**Patient Information**

Name _____ Age _____ Gender: M F (Pregnant: Yes No)

Home Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

Email Address _____

Birth date _____ Social Security Number _____ Marital Status: S M D W P

Occupation, Employer _____

Emergency Contact _____ Phone _____

How were you referred to this office? _____

Who is your Primary Care Doctor? _____

**Is This Visit Related To A:** Work Injury Car Collision Injury Home Injury Non-Injury Symptoms Other

**Experience with Chiropractic**

Have you seen a Chiropractor before? ☐Yes ☐No Who? _____

Reason for visit(s) with previous provider: _____

Did your previous provider take x-rays? ☐Yes ☐No What was the diagnosis? _____

Did they recommend a specific course of treatment? ☐Yes ☐No

Did they recommend a home health care program? ☐Yes ☐No If yes, what? _____

How long were you treated? _____ Last treatment date: _____

How did you respond? _____

**Health & Lifestyle**

Do you exercise? ☐Yes ☐No How often? _____ day(s) per week; Other: _____

What are your current Hobbies? _____

Do you smoke? ☐Yes ☐No How much/how often? _____

Do you drink alcohol? ☐Yes ☐ No How much/how often? _____

Do you drink coffee? ☐Yes ☐No How much/how often?_____

How much water do you drink daily? _____ cups (1 cup = 8oz)

Do you take supplements? ☐Yes ☐No Please list: _____

Do you sleep on your: □ Back □ Side □ Stomach

**Health History**

Have any of your family members even been diagnosed with the following?

| | | | | |
|---|---|---|---|---|
| ___ Diabetes | ___ Varicose Veins | ___ Neurological Problems | ___ Lung Disease | ___ Lumbago |
| ___ Rheumatic fever | ___Circulatory Problems | ___ Migraine Headaches | ___ Heat Murmur | ___ Eczema/Psoriasis |
| ___ High Blood Pressure | ___Heart Disease | ___ Cancer | ___ Osteoporosis | ___ Epilepsy/Seizures |
| ___ Kidney Disease | ___ Paralysis | ___ Arthritis | ___ Stroke | ___ Small Pox |
| ___ Liver Disease | ___ Metal Implants | ___ Infectious Disease | ___ Gall Bladder | ___ Measles |
| ___ Broken Bones/Fractures | ___ Appendectomy | ___ Tonsillectomy | ___ Hernia | ___Pleurisy |
| ___ Pneumonia/Bronchitis | ___ Polio | ___ Tuberculosis | ___ Anemia | ___ Mumps |
| ___ Whooping Cough | ___ Chicken Pox/Shingles | ___ Blood Sugar Problems | ___ Influenza | ___Thyroid Problems |

___ Other: _____

List ALL past auto collisions: _____ Was care given? _____

_____

_____

List any past work injuries: _____ Was care given? _____

List any past sport/recreational/home injuries: _____

Please list any hospitalizations and surgeries in the past 3 years: _____

Please list all medications you are currently taking:_____

**1. Injury Information**

| | |
|---|---|
| Date of Injury | Date: Time: |
| Name of Employer at Time of Injury | |
| Address of Employer | |
| Job Title | Title: Length of time employed (months/yrs) |

| | |
|---|---|
| Have you notified your employer about your injury? | Yes □ □ No |
| Has your employer notified their workers' compensation insurance carrier? | Yes □ □ No |
| Have you filled out an injured worker's claim form? | Yes □ □ No |
| Do you have an attorney representing you for this work-related injury? | Yes □ □ No |
| If yes, provide name/address/telephone: | |
| Have you missed any time off work? | Yes □ □ No |
| If yes, please indicate the dates you have been off work: From: _____ To: _____ | |
| What is your job description? | |
| How many hours did you work in a typical day? | |
| How many hours did you work in a typical week? | |

**2. Worker's Compensation Insurance Information**

| | |
|---|---|
| Name of Insurance Carrier | |
| Address of Insurance Carrier | |
| Claims Adjusters Information | Name: Telephone: |
| Claim Number | |

| **3. Job Duties at Time of Injury** (Check column that applies to the frequency of a specific activity at your job) | **Never** (0 Hours) | **Occasionally** (1-15x/hr) (Up to 3 hrs) | | **Frequently** (16-60 x/hr) (3-6 hrs a day) | | **Constant** (More than 60 x/hr) (6-8 hrs a day) | |
|---|---|---|---|---|---|---|---|
| Bending head and neck | | | | | | | |
| Twisting head and neck | | | | | | | |
| Bending Waist | | | | | | | |
| Twisting Waist | | | | | | | |
| Lifting less than 25 pounds | | | | | | | |
| Lifting heavier than 25 pounds | | | | | | | |
| Bending while lifting | | | | | | | |
| Reaching above the level of your head | | | | | | | |
| Reaching above the level of your shoulder | | | | | | | |
| Carrying objects in hand | | | | | | | |
| Gripping or fingering objects left hand | | | | | | | |
| Gripping or fingering objects right hand | | | | | | | |
| Fine movement with fingers | | | | | | | |
| Handwriting | | | | | | | |
| Pushing and pulling with left hand | | | | | | | |
| Pushing and pulling with right hand | | | | | | | |
| Keyboarding on computer | | | | | | | |
| Heavy or power use of hands | | | | | | | |
| Crawling | | | | | | | |
| Crouching or squatting | | | | | | | |
| Walking | | | | | | | |
| Kneeling | | | | | | | |
| Standing | | | | | | | |
| Climbing | | | | | | | |
| Sitting while driving a vehicle | | | | | | | |
| Sitting (other than driving) | | | | | | | |

**4. Symptom Information**

**Did anyone Witness?**

□ Co-Worker □ _____

□ Supervisor □ _____

**When did you first notice pain or symptoms?**

□ Immediately □ Within 24 Hours

□ Within 1-7 Days □ Other

**Was any part of your head hit?**

| | |
|---|---|
| Forehead | Yes □ □ No |
| Back of head | Yes □ □ No |
| Left side of head | Yes □ □ No |
| Right Side of head | Yes □ □ No |
| Top of head | Yes □ □ No |

Other: _____

| | |
|---|---|
| Did you lose consciousness? | Yes □ □ No |
| Did you black out? | Yes □ □ No |
| Have you lost any memories prior to your injury? | Yes □ □ No |
| Immediately after did you feel an altered state of awareness, dazed, confused, shock, or anger? | Yes □ □ No |
| Has your memory been different since your injury? | Yes □ □ No |
| Did you have a lump or bruise on a part of your head? | Yes □ □ No |
| Have you had any head injuries in your past? | Yes □ □ No |

Please Explain:

**Where did you go after the accident?**

□ Home □ Work □ ER □ Private Doctor

**How did you get there?**

□ Drove Self □ Police □ Ambulance □ Somebody Else

**Were XRAYS taken? Yes □ □ No** **Was lab work done? Yes □ □ No**

**Body parts XRAYed? _____**

**What lab work? _____**

**The XRAYS revealed: _____**

**Did you have an MRI or CT Scan?** Yes □ □ No

**Treatments: □ Cervical Collar □ Ice □ Other: _____**

**Medications: _____**

**Follow-Up Instructions: _____**

**Check off your symptoms right after and a few days following:**

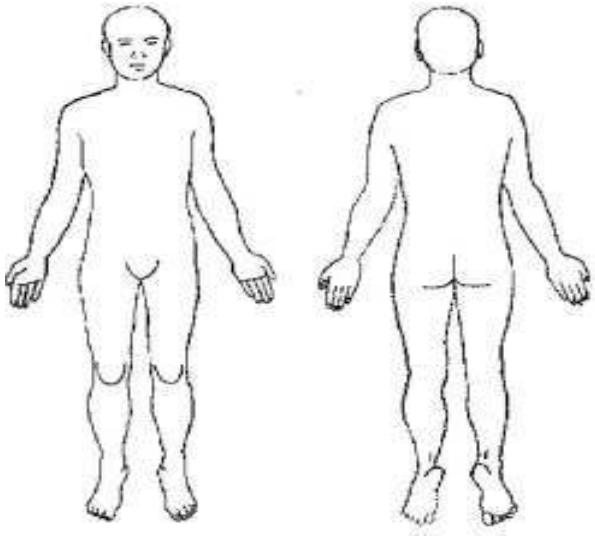
| | | |
|---|---|---|
| □ Headaches | □ Dizziness | □ Loss of Concentration |
| □ Neck pain | □ Nausea | □ Reduce3d Drive/Motivation |
| □ Neck Stiffness | □ Confusion | □ Reduced Tolerance to Alcohol |
| □ Fainting | □ Fatigue | □ Absence of ability to Anticipate |
| □ Ringing in Ears | □ Tension | □ Difficulty Finishing Task |
| □ Loss of Smell | □ Irritability | □ Abnormal Levels of Anxiety |
| □ Poor Memory | □ Inflexibility | □ Impaired Sexual Function |
| □ More Assertive | □ LanguageDifficulty | □ Difficulty handling multiple tasks |
| □ Forgetful | □ Personal Change | □ Less Diplomatic than Normal |
| □ Anger Outbursts | □ Head Tremors | □ Reduced Attention Span |
| □ Depression | □ Mood Swings | □ Indefference to other People |
| □ Mid Back Pain | □ Cold Hands | □ More Shallow Relationships |
| □ Low Back Pain | □ Cold Feet | □ Difficulty with Problem Solving |
| □ Nervousness | □ Diarrhea | □ Less Mental Stamina |
| □ Loss of Taste | □ Depression | □ Performance Inconsistencies |
| □ Toe Numbness | □ Anxious | □ Verbal Learning Problems |
| □ Constipation | □ Chest Pain | □ Slower Reaction Times |
| □ Fatigue | □ Impaired Judgement | □ Sleeping Problems |
| □ Blackouts | □ Blurry Vision | □ Shortness of Breath |
| □ Loss of Balance | | □ Need Reminders |
| □ Pain behind eyes | | |
| □ Others: _____ | | |

**5. Please describe, to the best of your knowledge, exactly what happened minutes before your injury until you arrived home. Including body positioning, surroundings, work conditions, who helped, etc.**

Please draw a picture of the surroundings as it applies to your injury.

On the picture below, use the **indicated marks** to show areas where you have, at any time, experienced:

| **Indicator Marks:** | |
|---|---|
| **Pain:** | **XXXX** |
| **Numbness:** | **////** |
| **Tingling:** | ******** |



**6. Description of Symptoms**

## Please indicate your pain from 0-10; with 10 being the worst pain and 0 being no pain. Circle all that Apply

### Cervical (Neck) ____/10

Is the pain on the: **Left** **Right** **Center**

| **Type of Pain:** | Burning | Numbness |
|---|---|---|
| Stabbing | Dull | Sharp |
| Throbbing | Tight | Aching |
| Tingling | Tender | |

**How Often is Pain during Waking Hours?**

Intermittent (0-25%)

Occasional (26-50%)

Frequent (51-75%)

Constant (76-100%)

Are you experiencing Headaches? Yes □ □ No

Are you experiencing pain down your arms? Yes □ □ No

If yes, Left Arm or Right Arm or Both

### Thoracic (Mid-Back) ___/10

Is the pain on the: **Left** **Right** **Center**

| **Type of Pain:** | Burning | Numbness |
|---|---|---|
| Stabbing | Dull | Sharp |
| Throbbing | Tight | Aching |
| Tingling | Tender | |

**How Often is Pain during Waking Hours?**

Intermittent (0-25%)

Occasional (26-50%)

Frequent (51-75%)

Constant (76-100%)

### Lumbar (Low-Back) ___/10

Is the pain on the: **Left** **Right** **Center**

| **Type of Pain:** | Burning | Numbness |
|---|---|---|
| Stabbing | Dull | Sharp |
| Throbbing | Tight | Aching |
| Tingling | Tender | |

**How Often is Pain during Waking Hours?**

Intermittent (0-25%)

Occasional (26-50%)

Frequent (51-75%)

Constant (76-100%)

Do you have pain with coughing, sneezing or going to the bathroom? Yes □ □ No

Do you have pain in butt or down the leg? Yes □ □ No

**Please Indicate Right or Left by Circling R or L**

**List of Extremities:**

| | | |
|---|---|---|
| Shoulder | TMJ/Jaw | Knee |
| Elbow | Ribs | Ankle |
| Wrist | Hand | Foot |

**Please indicate Right or Left by Circling R or L**

Extremity: **R** **L**_____ ___/10

| **Type of Pain:** | Burning | Numbness |
|---|---|---|
| Stabbing | Dull | Sharp |
| Throbbing | Tight | Aching |
| Tingling | Tender | |

**How Often is Pain during Waking Hours?**

Intermittent (0-25%)

Occasional (26-50%)

Frequent (51-75%)

Constant (76-100%)

Extremity: **R** **L**_____ ___/10

| **Type of Pain:** | Burning | Numbness |
|---|---|---|
| Stabbing | Dull | Sharp |
| Throbbing | Tight | Aching |
| Tingling | Tender | |

**How Often is Pain during Waking Hours?**

Intermittent (0-25%)

Occasional (26-50%)

Frequent (51-75%)

Constant (76-100%)

**7. Overall Condition**

What time of Day is your pain the worst?

□ All Day □ Morning □ Mid-Day □ Evening

What CAN'T you do since your injury? (Hobbies, Work, house duties, play w kids, etc.)

What activities/duties cause pain? (Standing, sitting, working, house chores, hobbies, etc.)

What makes your conidition better?

□ Ice □ Heat □ Stretching □ Medication □ Rest
□ Massage □ Chiropractic □ Physical Therapy
□ Other:

How is your pain compared to when the pain episode first started?

□ Much Improved
□ A Little Worse
□ Somewhat Improved
□ Much Worse
□ No Change

Please Describe:

**Please mark each that apply to your Daily Activities**

□ Stays at home most of the time due to the problem
□ Changes position frequently to try and get comfortable
□ Walks more slowly than usual because of the problem
□ Does not do jobs about the house because of the problem
□ Has to use handrails to get up the stairs
□ Has to lie down and rest frequently due to the problem
□ Has to hold onto something to sit or stand from a chair
□ Has to get other people to do things for you
□ Has difficulty getting dressed due to the problem
□ Can only stand for short periods due to the problem
□ Has difficulty bending or kneeling due to the problem
□ Has difficulty turning over in bed due to the problem
□ Has a loss of appetite due to the problem
□ Can only walk short distances because of the problem
□ Has difficulty sleeping because of the problem
□ Has to get dressed with someone's help
□ Has to sit most of the day because of the problem
□ Has become more irritable because of the problem
□ Stays in bed most of the day because of the problem

**How often do you have to stop activities and sit or lie down to control your pain?**

□ All Day □ Several times a day □ Approx Once per day
□ Occasionally □ Never

Other Information regarding this injury:

**8. Prior Symptom History**

Prior Similar Symptoms

□ I have NOT had prior symptoms similar to my current complaints.
□ My current complaints DID exsist before, but have not been bothering me.
□ My current complaints ALREADY existed and were worsened.

Has your History contributed to your current symptoms?

□ My history HAS contributed to my current symptoms.
□ My history HAS NOT contributed to my current symptoms.
□ I'm NOT SURE if my history has contributed.

Patient Name: _____ Patient Signature: _____

# Pain Disability Questionnaire

Name: _____ Date: _____

Instructions: This survey asks for your views about how your pain affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by marking and "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

1. Does your pain interfere with your normal work inside and outside the home?

Work Normally Unable to work at all

2. Does your pain interfere with personal care (such as wassing, dressing, etc)?

Take care of myself completely Need help with all my personal care

3. Does your pain interfere with your traveling?

Travel anywhere I like Only travel to see Doctors

4. Does your pain affect your ability to sit or stand?

No problems Cannot do at all

5. Does your pain affect your ability to life overhead, grasp objects, or reach for things?

No problems Cannot do at all

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems Cannot do at all

7. Does your pain affect your ability to walk or run?

No problems Cannot do at all

Complete Other Side ⟶

Name: _____ Date: _____

8. Has your income declined since your pain began?

| | | | | |
|---|---|---|---|---|
| | | | | |

No Decline Lost all income

9. Do you have to take medication every day to control your pain?

| | | | | |
|---|---|---|---|---|
| | | | | |

No medication needed On pain medication throughout the day

10. Does your pain force you to see doctors much more often that before your pain began?

| | | | | |
|---|---|---|---|---|
| | | | | |

Never see doctors See doctors weekly

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

| | | | | |
|---|---|---|---|---|
| | | | | |

No problem Never see them

12. Does your pain interfere with recreational activities and hobbies that are important to you?

| | | | | |
|---|---|---|---|---|
| | | | | |

No interference Total interference

13. Do you need help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

| | | | | |
|---|---|---|---|---|
| | | | | |

Never need help Need help all the time

14. Do you now feel more depressed, tense, or anxious than before your pain began?

| | | | | |
|---|---|---|---|---|
| | | | | |

No depression/tension Severe depression/tension

15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?

| | | | | |
|---|---|---|---|---|
| | | | | |

No problems Severe Problems

---

Office Use Only

Functional: 1_____ +2_____ +3_____ +4_____ +5_____ +6 _____ +7_____ +12 _____ +13 _____ = _____

Psycholosocial: 8 _____ +9 _____ +10 _____ +11 _____ +14 _____ +15 _____ = _____

Total = _____