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MOORE CHIROPRACTIC

Chiropractic Patient Information Form

PATIENT NAME			HOME PHONE		WORK PHONE	
STREET ADDRESS			CITY		STATE ZIP	
EMAIL			CELL PHONE		BY WHOM WERE YOU REFERRED?	
BIRTHDATE	AGE	SOCIAL SECURITY #	DRIVER'S LICENSE #		HEIGHT	WEIGHT
OCCUPATION		EMPLOYER	EMPLOYER'S ADDRESS			
SPOUSE'S NAME		SPOUSE'S BIRTHDATE				
SPOUSE'S OCCUPATION		SPOUSE'S EMPLOYER				

Is illness or injury related to: ☐Work ☐Auto ☐Other

Do you have other insurance that might cover this injury/illness? ☐Yes ☐No

If yes, please list other insurance company name

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), circle the number that best reflects your condition: ↓ none . . . . . to . . . . . severe ↓	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
1 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
2 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
3 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%
4 _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-100%

For each of the reasons or conditions listed above, please mark how it happened:

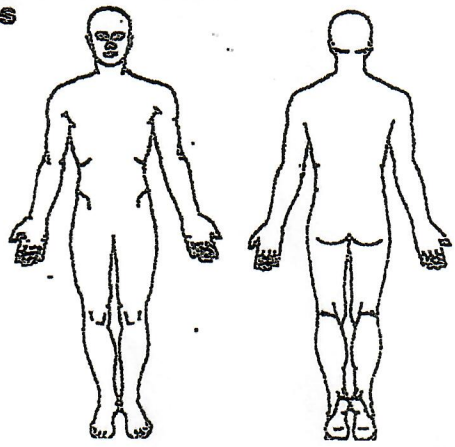
1. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
2. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
3. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know
4. ☐Developed over time ☐Illness ☐Injury ☐Auto accident ☐Other _____ ☐ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)	
	better	worse	better	worse	better	worse	better	worse	better	worse
Reason 1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____
Reason 4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ _____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/// Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Intercourse	☐	☐	☐
Computer work/typing	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐

MOORE CHIROPRACTIC

Chiropractic Patient Information Form

Please continue ...

a. During what time of the day do you feel worse? _____

b. Do you sleep well? ☐ Yes ☐ No What are your normal sleeping hours? _____ to _____

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
☐ No ☐ Yes ⇒ For what condition? _____

Name of doctor/provider _____ Phone number _____

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
☐ No ☐ Yes If yes, please describe each event below:

Event _____ Year _____

Event _____ Year _____

e. Do you exercise? ☐ Yes ☐ No If yes, please describe activity _____

How many days a week? _____ How many minutes per session? _____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ☐ Neck pain with difficulty swallowing
- ☐ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ☐ Leg pain that worsens with exercise but is relieved by resting
- ☐ Loss of feeling in inner thighs
- ☐ Back pain with urinary problems

Types of pain

- ☐ Severe pain interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ☐ Unable to balance when walking
- ☐ Recent unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Recent or current fever over 102°F
- ☐ Loss of bowel or bladder control
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Recent major accident such as a fall from height, whiplash or blow to the head
- ☐ Memory loss after injury

Previously diagnosed conditions/ medical history

- ☐ Congenital bone or joint disorder
- ☐ Rheumatoid arthritis
- ☐ Severe degenerative arthritis
- ☐ History of compression fracture
- ☐ History of heart attack
- ☐ History of stroke or aneurysm
- ☐ Past history of cancer or currently diagnosed with cancer
- ☐ Diabetes with cold, burning or numb feet
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression such as from chemotherapy, organ transplant, etc.
- ☐ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family history

☐ Autoimmune disorders ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Kidney disease ☐ Mental illness ☐ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____

Please list medications if any:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

REVISED NECK DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected you ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE 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
- **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 was 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 weights off the floor, but I can manage if they are conveniently positioned (ex: on a table)
- **D** Pain prevents me from lifting heavy weight, 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 to with no pain in my neck
- **B** I can read as much as I want to 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 cannot read as much as I want 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 work 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 my car without any neck pain
- **B** I can drive my car as long as I want with slight pian in my neck
- **C** I can drive my car as long as I want with moderate pain in my neck
- **D** I cannot drive my car 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 hour sleepless)
- **C** My sleep is mildly disturbed (1-2 hours sleepless)
- **D** My sleep is moderately disturbed (2-3 hours sleepless)
- **E** My sleep is greatly disturbed (3-5 hours sleepless)
- **F** My sleep is completely disturbed (5-7 hours sleepless)

Section 10—Recreation
- **A** I am able to engage in all of my recreational activities, with no neck pain at all
- **B** I am able to engage in all of 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 pain in my neck
- **D** I am able to engage in a few of my usual recreational activities because of pain in my neck
- **E** I can hardly do any recreational activities because of pain in my neck
- **F** I cannot do any recreational activities at all

Comments:_____

Patient Signature:_____ Date:_____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected you ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE 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 causes 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 (e.g. 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 while using a cane or on 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 from sitting more than 1 hour
- D Pain prevents me from sitting more than ½ hour
- E Pain prevents me from sitting more than 10 minutes
- F Pain prevents me from sitting at all

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 one 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 I avoid standing, because it increases the pain

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 ¼
- D Because of pain, my normal night's sleep is reduced by less than ½
- E Because of pain, my normal night's sleep is reduced by less than ¾
- 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 (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

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

Comments:_____

Patient Signature:_____ Date:_____