FOR OFFICE USE ONLY:
Patient Number: _____
Doctor: _____
Insurance: _____
Emp. Initials: _____

PT REVAL:

PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records.****
Patient Name: Last _____ First _____ Date _____ / _____ / _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: (_____) _____ - _____ Home Phone (_____) ____ - _____ Birth date ____ / ____ / ____ Age ____
Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # _____ - _____ - _____
Marital Status: S M D W Spouse's Name: _____ Referred by: _____
Person responsible for payment: _____ Patient Employed by: _____
Occupation: _____ Work Phone: (____) ____ - _____
Email: _____ Emergency Contact Name / # / Relationship: _____/_____/_____
Primary Care Physician/Facility:_____ Primary Care Phone:_____
Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email
Have you ever been to a Chiropractor before?: YES NO
Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation
ARE YOU CURRENTLY PREGNANT? YES NO

CHIEF COMPLAINT: Answer the questions as completely as possible. If a question does not apply, leave it blank.

Reason for today's appointment: ☐ Neck pain ☐ Upper back pain ☐ Low back pain ☐ Other: _____

Which side of your body is the complaint on? ☐ Right ☐ Left ☐ Both

How long have you had this problem?
Date: _____ or _____day(s) _____ week(s) _____ month(s) _____ year(s)

How do you think your problem began?
_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (50-75%) ☐ Intermittently (26-49%) ☐ Occasionally (0-25%)

Rate the severity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe

How does this effect your movement?
☐ Stiffness ☐ Spasms ☐ Cramps

What makes the symptoms worse?
_____

What makes the symptoms better?
_____

Please add any other information about the primary complaint that may be helpful:
_____

*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****
_____

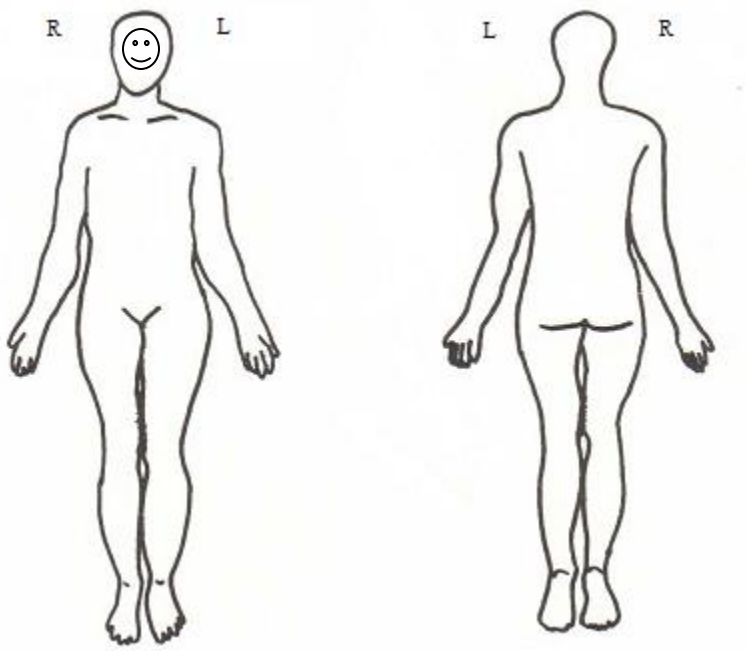
If you are being RE-EVALUATED ONLY:
What percentage of improvement have you had from 0-100%: _____ %
INITIALS:_____ DATE:_____

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, at its worst and at its best.***

Example:

Headache *Neck* *Low back*

No Pain ——— **Worst pain**

0 (1) 2 3 4 (5) 6 7 8 (9) 10

What is your pain RIGHT NOW?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its BEST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its WORST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:

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 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 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 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 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 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 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 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 9 Sleeping

- **A**. I have no trouble sleeping.
- **B**. My sleep is slightly disturbed (less then 1hr. sleepless).
- **C**. My sleep is mildly 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 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.

Low Back Pain and Disability Index

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your **low back 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**. 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 very severe.
- **F**. The pain is very severe and doesn't vary much.

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 can't dress myself. I wash with difficulty and stay in bed.

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.
- **D**. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- **E**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- **F**. I can only lift very light weights at the most.

Section 4 Walking

- **A**. I have no pain while walking.
- **B**. I cannot walk more than one mile without increasing pain.
- **C**. I cannot walk more than ½ mile without increasing pain.
- **D**. I cannot walk more than ¼ mile without increasing pain.
- **E**. I can walk with crutches.
- **F**. I cannot walk at all without increasing pain.

Section 5 Sitting

- **A**. I can sit in any chair as long as I like.
- **B**. I can only sit in my favorite chair as long as I like.
- **C**. Pain prevents me from sitting more than one hour.
- **D**. Pain prevents me from sitting more than a half hour.
- **E**. Pain prevents me from sitting more than 10 minutes.
- **F**. I avoid sitting because it increases pain straight away.

Section 6 Standing

- **A**. I can stand as long as I want without pain.
- **B**. I have some pain on 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 a ½ hour without increasing pain.
- **E**. I can't stand for longer than 10 minutes without increasing pain.
- **F**. I avoid standing because it increases the pain straight away.

Section 7 Sleeping

- **A**. I get no pain in bed.
- **B**. I get pain in bed but it doesn't prevent me from sleeping well.
- **C**. Because of pain my normal night's sleep is reduced by < 1/4.
- **D**. Because of pain my normal night's sleep is reduced by < 1/2.
- **E**. Because of pain my normal night's sleep is reduced by < 3/4.
- **F**. Pain prevents me from sleeping at all.

Section 8 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 9 Social life

- **A**. My social life is normal and gives me no pain.
- **B**. My social life is normal but increases the degree of pain.
- **C**. Pain limits 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.
- **F**. I have hardly any social life because of the pain.

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.

ANSWER BELOW *ONLY* FOR *UPPER* EXTREMITY(SHOULDER/ARM/HAND) COMPLAINTS:

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

ANSWER BELOW *ONLY* FOR *LOWER* EXTREMITY (HIP, KNEE, LEG, FOOT) COMPLAINTS:

Today, *do you* or *would you* have any difficulty at all with:

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1. Any of your usual work, housework or school activities.	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3. Getting into or out of the bath.	0	1	2	3	4
4. Walking between rooms.	0	1	2	3	4
5. Putting on your shoes or socks.	0	1	2	3	4
6. Squatting.	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8. Performing light activities around your home.	0	1	2	3	4
9. Performing heavy activities around your home.	0	1	2	3	4
10. Getting into or out of a car.	0	1	2	3	4
11. Walking 2 blocks.	0	1	2	3	4
12. Walking a mile.	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14. Standing for 1 hour.	0	1	2	3	4
15. Sitting for 1 hour.	0	1	2	3	4
16. Running on even ground.	0	1	2	3	4
17. Running on uneven ground.	0	1	2	3	4
18. Making sharp turns while running fast.	0	1	2	3	4
19. Hopping.	0	1	2	3	4
20. Rolling over in bed.	0	1	2	3	4
Column Totals:					