Case History

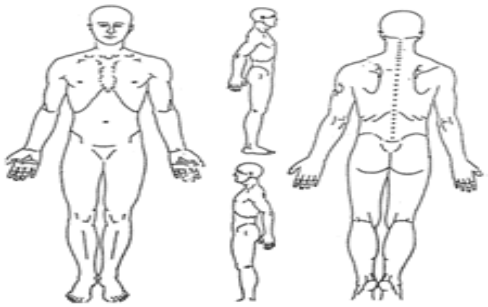
Name:_____

Is this due to ___Auto ___Work ___Other (Specify)_____

1. Circle the severity (0 = No pain to 10 + very severe pain) and Frequency of pain (% of the week you experience the pain).

Condition/Problem	**Severity**		**Frequency (% of week)**	
	Minimal	Severe	Occasional	Constant
A._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	
B._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	
C._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	
D._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	
E._____	0 1 2 3 4 5 6 7 8 9 10		0 10 20 30 40 50 60 70 80 90 100	

(Please mark the figures where you experience pain.)



2. Symptoms are **WORSE** in the (circle what applies)
   - Morning
   - Afternoon
   - Night
   - Increase during the day
   - Same all day
   - Decrease during the day

3. **Symptoms (A)** are: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. **Symptoms (B)** are: Sharp / Dull/ Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. **Symptoms (C)** are: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
6. **Symptoms (D)** are: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
7. **Symptoms (E)** are: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
8. When did your symptoms begin? (OnesetDate?)_____
9. How did your symptoms begin?_____
10. Have you experienced these before?_____
11. Do your symptoms radiate?_____
12. Has your condition? _____Improved _____Gotten Worse _____ Stayed the same since it began
13. Circle the things that make your problem worse:
    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
14. Is there anything you can do to relieve the problems? ____No ____ Yes Describe_____
    If No, what have you tried that has not helped?_____
15. Have you been treated for this before? ____No ____Yes. How long ago & if Yes, what care did you receive?_____
16. Results of pervious treatment? ____Good ____Poor Comments_____
17. Is this condition interfering with ____Work ____Sleep ____Daily Routine ____Recreation

I certify that the above information is accurate to the best of my knowledge

Patient/Guardian Signature_____ Date:_____

Chiropractic Case History/Patient Information

Name_____ Social Security #_____ Home Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Fax #_____ Cell Phone:_____ Age:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address: _____

Office Phone:_____ Days lost from work due to complaint:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____ Names and Ages of children:_____

Name of nearest relative:_____ Address:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____ Date of last Physical examination :_____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor of chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, health care operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information_____

_____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care:_____ Date:_____

PERSONAL & FAMILY HISTORY

Please review the below listed diseases/conditions and indicate those that are **CURRENT** and **PAST** personal and familial health problems. Check only those conditions that apply to you or your family, leave other's blank.

Condition/Symptoms	YOU	FATHER	MOTHER	SPOUSE	BROTHER(S)	SISTER(S)	CHILDREN
AIDS/HIV							
Alzheimer's							
Anemia							
Anorexia/Bulimia							
Arthritis							
Asthma							
Cancer							
Chest pains/tightness							
Crohn's Disease							
Constipation/Diarrhea							
Depression							
Diabetes							
Digestive Issues							
Emphysema							
Epilepsy							
Gallbladder problems							
Heart disease							
Hepatitis							
Herniated Disc							
High Blood Pressure							
High Cholesterol							
Insomnia							
Kidney Disease							
Liver Disease							
Migraine Headaches							
Miscarriage							
Natural Labor							
Osteoporosis							
Pacemaker							
Parkinson's Disease							
Pinched Nerve							
Pneumonia							
Polio							
Prostate Problems							
Scoliosis							
Shortness of Breath							
Stroke							
Thyroid Problems							
Ulcerative Colitis							
Unexplained Weight loss/gain							
Urinary Incontinence							

If any of the above family members are deceased, please list their age at death and cause:

_____

_____

_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

	Often	Sometimes	Never
Exercise			
Alcohol use			
Drug use			
Tobacco Use (Packs/day)			
Caffeine (# of cups/day)			
Sexual Activity			
High stress activity			
Family Pressures			
Financial Pressures			

Allergies/Sensitivities

Please check **all** that apply:

- ☐ Animal Dander/Fur
- ☐ Dairy
- ☐ Dust
- ☐ Latex
- ☐ Nuts
- ☐ Pollen
- ☐ Seafood
- ☐ Tape or Adhesive
- ☐ Therapeutic Cold/Heat Sensitivities
- ☐ Wheat
- ☐ Other (Specify):

_____

_____

Accidents/Surgeries

Please List ALL accidents you have been involved in throughout your life.
(Accidents includes falls, motor-vehicle, sports related injuries, fractures, ect.)

_____

_____

Please List ALL surgeries you have had throughout your life.

_____

_____

Do you have any other congenital condition? _____ Yes _____ No

If so please describe: _____

WOMEN ONLY:

Please include information about childbirth (including dates):

_____

_____

Are you **OR** could you be pregnant? _____ If so how many months? _____

Date of last menstrual cycle? _____

I certify that the information provided is accurate to the best of my knowledge:

Name of patient: _____

Signature of Patient/legal guardian: _____ Date: _____

Red Flag Questionnaire

Name: _____ Date: _____ Age: _____

Please check the appropriate response. If “yes”, please explain. If you are not sure, check the “?” box.

No	Yes	?	
☐	☐	☐	Do you have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Does your pain improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)/?
☐	☐	☐	Have you had spinal pain greater than 4 weeks?

No	Yes	?	
☐	☐	☐	Prolonged use of corticosteroids (such as organ transplant Rx)?
☐	☐	☐	Intravenous drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract, or other infection?
☐	☐	☐	Immunosuppression medication &/or condition?

No	Yes	?	
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person >50 years old?
☐	☐	☐	Do you have osteoporosisn (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Any history of prolonged use of corticosteroids?

No	Yes	?	
☐	☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear)?
☐	☐	☐	Loss of anal sphincter tone of fecal incontinence (bowel accidents)?
☐	☐	☐	Saddle anesthesia (numbness in the groin region)?
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)?

Comments:_____

_____

_____

_____

_____

_____

REVISED OSWESTRY DISABILITY

Name _____ Date____/____/_____ File #_____

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4- Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not, increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain immediatley.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal nights sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Form by N. Hudson- Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR. Eds. Back Pain.
Manchester University Press 1989: 187-204

NECK DISABILITY INDEX

Name_____ Date_____/_____/_____ File #_____
(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing etc.)

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

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are coveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

From Vernon H, Mior S. JMPT 1991; 14(7): 409-415

SECTION 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7- Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr.sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs.sleepless.).
- ☐ My sleep is moderately disturbed (2-3 hrs.sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs.sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs.sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.