# Welcome to our office

TODAY'S DATE ____/____/____

## 1. Patient Information (please print)

Name _____
First Last MI

Address _____

_____
City State Zip

Sex ☐M ☐F Date of Birth ____/____/____ Age_____

☐Single ☐Married ☐Widow ☐Separated ☐Divorced

SSN ☐☐☐-☐☐-☐☐☐☐

Occupation_____ ☐Full Time ☐Part Time

Employer_____

Employer Address_____

_____

Spouse's Name_____

Date of Birth ___/___/___ SSN_____

## 2. Phone Numbers

H_____ W_____ Ext_____

Cell_____ ☐ Check box if OK to leave message on your cell or text you with HIPAA protected information.

E-mail_____

☐ Check box if OK to contact you via E-mail with HIPAA protected information.

Whom should we contact in case of emergency?

Name _____

Relationship _____

Cell Work

## 3. Financial Information

Are you the parent or legal guardian of the patient?

☐ Yes Your Name_____

Relationship to Patient _____

### Insurance Information: ☐None

Insurance Company _____

I.D. Number_____ Group_____

Phone Number _____

Subscriber's Name _____

Date of Birth _____ Relationship_____

### Additional Insurance: ☐None

Insurance Company _____

I.D. Number_____ Group_____

Phone Number _____

Subscriber's Name _____

Date of Birth Relationship

## 4. Accident Information

Is your condition due to an accident? ☐ Yes ☐ No

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of this accident?

☐ Auto Insurnace ☐ Employer ☐ Work Comp ☐ Other

Attorney Phone

## 5. Patient Condition – your main complaint...

Reason for Today's Visit _____ Date Started ___/___/___

Do you know what may have caused this? _____

Is your PAIN / DISCOMFORT: ☐ Dull ☐ Sharp ☐ Burning ☐ Tingling ☐ Throbbing ☐ Numbness ☐ Stabbing

And is it? Mild Moderate Severe Pain Scale: MILD 1 2 3 4 5 6 7 8 9 10 SEVERE

How often do you suffer from this? ☐Daily ☐ ___Times Per Week ☐ ___Times Per Month ☐ ___Times Per Year

How long does it last?_____ And Is It: ☐ Intermittent ☐ Frequent ☐ Constant

What makes it better?_____ What makes it worse?_____

Does it interfere with: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Walking ☐ Bending ☐Standing ☐ Sitting

What have you tried to relieve your symptoms?

# 6. Past Health History

PATIENT NAME:

**Do you have any of the following?** **Please check YES or NO for each condition.**

**Relative Contraindications:**

- Articular Hypermobility Disease ☐ Yes ☐ No
- Severe Demineralization of Bone ☐ Yes ☐ No
- Benign Bone Tumor (Spine) ☐ Yes ☐ No
- Bleeding Disorder ☐ Yes ☐ No
- Are You Taking Anticoagulants Therapy ☐ Yes ☐ No
- **Radiculopathy with Progressive Neurological Signs,** Radiating Pain, Numbness or Weakness into:
  - ☐ Upper Extremities ☐ Yes ☐ No
  - ☐ Lower Extremities ☐ Yes ☐ No

**Absolute Contraindications:**

- Rheumatoid Arthritis ☐ Yes ☐ No
- Ankylosing Spondylitis ☐ Yes ☐ No
- Fracture(s) _____ ☐ Yes ☐ No
- Dislocation(s) _____ ☐ Yes ☐ No
- Unstable OS Odontoedum ☐ Yes ☐ No
- Malignancies ☐ Yes ☐ No
- Infection of bones or joints of the vertebral column ☐ Yes ☐ No
- Myelopathy ☐ Yes ☐ No
- Cauda Equina Syndrome ☐ Yes ☐ No
- Vertebrobasilar Insufficiency Syndrome ☐ Yes ☐ No
- Major Artery Aneurysm ☐ Yes ☐ No

**Previous Major Illnesses and Injuries** _____

**Operations, Hospitalizations, Surgeries** _____

**Medications you are currently taking:** ☐ None

☐ **High Blood Pressure** _____ ☐ **Cholesterol** _____ ☐ **Pain** _____ ☐ **Arthritis** _____

☐ **Depression** _____ ☐ **Anxiety** _____ ☐ **ADD/ADHD** _____ ☐ **Insulin** _____

☐ **Other** _____

**Allergies** **Supplements**

## Family History - Immediate Family Members (Father, Mother, Brother, Sister)

**Health status of family members:** _____

**Are there any family members that suffer from:**

☐ **Stroke** ☐ **Heart Disease** ☐ **Cancer** ☐ **Tumor** ☐ **Degenerative Disc Disease** ☐ **Arthritis** ☐ **Osteoporosis**

☐ **Other** _____

If any of the above items are checked, then whom in your family suffers? _____

Are there any diseases that are "hereditary" or seem to run in your family?

## Social History - Please answer the following:

**Please tell the Doctor about your activities:**

| Exercise: | Work / School: | Habits: ☐ None | Education: |
|---|---|---|---|
| ☐ None | ☐ Sitting | ☐ Smoking - Packs Per Day____ ☐ None Drugs _____ ☐ None | ☐ High School |
| ☐ Occasional | ☐ Standing | ☐ Alcohol - Times Per Week_____ ☐ None | ☐ Some College |
| ☐ Daily | ☐ Light Labor | ☐ Caffeine: Coffee, Tea, Sodas... Cups Per Day _____ ☐ None | ☐ College Grad |
| ☐ Weekly | ☐ Heavy Labor | Hobbies _____ ☐ None | ☐ Post Grad |
| ☐ Other | ☐ Computer | | |

I certify the information on these forms are true to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic and therapeutic care for my condition if I am accepted as a patient.

**Patient Signature** _____ **Date** ____/____/____

**Doctor's Signature** _____ **Date** ____/____/____

# Symptom(s) Questionnaire

Patient Name _____ ☐ Initial Visit ☐ Subsequent Visit

Please tell us about your symptoms: _____

_____

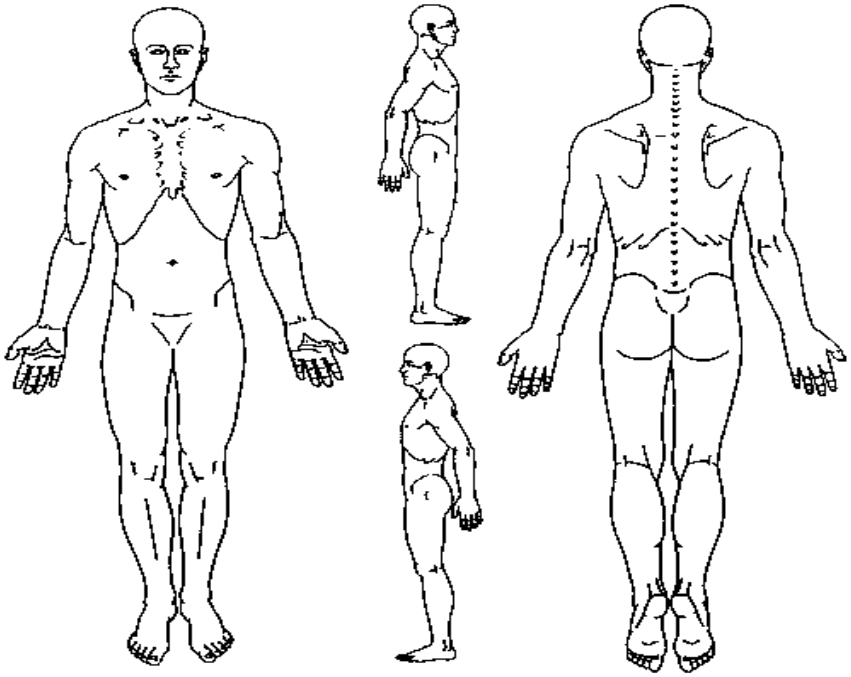
My pain / symptom(s) are getting: Better Worse About the same Other

## Please use the key to mark the diagram

Pain / Discomfort Scale: (please Circle) Least 0 1 2 3 4 5 6 7 8 9 10+ Worst

A = Ache B = Burning N = Numbness S = Stiff SR = Sore

T = Tingle P = Pain W = Weak P&N = Pins & Needles



## Please tell us how your symptoms are affecting your activities

| HOME | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Sleeping | ☐ | ☐ | ☐ | ☐ |
| Self Care | ☐ | ☐ | ☐ | ☐ |
| Household Chores | ☐ | ☐ | ☐ | ☐ |
| Yard Work | ☐ | ☐ | ☐ | ☐ |
| Enjoyment | ☐ | ☐ | ☐ | ☐ |
| Productivity | ☐ | ☐ | ☐ | ☐ |

| WORK | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Concentration | ☐ | ☐ | ☐ | ☐ |
| Duties, Activities | ☐ | ☐ | ☐ | ☐ |
| Mood | ☐ | ☐ | ☐ | ☐ |
| Travel | ☐ | ☐ | ☐ | ☐ |
| Enjoyment | ☐ | ☐ | ☐ | ☐ |
| Productivity | ☐ | ☐ | ☐ | ☐ |

| OTHER ACTIVITIES | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Sit, Stand, Walk | ☐ | ☐ | ☐ | ☐ |
| Raising from Chair | ☐ | ☐ | ☐ | ☐ |
| Bend, Lift, Twist | ☐ | ☐ | ☐ | ☐ |
| Turn Head | ☐ | ☐ | ☐ | ☐ |
| Hobbies, Exercise, Sports | ☐ | ☐ | ☐ | ☐ |
| Enjoyment | ☐ | ☐ | ☐ | ☐ |

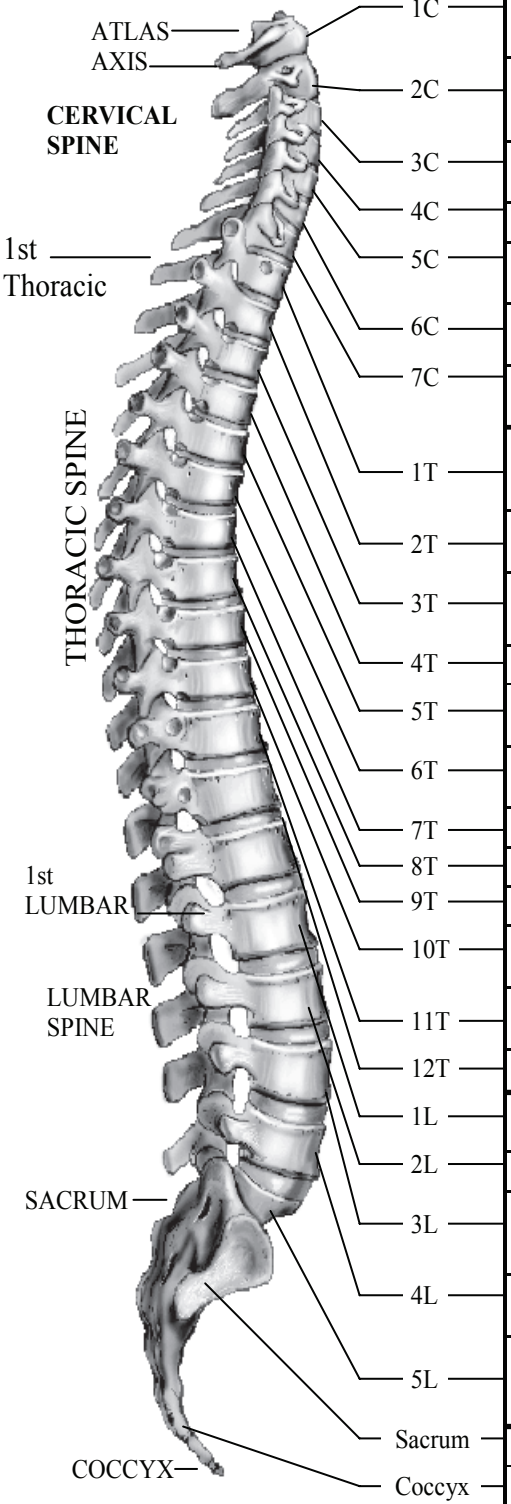
Patient Signature _____ Date ____/____/____

Doctor Signature Date ____/____/____

Patient _____ Date _____

**REVIEW OF SYSTEMS:** ☐Musculoskeletal ☐Neurological ☐Constitutional ☐Eyes ☐ENMT ☐Cardiovascular ☐Respiratory ☐Gastro Intestinal ☐Genitourinary ☐Integumentary ☐Psyciatric ☐Endocrine ☐Hematologic ☐Immunologic ☐All Others Negative

**Instructions:** Please mark **ALL** you have suffered with **now** or in the **past.**




| Vertebrae | Area Controlled * | Possible Effects of Malfunction | |
|---|---|---|---|
| 1C | Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system. | ☐**Headaches** ☐**Migraine Headaches** ☐Head Colds ☐High Blood Pressure ☐Chronic Tiredness ☐Amnesia ☐ADD/ADHD ☐Nervousness ☐Insomnia ☐Dizziness | |
| 2C | Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead. | ☐Sinus Trouble ☐Allergies ☐Pain Around the Eyes ☐Earaches ☐Crossed Eyes ☐Blindness (some) ☐Deafness ☐Fainting | NECK REGION |
| 3C | Cheeks, outer ear, face bones, teeth, trifacial nerve. | ☐Neuralgia ☐Neuritis ☐Acne / Pimples ☐Eczema ☐**Neck Pain, Stiffness, Soreness** | NECK REGION |
| 4C | Nose, lips, mouth, Eustachian tube. | ☐Hay Fever ☐Runny Nose ☐Swollen Adnoids | NECK REGION |
| 5C | Vocal Cords, neck glands, pharynx. | ☐Laryngigitis ☐Hoarseness ☐**Hand/Finger Numbness** ☐Sore Throats ☐Tonsillitis | NECK REGION |
| 6C | Neck muscles, shoulders, tonsils. | ☐**Stiff Neck** ☐**Pain in Upper Arm** ☐Chronic Cough ☐Croup ☐**Hand/Finger Numbness** ☐**Shoulder Pain** | NECK REGION |
| 7C | Thyroid Gland, bursae in the shoulders, elbows. | ☐Bursitis ☐Colds ☐Thyroid Conditions ☐**Wrist, Hand / Finger Pain or Numbness** | NECK REGION |
| 1T | Arms from the elbows down, including hands, wrists, and fingers, esophagus and trachea. | ☐Asthma ☐Cough ☐Difficulty Breathing ☐**Pain into Arms or Hands** ☐Shortness of Breath | MID-BACK |
| 2T | Heart, including its valves and covering, coronary arteries. | ☐Heart Problems ☐Chest Pain ☐High Blood Pressure | MID-BACK |
| 3T | Lungs bronchial tubes, pleura, chest, breast. | ☐Bronchitis ☐Pleurisy ☐Pneumonia ☐Congestion ☐Influenza ☐**Mid Back Pain, Burning, Stiffness, Soreness** | MID-BACK |
| 4T | Gallbladder, common duct | ☐Gallbladder Conditions ☐Jaundice ☐Shingles | MID-BACK |
| 5T | Liver, solar plexus, circulation-general | ☐Liver Conditions ☐Fevers ☐Arthritis ☐Poor Circulation ☐Other Blood Pressure Problems | MID-BACK |
| 6T | Stomach. | ☐Stomach Troubles ☐Nervous Stomach ☐Indigestion ☐Heartburn ☐Dyspepsia ☐Nausea | MID-BACK |
| 7T | Pancreas, duodenum. | ☐Ulcers ☐Gastritis ☐**Mid Back Pain or Burning** | MID-BACK |
| 8T | Spleen | ☐Lowered Immune System | MID-BACK |
| 9T | Adrenal and Suprarenal glands | ☐Allergies ☐Hives ☐**Mid Back Soreness** | MID-BACK |
| 10T | Kidneys | ☐Kidney Problems ☐Pyelitis ☐Hardening of the Arteries ☐Chronic Tiredness ☐Nephritis ☐**Back Pain** | MID-BACK |
| 11T | Kidneys, ureters | ☐Skin Conditions ☐Pimples ☐Boils ☐Acne ☐Eczema | MID-BACK |
| 12T | Small intestines, lymph circulation | ☐Rheumatism ☐Gas Pains ☐Certain Types of Sterility | MID-BACK |
| 1L | Large intestines, inguinal rings | ☐Constipation ☐Colitis ☐Dysentery ☐Diarrea ☐Some Hernias ☐**Back Pain** | LOW BACK |
| 2L | Appendix, abdomen, upper leg | ☐Cramps ☐Difficulty Breathing ☐Minor Varicose Veins | LOW BACK |
| 3L | Sex organs, uterus, bladder, knees | ☐Bladder Problems ☐Painful or Irregular Periods ☐Miscarriages ☐Bed Wetting ☐Impotency ☐Change of Life Symptoms ☐**Knee Pains** | LOW BACK |
| 4L | Prostate gland, muscles of the lower back, sciatic nerve | ☐Sciatica ☐Difficult, Painful, or Too Frequent Urination ☐**Backaches** ☐**Pain, Burning or Numbness in Legs** | LOW BACK |
| 5L | Lower legs, ankles, feet | ☐Weak Ankles and Arches ☐Cold Feet ☐Swollen Ankles ☐Plantar Fascitis ☐**Foot Pain** ☐Weakness in Legs ☐Leg Cramps ☐Heel Spurrs ☐Poor Circulation in Legs | LOW BACK |
| Sacrum | Hip bones, buttocks | ☐**Lower Back Pain into the Hip or Legs** ☐Spinal Curvature | PELVIS |
| Coccyx | Rectum, anus | ☐**Pain in Tailbone with Sitting** ☐Hemorrhoids ☐Pruritis | PELVIS |

*Directly or indirectly controlled.

Patient Signature _____

Doctor's Signature _____

# Case History

Patient Name _____ Today's Date ___/___/___

**C**hief **C**omplaint _____ Date of Onset ___/___/___

**H**istory of **P**resent **I**llness: ☐ Auto Accident ☐ Work ☐ Other _____

**Location** (One side, both sides, radiating, referred) _____

**Quality** (circle) Dull Sharp Throbbing Stabbing Numb Tingling Sore Ache Stiff Worsening

**Severity** (Where does the pain rate): Minimal 0 1 2 3 4 5 6 7 8 9 10 Severe

**Duration** (How long does it last) _____

**Timing** (Circle) Intermittent Frequent Constant **That occurs** (circle) Morning Afternoon Evening Night

**Context** (What is the patient doing when the pain begins? Is it during an activity?)

Aggravating Activities: (circle) Sitting Lifting Bending Standing Walking Laying Reaching

How does it affect you? (Functional Loss):

**Home** _____

_____

_____

**Work** _____

_____

_____

**Outside Activity** _____

_____

_____

**What Makes It Better or Worse** (What has the patient attempted to do to obtain relief? Does sitting, standing, walking, etc. make it better or worse? What medications; prescription or over the counter, has the patient tried?)

_____

**Associated Signs and Symptoms** (The consultation may lead to further questioning regarding additional signs or symptoms. Such as; low back pain associated with foot numbness.)

_____

**Review of Systems**: ☐ Musculoskeletal ☐ Neurological ☐ Constitutional ☐ Eyes ☐ ENMT ☐ Cardiovascular ☐ Respiratory ☐ Immunologic ☐ Gastro Intestinal ☐ Genitourinary ☐ Integumentary ☐ Psyciatric ☐ Endocrine ☐ Hematologic ☐ All Others Negative

**PFSH:** ☐ None ☐ One ☐ 2 Re Exam ☐ 3 Initial Exam ☐ Reviewed Intake Dated _____ No Change

Signature of Staff / Doctor Taking History _____

| Level of History | 99201 99212 | 99202 99213 | 99203 99214 | 99204 99205 99215 |
|---|---|---|---|---|
| HPI | 1 - 3 | 1 - 3 | 4 + | 4 + |
| ROS | None | 1 Problem Pertinent | 2 – 9 Systems | 10 + OR some with a statement, "all others negative" |
| P F S H | None | None | 1 Problem Pertinent | 2 or 3 |

# Neck Index

***Patient Name*** _____ ***Date*** _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

### *Pain Intensity*

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

### *Sleeping*

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

### *Reading*

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

### *Concentration*

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

### *Work*

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

### *Personal Care*

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

### *Lifting*

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

### *Driving*

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

### *Recreation*

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

### *Headaches*

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

*Neck Index Score*

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

# Back Index

***Patient Name*** _____ ***Date*** _____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

### *Pain Intensity*

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

### *Sleeping*

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

### *Sitting*

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

### *Standing*

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

### *Walking*

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

### *Personal Care*

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

### *Lifting*

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

### *Traveling*

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

### *Social Life*

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

### *Changing degree of pain*

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Back Index Score*