chiropractic

remove obstacles • restore function • improve performance • maximize potential

Patient Registration

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id | date

1 PATIENT CONTACT

last name	first name	m.i.
preferred to be called		
street		
city	state	zip
home phone	mobile phone	
work phone	e-mail	

2 PATIENT PERSONAL

age	date of birth	social security #	sex ☐ male	☐ female

status ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

3 EMERGENCY CONTACT

name	home phone
relationship	work phone

4 SPOUSE OR GUARDIAN

last name	first name	m.i.
employer name		
work phone	date of birth	social security #

5 PATIENT EMPLOYMENT

employer name	occupation
street	
city	state	zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost

patient or guardian signature

date

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Patient Case History

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you.
We want your visit with us to be comfortable, helpful, and educational.

confidential health information

clinic id | date

1 PATIENT INFORMATION

last name | first name | m.i.

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐ yes ☐ no

What services interest you? (mark all that apply)

- ☐ injury prevention
- ☐ balance and coordination training
- ☐ range of motion, mobility, or flexibility therapy
- ☐ treatment for pain
- ☐ spinal and body alignment
- ☐ strengthening and stamina exercise
- ☐ patient education classes
- ☐ body composition counseling
- ☐ nutritional and supplement counseling
- ☐ other: _____

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ cold

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1	2	3	4	5	6	7	8	9	10
no pain or discomfort	slight discomfort	pain that does not affect my activity	pain that affects my daily activities	pain that prevents performing my daily activities	pain that limits my work schedule	pain that prevents working at all	pain that prevents working and all personal activity	pain that keeps me bed ridden	pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

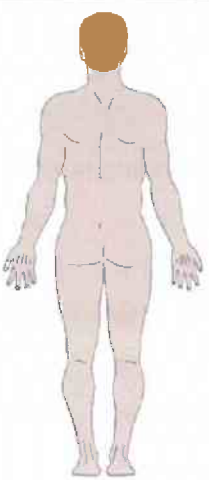
List other health complaints (2-5) on the following lines.

2 _____ 4 _____

3 _____ 5 _____

Do you have any other condition other than what brings you here? ☐ yes ☐ no
If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.



3 LIFESTYLES & HABITS

patient name

How many hours of television do you watch a day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

Do you usually snack while watching television? ☐ yes ☐ no

How many hours per day do you use a computer at work or home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How often do you exercise? ☐ daily ☐ 3x's/week ☐ 2x's/week ☐ 1x/week ☐ I don't exercise

How long do your exercise work outs last? ☐ >1 hour ☐ 1 hour ☐ 30 minutes ☐ < 30 minutes ☐ NA

What are your exercise activities? (mark all that apply) ☐ I don't exercise

☐ walking ☐ swimming ☐ weight lifting

☐ stretching/flexibility ☐ yoga/Pilates ☐ resistance bands

☐ running/treadmill/rowing/climbing ☐ group exercise classes ☐ other_____

Do you take a multi-vitamin? ☐ yes ☐ no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

How often do you use tobacco? ☐ never ☐ daily ☐ weekly ☐ monthly ☐ yearly

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
heart problems	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
kidney problems	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
cancer	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
headaches	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
back pain	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
obesity	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister
poor conditioning	☐n ☐p ☐c mother	☐n ☐p ☐c father	☐n ☐p ☐c brother	☐n ☐p ☐c sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	☐ yes ☐ no	epilepsy	☐ yes ☐ no	low back pain	☐ yes ☐ no	polio	☐ yes ☐ no
anemia	☐ yes ☐ no	goiter	☐ yes ☐ no	measles	☐ yes ☐ no	rheumatic fever	☐ yes ☐ no
appendicitis	☐ yes ☐ no	heart disease	☐ yes ☐ no	mental disorder	☐ yes ☐ no	tuberculosis	☐ yes ☐ no
arthritis	☐ yes ☐ no	HIV positive	☐ yes ☐ no	mumps	☐ yes ☐ no	venereal infection	☐ yes ☐ no
cancer	☐ yes ☐ no	influenza	☐ yes ☐ no	pleurisy	☐ yes ☐ no	whiplash	☐ yes ☐ no
				pneumonia	☐ yes ☐ no	whooping cough	☐ yes ☐ no

6 INJURIES

patient name

List any auto collisions that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any job injuries that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any sports injuries that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any other injuries caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

7 HOSPITAL / MEDICINE

Have you had breast implant surgery? ☐ yes ☐ no

Have you had knee or hip replacement surgery? ☐ yes ☐ no

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical devices in your body? ☐ yes ☐ no

Mark all of the following procedures as they pertain to you.

vaccinations	☐ yes	☐ no	tubes in ears	☐ yes	☐ no	rectal surgery	☐ yes ☐ no
tonsillectomy	☐ yes	☐ no	appendectomy	☐ yes	☐ no	sinus surgery	☐ yes ☐ no
gall bladder removal	☐ yes	☐ no	female/male surgery	☐ yes	☐ no	hernia surgery	☐ yes ☐ no
back surgery	☐ yes	☐ no	_____			thyroid surgery	☐ yes ☐ no
						stomach surgery	☐ yes ☐ no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? ☐ yes ☐ no Were you ever knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no

8 SYSTEM REVIEW

patient name

Mark the following conditions that are **currently** a cause of significant concern for you.

General

☐	consistent fainting	☐	chills	☐	convulsions	☐	depression	☐	dizziness
☐	loss of weight	☐	fatigue	☐	fever	☐	headache	☐	loss of sleep
☐	weight gain	☐	neuralgia	☐	night sweats	☐	wheezing	☐	nervousness

Gastro-Intestinal

☐	constipation	☐	diarrhea	☐	gall bladder problems	☐	hemorrhoids	☐	jaundice
☐	liver problems	☐	nausea	☐	stomach pain	☐	poor appetite	☐	poor digestion
☐	rectal bleeding	☐	vomiting	☐	vomiting blood				

Eye/Ear/Nose/Throat

☐	asthma	☐	crossed eyes	☐	deafness	☐	earache	☐	ear discharge
☐	ear noises	☐	enlarged thyroid	☐	frequent colds	☐	hay fever	☐	hoarseness
☐	nasal obstruction	☐	nose bleeds	☐	pain in eyes	☐	poor vision	☐	sinusitis
☐	sore throat	☐	tonsillitis						

Respiratory

☐	chest pain	☐	chronic cough	☐	difficulty breathing	☐	spitting blood	☐	spitting phlegm

Muscles/Joints/Bones

☐	backache	☐	foot problems	☐	pain bet. shoulders	☐	painful tailbone	☐	stiff neck
☐	spinal curvature	☐	swollen joints	☐	tremors	☐	twitching	☐	weakness

Cardio-Vascular

☐	ankle swelling	☐	high blood pressure	☐	low blood pressure	☐	heart trouble	☐	pain over heart
☐	poor circulation	☐	rapid heart	☐	slow heart	☐	strokes		

Skin or Allergies

☐	bruise easily	☐	dryness	☐	eczema	☐	hives	☐	itching
☐	sensitive skin								

Women

☐	cramps	☐	excessive flow	☐	hot flashes	☐	irregular cycle	☐	painful periods

9 PREGNANCY — WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant? ☐ yes ☐ no

On what date did your last period begin?

Do you want to take a pregnancy test now? ☐ yes ☐ no

OFFICE USE ONLY
result of clinic pregnancy test: + -

Mark the following situations as they pertain to you.

tubal ligation	☐ yes ☐ no	complete or partial hysterectomy	☐ yes ☐ no	partner had a vasectomy	☐ yes ☐ no
less than 10 days since the start of my last period	☐ yes ☐ no	taking birth control pills	☐ yes ☐ no		

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

X _____
patient or guardian signature

X _____
date

QUADRUPLE VISUAL ANALOGUE SCALE

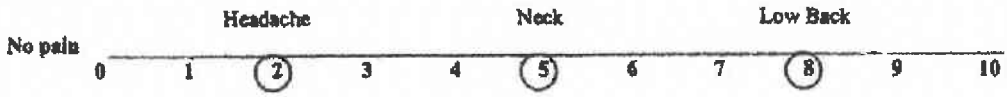
Patient Name _____ Date _____

Please read carefully:

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 the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



1 – What is your pain RIGHT NOW?

2 – What is your TYPICAL or AVERAGE pain?

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____ Date _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE*** *which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just* ***mark the one box which most closely describes your problem right now.***

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 severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned–eg, on a table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

_____

_____

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, 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 9 – 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 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 at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

_____
Examiner

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name _____ Date _____

Please read carefully:

*This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just **mark the one box which most closely describes your problem right now.***

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 (washing, dressing, etc.)

A. I can look after myself 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, wash with difficulty and stay in bed.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to 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 cannot read as much as I want 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 the time.

SECTION 6 – Concentration

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

SECTION 7 – Work

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

SECTION 8 – Driving

A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. 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 my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

OTHER COMMENTS:

_____

_____

_____

_____
Examiner