

# WELCOME

# 1 one

## ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Employer:** \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many? \_\_\_\_\_

# 2 two

## INSURANCE INFO

Primary Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Secondary Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

# 3 three

## ACCOUNT INFO

**Person ultimately responsible for account**

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

**Payment method:**  Cash  Check

Credit Card - \_\_\_\_\_

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

# 4 four

## IN EVENT OF EMERGENCY

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

PLEASE CONTINUE ON BACK 

Reason for today's visit:  Emergency  New injury  Old injury  Chronic pain  Wellness  
 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: \_\_\_\_\_

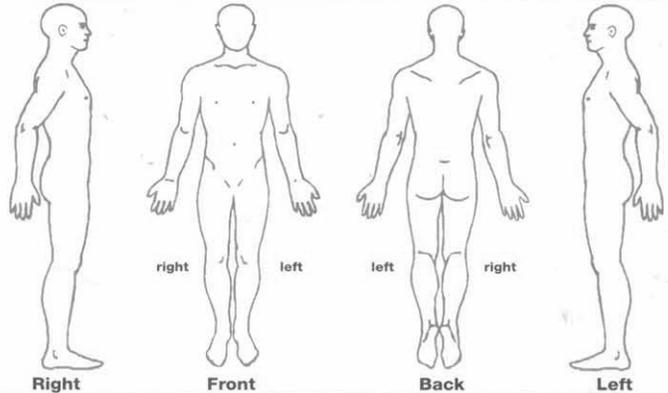
**Using the adjacent body charts, please circle all affected areas.**

Have you been treated by a Medical Physician for this condition?  Yes  No If so, where? \_\_\_\_\_

Have you ever been treated by a Chiropractor?  Yes  No

Clinic or Dr's name: \_\_\_\_\_

Clinic phone#: \_\_\_\_\_



HEALTH HISTORY

**Are you taking any of the following medications?**  Nerve pills  Pain killers(including aspirin)  Muscle relaxers

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 HIV+ / AIDS / ARC     |
| Y N Shingles                | Y N Cancer                     | Y N Frequent Neck Pain  | Y N Glaucoma                         | Y N Anemia / Diabetes     |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems       | Y N Rheumatic Fever     | Y N Severe / Frequent Headaches      | Y N Kidney Problems       |
| Y N Ulcers / Colitis        | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems      | Y N Emphysema / Asthma               | Y N Tuberculosis          |
| Y N Difficulty Breathing    | Y N Chemotherapy               | Y N Lower Back Problems | Y N Artificial Bones/Joints/Implants | Y N Arthritis             |

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: \_\_\_\_\_

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 woman:** Are you taking Birth Control?  Yes  No

Are you Nursing?  Yes  No Are you Pregnant?  No  Yes If so, how many weeks? \_\_\_\_\_



PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best health 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

**UPDATE (OFFICE USE)**

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date

Comments \_\_\_\_\_

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date

Comments \_\_\_\_\_

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Date

Comments \_\_\_\_\_

# PAIN CHART

## ABOUT YOU

Name: \_\_\_\_\_ File #: \_\_\_\_\_

What is your current weight: \_\_\_\_\_ lbs., and height, \_\_\_\_\_ Ft. \_\_\_\_\_ In..

Please describe your condition:

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Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness  
Symbol → NNNN

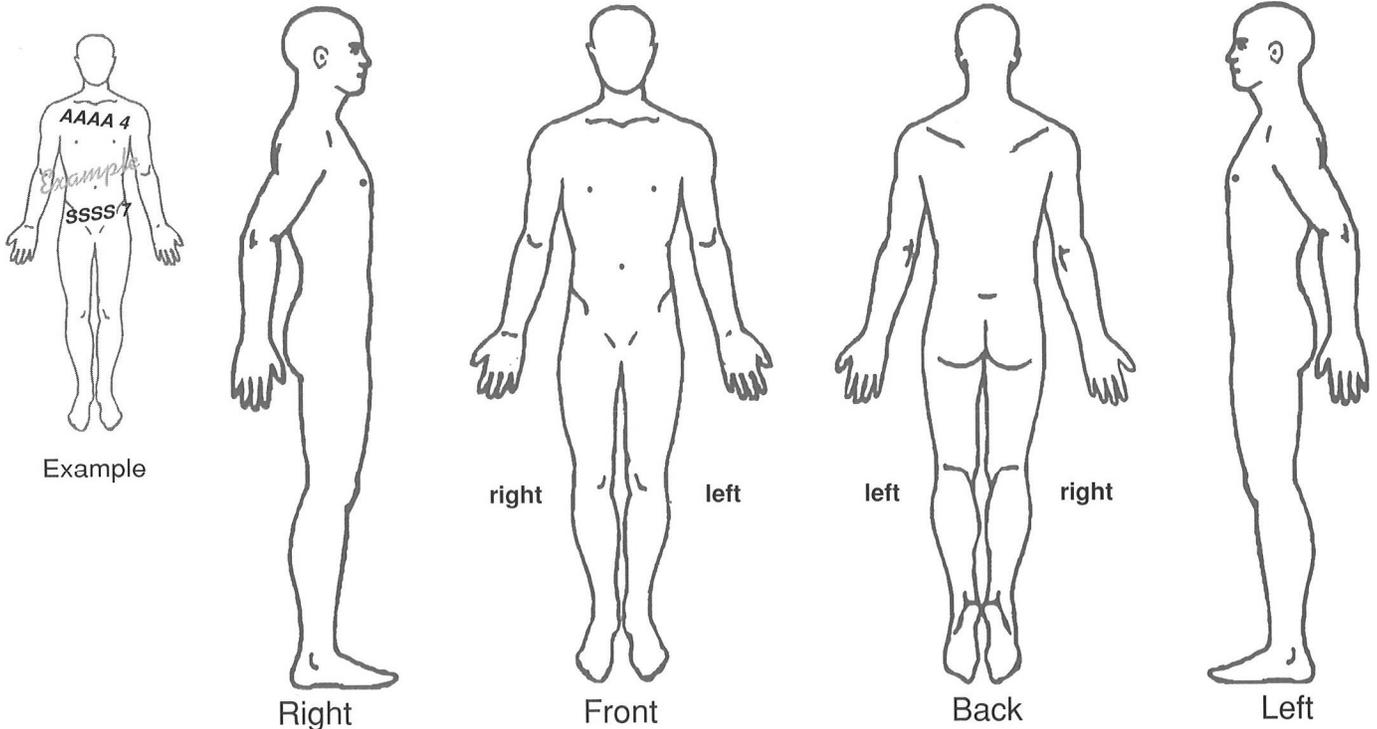
Pins & Needles  
PPPP

Burning  
BBBB

Aching  
AAAA

Stabbing  
SSSS

○ Circle any area of pain not represented by a symbol.



## DOCTOR'S NOTES

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PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET 

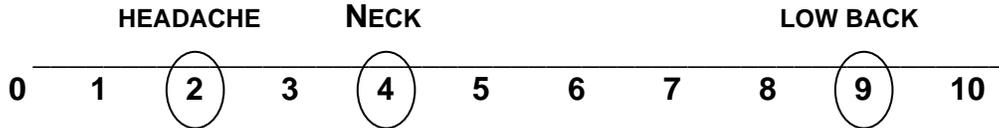
# QUADRUPLE VISUAL ANALOGUE SCALE

Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

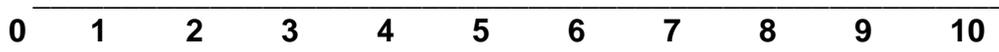
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

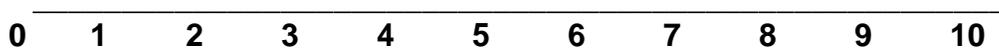
**EXAMPLE:**



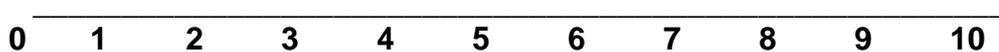
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

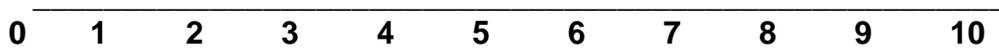


3. What is your pain AT ITS BEST (How close to “0” does your pain get at its best)?



What percentage of your awake hours is your pain at its best? \_\_\_\_\_%

4. What is your pain AT ITS WORST (How close to “10” does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? \_\_\_\_\_%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

## NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which 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 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 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 weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
- 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 slight pain in my neck.
- I can read as much as I want with moderate pain.
- I can't read as much as I want 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 headaches at all.
- I have slight headaches which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.  
 (Score  x 2) / (  Sections x 10) =  %ADL

### 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 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 can't do any work at all.

### Section 8 – Driving

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

### Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

### Section 10 – Recreation

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

Comments \_\_\_\_\_ %ADL

# Modified Oswestry Low Back Pain Disability Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please Read:**

This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

<p><b>Section 1 – Pain Intensity</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can tolerate the pain I have without having to use pain medication.</li> <li><input type="checkbox"/> The pain is bad but I manage without having to take pain medication.</li> <li><input type="checkbox"/> Pain medication provides me complete relief from pain.</li> <li><input type="checkbox"/> Pain medication provides me moderate relief from pain.</li> <li><input type="checkbox"/> Pain medication provides me little relief from pain.</li> <li><input type="checkbox"/> Pain medication has no effect on the pain</li> </ul>	<p><b>Section 6 – Standing</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can stand as long as I want without increased pain.</li> <li><input type="checkbox"/> I can stand as long as I want but increases my pain.</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from standing for more than ½ hour.</li> <li><input type="checkbox"/> Pain prevents me from standing for more than 10 mins.</li> <li><input type="checkbox"/> Pain prevents me from standing at all.</li> </ul>
<p><b>Section 2 – Personal Care (Washing, Dressing, etc.)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can take care of myself normally without causing increased pain.</li> <li><input type="checkbox"/> I can take care of myself normally but it increases my pain.</li> <li><input type="checkbox"/> It is painful to take care of myself and I am slow and careful.</li> <li><input type="checkbox"/> I need help but I am able to manage most of my personal care.</li> <li><input type="checkbox"/> I need help every day in most aspects of my care.</li> <li><input type="checkbox"/> I do not get dressed, wash with difficulty and stay in bed.</li> </ul>	<p><b>Section 7 – Sleeping</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me from sleeping well.</li> <li><input type="checkbox"/> I can sleep well only by using pain medication.</li> <li><input type="checkbox"/> Even when I take pain medication, I sleep less than 6 hours.</li> <li><input type="checkbox"/> Even when I take pain medication, I sleep less than 4 hours.</li> <li><input type="checkbox"/> Even when I take pain medication, I sleep less than 2 hours.</li> <li><input type="checkbox"/> Pain prevents me from sleeping at all</li> </ul>
<p><b>Section 3 – Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can lift heavy weights without increased pain.</li> <li><input type="checkbox"/> I can lift heavy weights but it causes increased pain.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.</li> <li><input type="checkbox"/> Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.</li> <li><input type="checkbox"/> I can lift only very light weights.</li> <li><input type="checkbox"/> I cannot lift or carry anything at all.</li> </ul>	<p><b>Section 8 – Social Life</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My social life is normal and does not increase my pain.</li> <li><input type="checkbox"/> My social life is normal, but it increases my level of pain.</li> <li><input type="checkbox"/> Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.</li> <li><input type="checkbox"/> Pain prevents me from going out very often.</li> <li><input type="checkbox"/> Pain has restricted my social life to my home.</li> <li><input type="checkbox"/> I have hardly any social life because of my pain.</li> </ul>
<p><b>Section 4 - Walking</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain does not prevent me walking any distance.</li> <li><input type="checkbox"/> Pain prevents me walking more than 1 mile.</li> <li><input type="checkbox"/> Pain prevents me walking more than ½ mile</li> <li><input type="checkbox"/> Pain prevents me walking more than ¼ mile</li> <li><input type="checkbox"/> I can only walk using crutches or a cane.</li> <li><input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet.</li> </ul>	<p><b>Section 9 – Traveling</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can travel anywhere without increased pain.</li> <li><input type="checkbox"/> I can travel anywhere but it increases my pain.</li> <li><input type="checkbox"/> Pain restricts travel over 2 hours.</li> <li><input type="checkbox"/> Pain restricts travel over 1 hour.</li> <li><input type="checkbox"/> Pain restricts my travel to short necessary journeys under ½ hour.</li> <li><input type="checkbox"/> Pain prevents all travel except for visits to the doctor/therapist or hospital.</li> </ul>
<p><b>Section 5 - Sitting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> I can sit in any chair as long as I like.</li> <li><input type="checkbox"/> I can only sit in my favorite chair as long as I like.</li> <li><input type="checkbox"/> Pain prevents me sitting more than 1 hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than ½ hour.</li> <li><input type="checkbox"/> Pain prevents me from sitting more than 10 mins.</li> <li><input type="checkbox"/> Pain prevents me from sitting at all.</li> </ul>	<p><b>Section 10 – Employment/Homemaking</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> My normal homemaking/job activities do not cause pain.</li> <li><input type="checkbox"/> My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.</li> <li><input type="checkbox"/> I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).</li> <li><input type="checkbox"/> Pain prevents me from doing anything but light duties.</li> <li><input type="checkbox"/> Pain prevents me from doing even light duties.</li> <li><input type="checkbox"/> Pain prevents me from performing any job/homemaking chores.</li> </ul>