can drive my car as long as I want with moderate pain in my neck
- D I cannot drive my car as long as I want because of moderate pain in my neck
- E I can hardly drive at all because of severe pain in my neck
- F I cannot drive my car at all

### Section 9—Sleeping

- A I have no trouble sleeping
- B My sleep is slightly disturbed (less than 1 hour sleepless)
- C My sleep is mildly disturbed (1-2 hours sleepless)
- D My sleep is moderately disturbed (2-3 hours sleepless)
- E My sleep is greatly disturbed (3-5 hours sleepless)
- F My sleep is completely disturbed (5-7 hours sleepless)

### Section 10—Recreation

- A I am able to engage in all of my recreational activities, with no neck pain at all
- B I am able to engage in all of my recreational activities, with some pain in my neck
- C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck
- D I am able to engage in a few of my usual recreational activities because of pain in my neck
- E I can hardly do any recreational activities because of pain in my neck
- F I cannot do any recreational activities at all

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

### Section 1—Pain Intensity

- A The pain comes and goes and is very mild
- B The pain is mild and does not vary much
- C The pain comes and goes and is moderate
- D The pain is moderate and does not vary much
- E The pain comes and goes and is severe
- F The pain is severe and does not vary much

### Section 2—Personal Care

- A I would not have to change my way of washing or dressing in order to avoid pain
- B I do not normally change my way of washing or dressing even though it causes some pain
- C Washing and dressing increases the pain, but I manage not to change my way of doing it
- D Washing and dressing increases the pain and I find it necessary to change my way of doing it
- E Because of the pain, I am unable to do some washing and dressing without help
- F Because of the pain, I am unable to do any washing or dressing without help

### Section 3—Lifting

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

### Section 4—Walking

- A Pain does not prevent me from walking any distance
- B Pain prevents me from walking more than 1 mile
- C Pain prevents me from walking more than ½ mile
- D Pain prevents me from walking more than ¼ mile
- E I can only walk while using a cane or on crutches
- F I am in bed most of the time and have to crawl to the toilet

### Section 5—Sitting

- A I can sit in any chair as long as I like without pain
- B I can only sit in my favorite chair as long as I like
- C Pain prevents me from sitting more than 1 hour
- D Pain prevents me from sitting more than ½ hour
- E Pain prevents me from sitting more than 10 minutes
- F Pain prevents me from sitting at all

### Section 6—Standing

- A I can stand as long as I want without pain
- B I have some pain while standing, but it does not increase with time
- C I cannot stand for longer than one hour without increasing pain
- D I cannot stand for longer than ½ hour without increasing pain
- E I cannot stand for longer than 10 minutes without increasing pain
- F I avoid standing, because it increases the pain

### Section 7—Sleeping

- A I get no pain in bed
- B I get pain in bed, but it does not prevent me from sleeping well
- C Because of pain, my normal night's sleep is reduced by less than ¼
- D Because of pain, my normal night's sleep is reduced by less than ½
- E Because of pain, my normal night's sleep is reduced by less than ¾
- F Pain prevents me from sleeping at all

### Section 8—Social Life

- A My social life is normal and gives me no pain
- B My social life is normal, but increases the degree of my pain
- C Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing etc)
- D Pain has restricted my social life and I do not go out very often
- E Pain has restricted my social life to my home

### Section 9—Traveling

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

### Section 10—Changing Degree of Pain

- A My pain is rapidly getting better
- B My pain fluctuates, but overall is definitely getting better
- C My pain seems to be getting better, but improvement is slow at present
- D My pain is neither getting better nor worse
- E My pain is gradually worsening
- F My pain is rapidly worsening

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_