

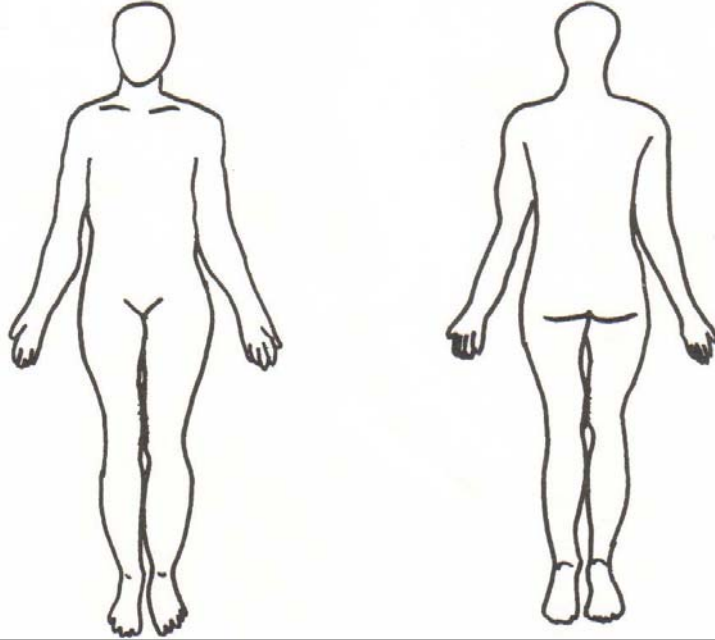
PATIENT PAIN PROFILE

PAIN DRAWING:

INSTRUCTIONS: *Mark the area on your body where you feel the described sensations:*

- *Use the appropriate symbol*
- *Mark the areas of spread*
- *Include all affected areas*

KEY:	
Numbness / Tingling	=====
Pins & Needles	oooooooo
Burning pain	xxxxxxxx
Dull / achy pain
Sharp / Stabbing pain	////////////////



VISUAL PAIN SCALE

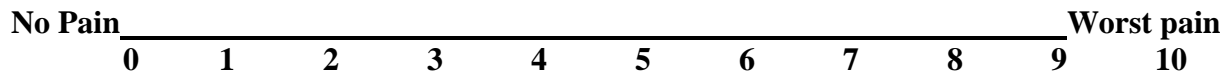
INSTRUCTIONS: *Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, and average pain.*

Example:

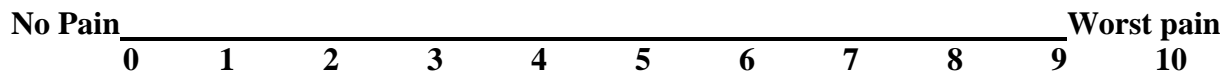
No Pain **Worst pain**
 0 1 2 3 4 5 6 7 8 9 10

(Note: In the example, the numbers 0, 4, and 7 are circled.)

What is your pain RIGHT NOW?



What is your TYPICAL or AVERAGE pain?



The information I have provided is complete and accurate to the best of my knowledge _____
signature

PATIENT INFORMATION

(OFFICE USE) Patient ID _____ DR. _____

Please give your Driver's license and insurance card to the front desk so they can make a copy for your records.

Patient Name: Last _____ First _____ Date ____/____/____

Address _____ City _____ State _____ Zip _____

Phone (____) ____-____ Diver's License # _____ Birthdate ____/____/____ Age ____

Sex: ___M___F Patient Soc. Sec. # _____ Marital Status S M D W Children # ____

Spouse's Name _____ Person responsible for payment _____

Patient employed by _____ Occupation _____

Work phone (____) ____-____ Referred by _____ E-mail _____

Have you ever been to Chiropractor before yes no Have you ever had similar complaint? yes no

Condition related to: Employment Auto accident personal injury

CURRENT COMPLAINTS

Complaint 1 _____

How severe is the problem?

- Mild
- Mild to moderate
- Moderate
- Moderately severe
- Severe

How frequently does it occur?

- Constant
- Frequent
- Intermittent
- Occasional

When was the onset?

- A day ago
- Several days ago
- About a week ago
- Several weeks ago
- About a month ago
- Several months ago
- About a year ago
- several years ago

Movement:

- Cramps
- Spasm
- Stiffness
- Restricted movement
- Inflexibility

What makes it feel better? _____

What makes it feel worse? _____

If you are being re-evaluated, what percent improvement have you had?

_____ %

Complaint 2 _____

How severe is the problem?

- Mild
- Mild to moderate
- Moderate
- Moderately severe
- Severe

How frequently does it occur?

- Constant
- Frequent
- Intermittent
- Occasional

When was the onset?

- A day ago
- Several days ago
- About a week ago
- Several weeks ago
- About a month ago
- Several months ago
- About a year ago
- several years ago

Movement:

- Cramps
- Spasm
- Stiffness
- Restricted movement
- Inflexibility

What makes it feel better? _____

What makes it feel worse? _____

If you are being re-evaluated, what percent improvement have you had?

_____ %

Complaint 3 _____

How severe is the problem?

- Mild
- Mild to moderate
- Moderate
- Moderately severe
- Severe

How frequently does it occur?

- Constant
- Frequent
- Intermittent
- Occasional

When was the onset?

- A day ago
- Several days ago
- About a week ago
- Several weeks ago
- About a month ago
- Several months ago
- About a year ago
- several years ago

Movement:

- Cramps
- Spasm
- Stiffness
- Restricted movement
- Inflexibility

What makes it feel better? _____

What makes it feel worse? _____

If you are being re-evaluated, what percent improvement have you had?

_____ %

Health History

Please indicate whether the following applies to the "T" Individual, "F" Family Member, or "B" Both.

Abdominal Pain	Dislocated Joints	High Blood Pressure	Multiple Sclerosis
Allergies	Dizziness	Hip Pain	Neck Pain
Angina	Duodenum Ulcer	HIV/AIDS	Osteoporosis
Anorexia	Emphysema	Hypertension	Painful Urination
Aortic Aneurysm	Epilepsy	Hyperthyroidism	PMS
Arthritis	Esophageal Cancer	Hypothyroidism	Polio
Asthma	Fainting	Irregular Bowel Habits	Profuse Menstrual
Blood Disorder	Fibromyalgia	Irregular Menstrual	Prostate Cancer
Bone Cancer	Gouty Arthritis	Kidney Disease	Prostate Problems
Brain Cancer	Hay Fever	Kidney Stones	Rapid Heart Rate
Breast Soreness	Headaches	Knee Pain	Rectum Cancer
Breast Cancer	Heart Attacks	Leg Pain	Scoliosis
Bulimia	Heart Disease	Liver Disease	Shoulder Pain
Chest Pain	Hepatitis A	Low Blood Pressure	Sinus Trouble
Colon Cancer	Hepatitis B	Lower Back Pain	Spinal Disc Disorder
Convulsions	Hepatitis C	Lung Cancer	Stomach Cancer
Diabetes	Hernias	Migrane	Stroke

Other History _____

Patient Exercises:	Moderately	Occasionally	Rarely	Regularly	Never		
Patient Smokes:	2+ Packs per day	2 Packs per day	1 Pack per day	½ Pack per day or less			
	Never	Quit (how long ago) _____					
Patient uses alcohol:	Excessively	Moderately	Occasionally	Rarely	Never	Quit	
Medication the patient is currently taking:	Analgesics	Anti-inflammatory	Asthma	Birth Control			
	Hypertension	Muscle Relaxants	Psychotropic	Tranquilizers	Vitamin Supplements		
	Other _____	Other _____	Other _____	Other _____			
Allergies:	Animal Dander	Dairy Products	Dust	Latex	Penicillin	Perfumes	Pollen
	Seasonal	Second Hand Smoke		Sulfa Drugs		No Known Allergies	
	Other _____	Other _____		Other _____			

Please list any pervious injuries and/or accidents with date _____

Past Surgical History (Indicate date, location, surgeon's name, type of surgery, and complications)

Past Hospitalizations (Indicate date, reason for hospitalization, and Complications) _____

History of Pregnancy _____

Treatment and Diagnostic Testing

Plain X-Rays	Date _____	Location _____	Results _____
CT Scan	Date _____	Location _____	Results _____
MRI	Date _____	Location _____	Results _____
EMG	Date _____	Location _____	Results _____
Bone Scan	Date _____	Location _____	Results _____
Nerve Block Injection	Trigger Point Injection	EMG Needle Exam	
Botox Injection	Epidural Injection	IV	
Other _____			
Other _____			
Other _____			

Neck Pain and Disability Index

Please Read Instructions:

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. In each section, please fill in ONE box only which most closely describes your problem.

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 6 Concentration

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

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 wash with difficulty and stay in bed.

Section 7 Work

- A. I can do as much work as I want.
- 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 can hardly do any work at all.
- E. I cannot do my usual work.
- F. I can't do any work at all.

Section 3 Lifting

- A. I can lift heavy weight without extra pain.
- B. I can lift heavy weight but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage it they are conveniently positioned.
- D. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything 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.
- D. I can't drive my car as long as I want because of moderate pain.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I can't drive my car at all.

Section 4 Reading

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

Section 9 Sleeping

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

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 of the time.

Section 10 Recreation

- A. I am able to engage in all recreational activities with no neck pain.
- B. I am able to engage in all 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 my neck pain.
- D. I am able to engage in a few of my usual recreational activities because of my neck pain.
- E. I can hardly do any recreational activities because of pain.
- F. I can't do any recreational activities at all.

Office Use Only

Date: _____ Score: _____

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.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Office Use Only

Date: _____ **Score:** _____