New Patient Questionnaire & Confidential Case History

FAMILY CHIROPRACTIC CENTER
35 Clayton Lane, Suite A
Grayton Beach, FL 32459

Case No. _____ Date: _____

Patient Name _____

Home Address _____

City _____ State_____ Zip_____

Home # _____ Office #_____ Cell Phone # _____
Which # is Primary (choose one); Home ___ Office ___ Cell ___
Which # is Secondary (choose one): Home ___ Office ___ Cell ___

Preferred Method of Communication (choose one):
Phone Call to Primary # ____ Text to Cell ___ Cell Carrier _____
E-Mail to Home ___ E-Mail ID _____

Employed by _____ Address _____

Age _____ Date of Birth _____ Occupation _____ Sex (M) ____ (F) ____

Marital Status: M__ S__ W__ D__ # of Children _____ Name of Spouse_____

Emergency Contact # _____ Referred by _____

Have you ever had chiropractic care before? _____ When? _____
For what problem? _____

Were the results satisfactory? Yes ___ No ___ N/A ___

Major complaints and symptoms – please be as specific as you can.

_____

_____

How do you believe your problem (pain) began? _____
_____ When? _____

Have you ever had this condition before or a similar condition? _____ When? _____

What positions or activities aggravate your condition? _____

Have you been treated by a Medical Physician for this ailment? _____ Where? _____

Describe the type of treatment _____
Results of treatment _____

Family Physician's Name _____

Have you ever been in any accidents – auto, fall down stairs, fall from ladder, etc. (even as a child)?
_____ When? _____

Are you allergic to anything? _____ What? _____

Are you presently taking any medications (aspirin included)? Yes _____ No _____
PLEASE LIST MEDICATIONS (or attach a listing) _____
_____

Have you ever broken (fractured) any bones? _____ Any dislocations? _____

What operations have you had? _____ Year _____
_____ Year _____
_____ Year _____

Have you had any cosmetic surgery (breast implants, etc.)? _____ Year _____
Have you had any surgery to replace hip, knee, etc? _____ Year _____

Give dates you have had any of the following? (if exact date is unknown, give approximate date)
Blood Tests _____ Urinalysis _____
MRI _____ CT Scan _____ Ultrasound _____
Radiation Treatment _____ X-Ray Examination _____
Any other special treatment _____ When? _____

At what hospital or office were these tests taken? _____
Name of doctor who ordered tests? _____

Do you have any reason to believe that you may be pregnant? Yes _____ No _____
Date of last menstrual period? _____

Do you have any health problems not listed above? _____
Do you faint easily? _____

Do you take vitamins? _____ If yes, please list them _____
Do you exercise regularly? _____ If yes, type of exercise _____

Habits: Cigarettes? _____ Quantity _____ Coffee? _____ Quantity _____
Alcohol? _____ Quantity _____ Tea? _____ Quantity _____

Hobbies _____

Have you been treated for any health condition by a physician in the past year? _____
If yes, what condition? _____

Have you lost or gained weight in the past year? _____

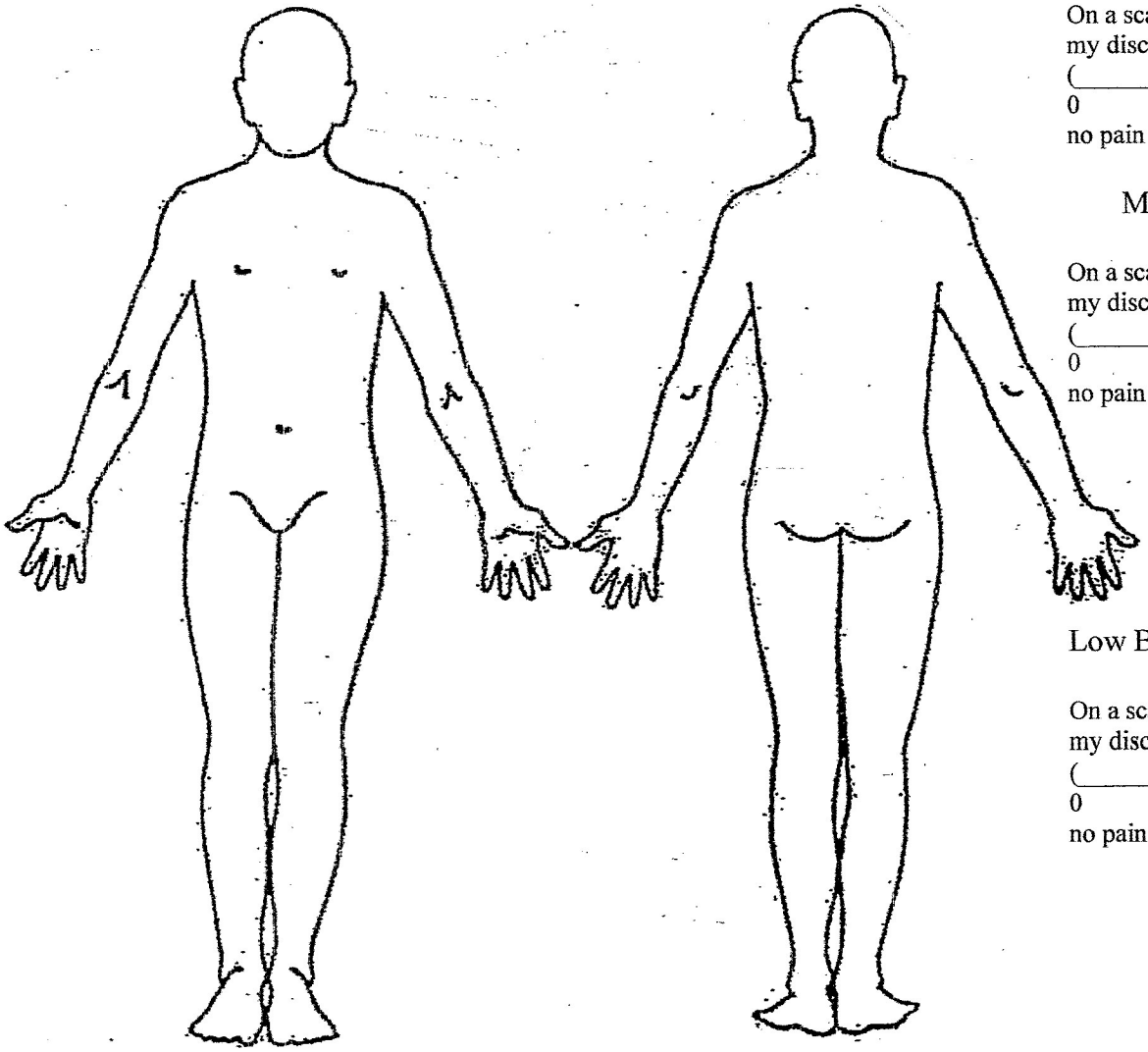
Doctor's Notes _____
_____
_____
_____
_____

PAIN CHART

Please use the following symbols to mark the area(s) on the body below where you feel the described sensations. Be sure to include all affected areas.

Numbness	- - - - -
Pins & Needles	OOOO
Burning	XXXX
Aching	******
Stabbing	/ / / / / /

On the pain scale on the right side of this page, please mark the level of pain you feel with this condition using 10 as being the worst pain and 0 being no pain.



Neck-Shoulder-Arm Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 10

no pain severe pain

Mid Back Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 10

no pain severe pain

Low Back and Leg Pain

On a scale of zero to ten, I rate my discomfort as follows:

(_____)

0 10

no pain severe pain

Date: _____ Patient's Signature: _____

NECK PAIN DISABILITY INDEX (NPDI)

Patient Name: _____ **File #:** _____ **Date:** _____

Activities of Daily Living Assessment

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your activities of daily living. Please mark the ONE box in each section that applies to you. You may consider that two or more of the statements in each section relate to you, however, mark the one box that 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

0☐ I can look after myself normally 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 causing extra pain.
1☐ I can lift heavy weights, but it gives me extra pain.
2☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
3☐ Pain prevents me from lifting heavy weights, but I can manage light 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 – READING

0☐ I can read as much as I want with no neck pain.
1☐ I can read as much as I want with slight neck pain.
2☐ I can read as much as I want with moderate neck pain.
3☐ I can't read as much as I want because of moderate neck pain.
4☐ I can hardly read at all because of severe neck pain.
5☐ I cannot read at all because of severe neck pain.

SECTION 5 – HEADACHES

0☐ I have no headaches at all.
1☐ I have slight headaches that come infrequently.
2☐ I have moderate headaches that come infrequently.
3☐ I have moderate headaches that come frequently.
4☐ I have severe headaches that come infrequently.
5☐ I have severe headaches that come frequently.
6☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

0☐ I can concentrate fully with no difficulty.
1☐ I can concentrate fully with slight difficulty.
2☐ I have a moderate degree of difficulty in concentrating.
3☐ I have a great deal of difficulty in concentrating.
4☐ I cannot concentrate at all.

SECTION 7 – WORK

0☐ I can do as much work as I want.
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 any neck pain.
1☐ I can drive my car as long as I want with slight neck pain.
2☐ I can drive my car as long as I want with moderate neck pain.
3☐ I can't drive my car as long as I want because of neck pain.
4☐ I can hardly drive at all because of severe neck pain.
5☐ I can't drive my car at all because of my neck pain.

SECTION 9 – SLEEPING

0☐ I have no trouble sleeping.
1☐ My sleep is slightly disturbed for less than 1 hour.
2☐ My sleep is mildly disturbed for up to 1-2 hours.
3☐ My sleep is moderately disturbed for up to 2-3 hours.
4☐ My sleep is greatly disturbed for up to 3-5 hours.
5☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 10 – RECREATION

0☐ I have no neck pain during all recreational activities.
1☐ I have some neck pain with a few recreational activities.
2☐ I have neck pain with most recreational activities.
3☐ I have some neck pain with all recreational activities.
4☐ I can hardly do recreational activities due to neck pain.
5☐ I can't do any recreational activities due to neck pain.

Pain Scale:

Score _____ [50]

Rate the severity of your pain by checking one box on the following scale:

0	1	2	3	4	5	6	7	8	9	10

No Pain — Unbearable Pain

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY INDEX)

Patient Name: _____ **File #:** _____ **Date:** _____

Activities of Daily Living Assessment

This questionnaire is designed to help us better understand how your back affects your activities of daily living. Please mark the **one box** in each section that applies to you. While you may think that two or more of the statements in each section relate to you, mark the one box that **most closely** describes your problem.

SECTION 1 – PAIN INTENSITY

0☐ My pain is mild to moderate. I do not need pain killers.
1☐ The pain is bad, but I manage without taking pain killers.
2☐ Pain killers give complete relief from pain.
3☐ Pain killers give moderate relief from pain.
4☐ Pain killers give very little relief from pain.
5☐ Pain killers have no effect on the pain.

SECTION 2 – PERSONAL CARE

0☐ I can look after myself normally 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 causing extra pain.
1☐ I can lift heavy weights, but it gives me extra pain.
2☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
3☐ Pain prevents me from lifting heavy weights, but I can manage light 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☐ I can walk as far as I wish.
1☐ Pain prevents me from walking more than 1 mile.
2☐ Pain prevents me from walking more than 1/2 mile.
3☐ Pain prevents me from walking more than 1/4 mile.
4☐ I can walk only if I use a cane or crutches.
5☐ I am in bed or in a chair for most of every day.

SECTION 5 – SITTING

0☐ I can sit in any chair for as long as I like.
1☐ I can only sit in my favorite chair as long as I like.
2☐ Pain prevents me from sitting more than 1 hour.
3☐ Pain prevents me from sitting more than 1/2 hour.
4☐ Pain prevents me from sitting more than 10 minutes.
5☐ Pain prevents me from sitting at all.

SECTION 6 – STANDING

0☐ I can stand as long as I want without extra pain.
1☐ I can stand as long as I want, but it gives me extra pain.
2☐ Pain prevents me from standing more than 1 hour.
3☐ Pain prevents me from standing more than 1/2 hour.
4☐ Pain prevents me from standing more than 10 minutes.
5☐ Pain prevents me from standing at all.

SECTION 7 – SLEEPING

0☐ Pain does not prevent me from sleeping well.
1☐ I sleep well, but only when taking medication.
2☐ Even when I take medication, I sleep less than 6 hours.
3☐ Even when I take medication, I sleep less than 4 hours.
4☐ Even when I take medication, I sleep less than 2 hours.
5☐ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

0☐ Social life is normal and causes me no extra pain.
1☐ Social life is normal, but increases the degree of pain.
2☐ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
3☐ Pain has restricted my social life, and I do not go out as often.
4☐ Pain has restricted my social life to my home.
5☐ I have no social life because of pain.

SECTION 9 – SEXUAL ACTIVITY

0☐ Sexual activity is normal and causes me no extra pain.
1☐ Sexual activity is normal, but causes some extra pain.
2☐ Sexual activity is nearly normal, but is very painful.
3☐ Sexual activity is severely restricted by pain.
4☐ Sexual activity is nearly absent because of pain.
5☐ Pain prevents any sexual activity at all.

SECTION 10 – TRAVELING

0☐ I can travel anywhere without extra pain.
1☐ I can travel anywhere, but it gives me extra pain.
2☐ Pain is bad, but I manage journeys over 2 hours.
3☐ Pain restricts me to journeys of less than 1 hour.
4☐ Pain restricts me to necessary journeys under 1/2 hour.
5☐ Pain prevents traveling except to the doctor/hospital.

Pain Scale:

Rate the severity of your pain by checking one box on the following scale:

Score _____ [50]

0	1	2	3	4	5	6	7	8	9	10

No Pain — Unbearable Pain