Full Name _____
Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell _____ Email _____
How do you prefer to be contacted? □ Text □ Home □ Cell □ Work Phone □ Email
Who can we thank for referring you to our office? _____
Age _____ Birthdate _____Marital Status _____
Primary Care Physician _____
Employer _____Type of work _____
Spouse's Full Name _____ Birthdate _____ Cell _____
Employed by _____
Emergency Contact _____ Phone _____ Relation_____

Family History, Illnesses, and Diseases (check all that apply)

	Cancer	Heart Disease	High Blood Pressure	Diabetes	Multiple Sclerosis	Stroke	Other	Living	Deceased
Mother									
Father									
Brother									
Sister									
Grandmother(s)									
Grandfather(s)									

Trauma History -- Please list all serious illnesses, accident, and/or surgeries and the year in which they occurred

_____ _____
_____ _____

Medications/dosage (A copy can be made if you need more space) **Reason for taking**

_____ _____
_____ _____
_____ _____
_____ _____

Allergies

_____

Recreational Activities
□ None
□ Walk ___ times/week
□ Run ___ times/week
□ Swim ___ times/week
□ Bike ___ times/week
□ Weights ___ times/week

Daily Job Description
□ Office
□ Standing
□ Construction
□ Heavy Labor
Hours _____

Daily Lifestyle Activities
Smoker □ Yes □ No □ Former
High stress □ Yes □ No
Reason_____
Alcohol use □ Yes □ No
□ Casual □ Moderate □ Heavy

I declare that I have examined this report to the best of my knowledge and believe it to be true, accurate, and complete.

_____ _____
(Patient Signature) (Date)

FOR OFFICE USE ONLY, DO NOT MARK BELOW
Have there been any changes since you last filled out this form at our office?
No or Yes describe_____ date _____ initial_____ Dr. Initial_____
No or Yes describe_____ date _____ initial_____ Dr. Initial_____
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No or Yes describe_____ date _____ initial_____ Dr. Initial_____
No or Yes describe_____ date _____ initial_____ Dr. Initial_____

Griesbaum Family Chiropractic, S.C.
1607 Visa Dr, Ste 1A
Normal, IL 61761

Modified Oswestry Low & Mid Back Pain Disability Questionnaire

Name_____ Date _____

Signature _____

Please Read: This questionnaire is designed to enable us to understand how much your middle and/or low back pain has affected your ability to manage your everyday activities. Please answer every section by checking ONE CHOICE that most applies to you. We realize that you may feel that two of the statements in any one section relate to you, but please check the **one choice which most closely describes your problem.**

Section 1 – Pain Intensity
(0) I can tolerate the pain I have without having to use pain medication.
(1) The pain is bad but I manage without having to take pain medication.
(2) Pain medication provides me complete relief from pain.
(3) Pain medication provides me moderate relief from pain.
(4) Pain medication provides me little relief from pain.
(5) Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)
(0) I can take care of myself normally without causing increased pain.
(1) I can take care of myself normally but it increases my pain.
(2) It is painful to take care of myself and I am slow and careful.
(3) I need help but I am able to manage most of my personal care.
(4) I need help every day in most aspects of my care.
(5) I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
(0) I can lift heavy weights without increased pain.
(1) I can lift heavy weights but it causes increased pain.
(2) Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
(3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift only very light weights.
(5) I cannot lift or carry anything at all.

Section 4 - Walking
(0) Pain does not prevent me walking any distance.
(1) Pain prevents me walking more than 1 mile.
(2) Pain prevents me walking more than ½ mile
(3) Pain prevents me walking more than ¼ mile
(4) I can only walk using crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like.
(2) Pain prevents me sitting more than 1 hour.
(3) Pain prevents me from sitting more than ½ hour.
(4) Pain prevents me from sitting more than 10 mins.
(5) Pain prevents me from sitting at all.

Score _____
For Office Use Only

Section 6 – Standing
(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want but increases my pain.
(2) Pain prevents me from standing for more than 1 hour.
(3) Pain prevents me from standing for more than ½ hour.
(4) Pain prevents me from standing for more than 10 mins.
(5) Pain prevents me from standing at all.

Section 7 – Sleeping
(0) Pain does not prevent me from sleeping well.
(1) I can sleep well only by using pain medication.
(2) Even when I take pain medication, I sleep less than 6 hours.
(3) Even when I take pain medication, I sleep less than 4 hours.
(4) Even when I take pain medication, I sleep less than 2 hours.
(5) Pain prevents me from sleeping at all

Section 8 – Social Life
(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my level of pain.
(2) Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
(3) Pain prevents me from going out very often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

Section 9 – Traveling
(0) I can travel anywhere without increased pain.
(1) I can travel anywhere but it increases my pain.
(2) Pain restricts travel over 2 hours.
(3) Pain restricts travel over 1 hour.
(4) Pain restricts my travel to short necessary journeys under ½ hour.
(5) Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking
(0) My normal homemaking/job activities do not cause pain.
(1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
(3) Pain prevents me from doing anything but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job/homemaking chores.

Griesbaum Family Chiropractic, S.C.
1607 Visa Dr, Ste 1A
Normal, IL 61761

Neck Disability Index

Patient Name _____ Date _____

Signature _____

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer every section by checking ONE CHOICE that most applies to you. We realize that you may feel that two of the statements in any one section relate to you, but please check the one choice which most closely describes your problem.

Section 1 – Pain Intensity
(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain is moderate at the moment.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc)
(0) I can look after myself without causing extra pain.
(1) I can look after myself normally but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help, but manage most of my personal care.
(4) I need help every day in most aspects of self-care.
(5) I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting
(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights, but it causes extra pain.
(2) Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
(3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
(4) I can lift very light weights.
(5) I can't lift or carry anything at all.

Section 4 – Reading
(0) I can read as much as I want to with no pain in my neck.
(1) I can read as much as I want with slight pain in my neck.
(2) I can read as much as I want with moderate pain in my neck.
(3) I can't read as much as I want because of moderate pain in my neck.
(4) I can't read as much as I want because of severe pain in my neck.
(5) I can't read at all.

Section 5 – Headache
(0) I have no headaches at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come frequently.
(5) I have headaches almost all the time.

Score _____
For Office Use Only

Section 6 – Concentration
(0) I can concentrate fully when I want to with no difficulty.
(1) I can concentrate fully when I want to with slight difficulty.
(2) I have a fair degree of difficulty in concentrating when I want to.
(3) I have a lot of difficulty in concentrating when I want to.
(4) I have a great deal of difficulty in concentrating when I want to.
(5) I can't concentrate at all.

Section 7 – Work
(0) I can do as much work as I want to.
(1) I can only do my usual work, but no more.
(2) I can do most of my usual work, but no more.
(3) I cannot do my usual work.
(4) I can hardly do any work at all.
(5) I can't do any work at all.

Section 8 – Driving
(0) I can drive my car without neck pain.
(1) I can drive my car as long as I want with slight pain in my neck.
(2) I can drive my car as long as I want with moderate pain in my neck.
(3) I can't drive my car as long as I want because of moderate pain in my neck.
(4) I can hardly drive my car at all because of severe pain in my neck.
(5) I can't drive my car at all.

Section 9- Sleeping
(0) I have no trouble sleeping.
(1) My sleep is slightly disturbed (less than 1 hour sleepless).
(2) My sleep is mildly disturbed (1-2 hours sleepless).
(3) My sleep is moderately disturbed (2-3 hours sleepless).
(4) My sleep is greatly disturbed (3-5 hours sleepless).
(5) My sleep is completely disturbed (5-7 hours sleepless).

Section 10- Recreation
(0) I am able to engage in all recreational activities with no pain in my neck at all.
(1) I am able to engage in all recreational activities with some pain in my neck.
(2) I am able to engage in most, but not all recreational activities because of pain in my neck.
(3) I am able to engage in few of my usual recreational activities because of pain in my neck.
(4) I can hardly do any recreational activities because of pain in my neck.
(5) I can't do any recreational activities at all.

Griesbaum Family Chiropractic, S.C. Name:_____ Date_____

Symptom 1: Your most painful area. (Circle only one) Neck - Upper/Mid Back - Low Back - R L Leg - R L Arm - R L Shoulder - Headache, Other_____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:

0 1 2 3 4 5 6 7 8 9 10

What percent of the time you are awake do you experience the above symptom at this intensity?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____did the symptom begin suddenly or gradually? (Circle one)

How did the symptom begin? _____

What makes the symptoms worse? (Circle all that apply)

Bending neck forward · bending neck backward · tilting head left · tilting head right · turning head left · turning head right · bending forward at waist · bending backward at waist · tilting left at waist · tilting right at waist · twisting left at waist · twisting right at waist · sitting · standing · getting up from a seated position · lifting · driving · walking · running · any movement · nothing other (please describe)_____

What makes the symptom better? (Circle all that apply)

Manipulations · rest · ice · heat · stretching · exercise · massage · pain medication · muscle relaxers · nothing other (please describe):_____

Describe the quality of the symptom (circle all that apply)

Sharp · dull · achy · burning · throbbing · piercing · stabbing · deep · nagging · shooting · stinging other (please describe):_____

Does the symptom radiate to another part of the body (circle one): Yes No

If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)

Morning · afternoon · evening · night · unaffected by the time of day

Prior treatment for this condition (circle all that apply): Chiropractic - medication - massage - physical therapy - or_____

Symptom 2: 2nd most painful area (circle only one) Neck - Upper/Mid Back - Low Back - R L Leg - R L Arm - R L Shoulder - Headache, Other_____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:

0 1 2 3 4 5 6 7 8 9 10

What percent of the time you are awake do you experience the above symptom at this intensity?

5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

When did the symptom begin? _____did the symptom begin suddenly or gradually? (Circle one)

How did the symptom begin? _____

What makes the symptoms worse? (Circle all that apply)

Bending neck forward · bending neck backward · tilting head left · tilting head right · turning head left · turning head right · bending forward at waist · bending backward at waist · tilting left at waist · tilting right at waist · twisting left at waist · twisting right at waist · sitting · standing · getting up from a seated position · lifting · driving · walking · running · any movement · nothing other (please describe)_____

What makes the symptom better? (Circle all that apply)

Manipulations · rest · ice · heat · stretching · exercise · massage · pain medication · muscle relaxers · nothing other (please describe):_____

Describe the quality of the symptom (circle all that apply)

Sharp · dull · achy · burning · throbbing · piercing · stabbing · deep · nagging · shooting · stinging other (please describe):_____

Does the symptom radiate to another part of the body (circle one): Yes No

If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)

Morning · afternoon · evening · night · unaffected by the time of day

Prior treatment for this condition (circle all that apply): Chiropractic - medication - massage - physical therapy - or_____

Symptom 3: 3rd most painful area (circle only one) Neck - Upper/Mid Back - Low Back - R L Leg - R L Arm - R L Shoulder - Headache, Other_____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
0 1 2 3 4 5 6 7 8 9 10
What percent of the time you are awake do you experience the above symptom at this intensity?
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
When did the symptom begin? _____did the symptom begin suddenly or gradually? (Circle one)
How did the symptom begin? _____
What makes the symptoms worse? (Circle all that apply)
Bending neck forward · bending neck backward · tilting head left · tilting head right · turning head left · turning head right · bending forward at waist · bending backward at waist · tilting left at waist · tilting right at waist · twisting left at waist · twisting right at waist · sitting · standing · getting up from a seated position · lifting · driving · walking · running · any movement · nothing
other (please describe)_____

What makes the symptom better? (Circle all that apply)
Manipulations · rest · ice · heat · stretching · exercise · massage · pain medication · muscle relaxers · nothing
other (please describe):_____

Describe the quality of the symptom (circle all that apply)
Sharp · dull · achy · burning · throbbing · piercing · stabbing · deep · nagging · shooting · stinging
other (please describe):_____

Does the symptom radiate to another part of the body (circle one): Yes No
If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)
Morning · afternoon · evening · night · unaffected by the time of day
Prior treatment for this condition (circle all that apply): Chiropractic - medication - massage - physical therapy - or_____

Symptom 4: 4th most painful area (circle only one) Neck - Upper/Mid Back - Low Back - R L Leg - R L Arm - R L Shoulder - Headache, Other_____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
0 1 2 3 4 5 6 7 8 9 10
What percent of the time you are awake do you experience the above symptom at this intensity?
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
When did the symptom begin? _____did the symptom begin suddenly or gradually? (Circle one)
How did the symptom begin? _____
What makes the symptoms worse? (Circle all that apply)
Bending neck forward · bending neck backward · tilting head left · tilting head right · turning head left · turning head right · bending forward at waist · bending backward at waist · tilting left at waist · tilting right at waist · twisting left at waist · twisting right at waist · sitting · standing · getting up from a seated position · lifting · driving · walking · running · any movement · nothing
other (please describe)_____

What makes the symptom better? (Circle all that apply)
Manipulations · rest · ice · heat · stretching · exercise · massage · pain medication · muscle relaxers · nothing
other (please describe):_____

Describe the quality of the symptom (circle all that apply)
Sharp · dull · achy · burning · throbbing · piercing · stabbing · deep · nagging · shooting · stinging
other (please describe):_____

Does the symptom radiate to another part of the body (circle one): Yes No
If yes, where does the symptom radiate?_____

Is the symptom worse at certain times of the day or night? (circle one)
Morning · afternoon · evening · night · unaffected by the time of day
Prior treatment for this condition (circle all that apply): Chiropractic - medication - massage - physical therapy - or_____

Griesbaum Family Chiropractic, S.C.

Name _____Date_____

Circle all that apply to your health history or circle **NONE** in each category that it applies

Musculoskeletal:

Pain		**Weakness**	**Tingling**	**Headaches**	**Other Conditions**	
Jaw	Neck	Arms	Arms	Migraine	Rheumatoid Arthritis	Arthritis (unknown type)
Shoulder	Elbow	Hands	Hands	Tension	Gout	Scoliosis
Wrist	Hand	Legs	Legs	Location:	Metal Implants	Difficulty standing
Upper back	Middle back	Feet	Feet	Back	Osteoarthritis	Difficulty walking
Low back	Pelvic			Front	Broken bones	Difficulty bending
Glutes	Hip			Top	Spinal fracture	Difficulty lifting
Knee	Ankle			Sides	Spinal Surgery	Restricted neck motion
Foot					Joint Surgery	

Pulmonary: (Lungs) Asthma | Difficulty Breathing | COPD | Emphysema | Other _____ NONE

Cardiovascular: (Heart) Heart surgeries | Congestive heart failure | Heart Murmur | Valve Disease | Heart attack | Heart disease | Hypertension |Pacemaker | Angina | Chest pain | Irregular heart beat Palpitations | Other _____ NONE

Neurological: (Nerve): Visual Changes| Loss of Vision| One-sided weakness of face or body (L | R) | History of Seizures |One-sided decreased feeling in face/body | Headaches |Memory Loss | Tremors | Vertigo |Loss of sense of smell | Stroke | TIA's | Other _____ NONE

Endocrine: (glands/hormonal) Thyroid Disease| Diabetes | Injectable Steroid Replacement | Other _____ NONE

Renal: (kidney/bladder) Renal Calculi/stones |Hematuria/ Blood in urine | Incontinence (can't control) | Bladder infections | Kidney disease | Dialysis | Difficulty urinating | Other _____NONE

Gastrointestinal: (digestive) Nausea | Difficulty Swallowing | Ulcerative Disease | Frequent Abdominal Pain | Hiatal Hernia | Constipation | Pancreatic Disease | Irritable Bowel/colitis | Hepatitis / Liver Disease | Bloody or Black Tarry Stools | Vomiting Blood | Bowel Incontinence | Gastroesophageal reflux/heartburn |Other _____ NONE

Hematological and Lymphatic: (blood) Anemia | Regular Anti-inflammatory use | HIV Positive | Abnormal Bleeding/Bruising | Sickle-Cell Anemia | Enlarged Lymph Nodes | Hemophilia |Anticoagulant Therapy | Hypercoagulation/Deep Vein Thrombosis | Regular Aspirin Use| Other _____ NONE

Oncology : Fevers/Chills/Sweats/Unexplained Weight Loss | Abnormal Bleeding/Bruising | Current/Past Oncology Disease |Other _____NONE

Dermatological: (skin) Significant Burns | Significant Rashes | Skin Grafts | Psoriatic Disorders | Other_____ NONE

Psychological: Psychiatric Diagnosis | Depression | Suicidal Ideations | Bipolar Disorder | Homicidal Ideations | Schizophrenia | Psychiatric Hospitalization |Other_____ NONE

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Have there been any changes since you last filled out this form at our office?

No or Yes describe_____ date _____ initial_____ Dr. Initial_____
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