

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%) Occasionally (26-49%) Intermittently (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%: _____ %

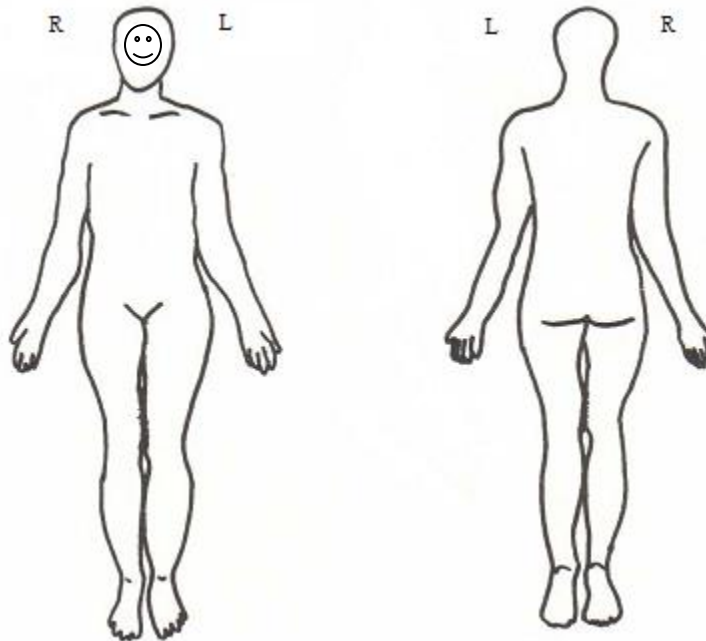
INITIALS: _____ DATE: _____

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*

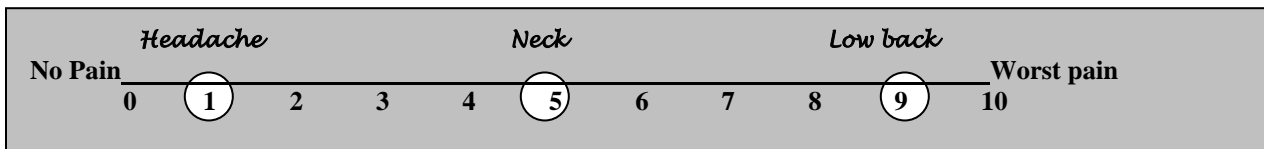
KEY:	
Numbness / Tingling	=====
Pins & Needles	oooooooo
Burning pain	xxxxxxxx
Dull / Achy pain
Sharp / Stabbing pain	////////////////



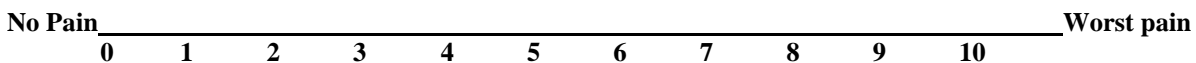
VISUAL PAIN SCALE

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.*

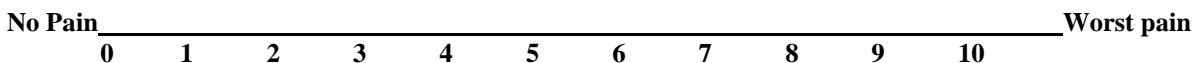
Example:



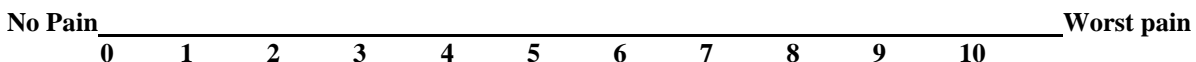
What is your pain RIGHT NOW?



What is your pain at its BEST?



What is your pain at its WORST?



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.

<p>Section 1 Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I have no pain at the moment. <input type="checkbox"/> B. The pain is very mild at the moment. <input type="checkbox"/> C. The pain is moderate at the moment. <input type="checkbox"/> D. The pain is fairly severe at the moment. <input type="checkbox"/> E. The pain is very severe at the moment. <input type="checkbox"/> F. The pain is the worst imaginable at the moment. 	<p>Section 6 Concentration</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I can concentrate fully when I want with no difficulty. <input type="checkbox"/> B. I can concentrate fully when I want with slight difficulty. <input type="checkbox"/> C. I have a fair degree of difficulty in concentrating when I want. <input type="checkbox"/> D. I have a lot of difficulty in concentrating when I want. <input type="checkbox"/> E. I have a great degree of difficulty in concentrating when I want. <input type="checkbox"/> F. I cannot concentrate at all.
<p>Section 2 Personal Care</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I can look after myself normally without causing extra pain. <input type="checkbox"/> B. I can look after myself normally but it causes extra pain. <input type="checkbox"/> C. It is painful to look after myself and I am slow and careful. <input type="checkbox"/> D. I need some help but manage most of my personal care. <input type="checkbox"/> E. I need help every day in most aspects of self care. <input type="checkbox"/> F. I do not get dressed, I wash with difficulty and stay in bed. 	<p>Section 7 Work</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I can do as much work as I want. <input type="checkbox"/> B. I can only do my usual work, but no more. <input type="checkbox"/> C. I can do most of my usual work, but no more. <input type="checkbox"/> D. I can hardly do any work at all. <input type="checkbox"/> E. I cannot do my usual work. <input type="checkbox"/> F. I can't do any work at all.
<p>Section 3 Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I can lift heavy weight without extra pain. <input type="checkbox"/> B. I can lift heavy weight but it gives extra pain. <input type="checkbox"/> C. Pain prevents me from lifting heavy weights off the floor, but I can manage it they are conveniently positioned. <input type="checkbox"/> D. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned. <input type="checkbox"/> E. I can lift very light weights. <input type="checkbox"/> F. I cannot lift or carry anything at all. 	<p>Section 8 Driving</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I can drive my car without any neck pain. <input type="checkbox"/> B. I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> C. I can drive my car as long as I want with moderate pain. <input type="checkbox"/> D. I can't drive my car as long as I want because of moderate pain. <input type="checkbox"/> E. I can hardly drive at all because of severe pain in my neck. <input type="checkbox"/> F. I can't drive my car at all.
<p>Section 4 Reading</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I can read as much as I want with no pain in my neck <input type="checkbox"/> B. I can read as much as I want with slight pain in my neck. <input type="checkbox"/> C. I can read as much as I want with moderate pain in my neck. <input type="checkbox"/> D. I can't read as much because of moderate pain in my neck. <input type="checkbox"/> E. I can hardly read at all because of severe pain in my neck. <input type="checkbox"/> F. I cannot read at all. 	<p>Section 9 Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I have no trouble sleeping. <input type="checkbox"/> B. My sleep is slightly disturbed (less than 1hr. sleepless). <input type="checkbox"/> C. My sleep is mildly disturbed (1-2 hrs. sleepless). <input type="checkbox"/> D. My sleep is moderately disturbed (2-3 hrs. sleepless). <input type="checkbox"/> E. My sleep is greatly disturbed (3-5 hrs. sleepless). <input type="checkbox"/> F. My sleep is completely disturbed (5-7 hrs. sleepless).
<p>Section 5 Headaches</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I have no headaches at all. <input type="checkbox"/> B. I have slight headaches which come infrequently. <input type="checkbox"/> C. I have moderate headaches which come infrequently. <input type="checkbox"/> D. I have moderate headaches which come frequently. <input type="checkbox"/> E. I have severe headaches which come frequently. <input type="checkbox"/> F. I have headaches almost all of the time. 	<p>Section 10 Recreation</p> <ul style="list-style-type: none"> <input type="checkbox"/> A. I am able to engage in all recreational activities with no neck pain. <input type="checkbox"/> B. I am able to engage in all my recreational activities, with some pain in my neck. <input type="checkbox"/> C. I am able to engage in most, but not all of my usual recreational activities because of my neck pain. <input type="checkbox"/> D. I am able to engage in a few of my usual recreational activities because of my neck pain. <input type="checkbox"/> E. I can hardly do any recreational activities because of pain. <input type="checkbox"/> 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 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 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 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 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 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 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 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 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 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:

QuickDASH

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

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

A QuickDASH score may not 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:					