Patient History (Please Print)

Date:_____

Name: _____ Email: _____

Phone: (Home) _____ (Mobile) _____ (Work) _____

Address: _____ City: _____ Zip: _____

Birth Date: ___/___/_____ □ Male □ Female Spouse/Parent Name: _____

# of Children: _____ □ Married □ Single □ Divorced □ Widowed

Height:_____ Weight:_____ Are you Pregnant? □ YES □ NO Due Date:_____

Occupation: _____ Social Security # (for VA patients): _____

How were you referred to our office? _____

If from the Internet, name of search engine and key words used: _____

Have you ever had Chiropractic Care before? _____ If yes, when? _____

List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: _____ For How Long? _____

What originally caused this problem? _____

Feels Like:

□ Sharp □ Throbbing □ Shooting □ Cramps □ Stiffness □ Dull Ache □ Numb/Tingling

□ Burning □ Other: _____

Bothers Me:

□ Constant (100%) □ Frequent (50%-75%) □ Occasional (25%-50%) □ Intermittent (1%-25%)

It Has Been:

□ Getting Worse □ Staying Same □ Getting Better

Pain Scale: (0=No Pain – 10=Severe Pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

During The Day It Is:

□ Worse in the AM □ Stays the same throughout the day □ Worse in the PM

The Following Increases Pain:

□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

The Following Decreases Pain:

□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

Does The Pain Travel/Radiate? :

□ Yes □ No If yes, where_____ to _____

Complaint 2: _____ For How Long? _____

What originally caused this problem? _____

Feels Like:

□ Sharp □ Throbbing □ Shooting □ Cramps □ Stiffness □ Dull Ache □ Numb/Tingling

□ Burning □ Other: _____

Bothers Me:

□ Constant (100%) □ Frequent (50%-75%) □ Intermittent (25%-50%) □ Occasional (1%-25%)

It Has Been:

□ Getting Worse □ Staying Same □ Getting Better

Pain Scale: (0=No Pain – 10=Severe Pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

During The Day It Is:

□ Worse in the AM □ Stays the same throughout the day □ Worse in the PM

The Following Increases Pain:

□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

The Following Decreases Pain:

□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

Does The Pain Travel/Radiate? :

□ Yes □ No If yes, where_____ to _____

Complaint 3: _____ For How Long? _____

What originally caused this problem? _____

Feels Like:

□ Sharp □ Throbbing □ Shooting □ Cramps □ Stiffness □ Dull Ache □ Numb/Tingling

□ Burning □ Other: _____

Bothers Me:

□ Constant (100%) □ Frequent (50%-75%) □ Intermittent (25%-50%) □ Occasional (1%-25%)

It Has Been:

□ Getting Worse □ Staying Same □ Getting Better

Pain Scale: (0=No Pain – 10=Severe Pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

During The Day It Is:

□ Worse in the AM □ Stays the same throughout the day □ Worse in the PM

The Following Increases Pain:

□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

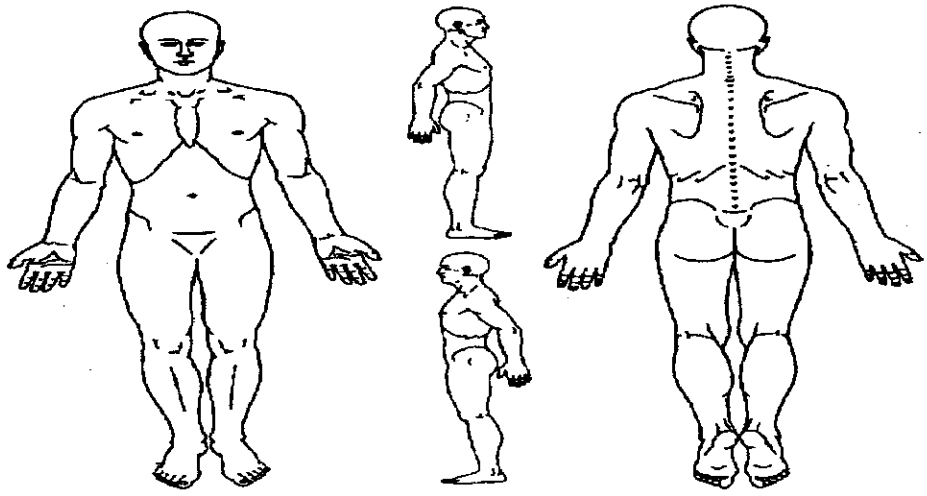
The Following Decreases Pain:

□ Moving □ Sitting □ Lifting □ Bending □ Walking □ Laying Down □ Other: _____

Does The Pain Travel/Radiate? :

□ Yes □ No If yes, where_____ to _____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas.



Does your condition interfere with your:

Work	□ NO	□ MILD	□ MODERATE	□ SEVERE
Sleep	□ NO	□ MILD	□ MODERATE	□ SEVERE
Daily Routine	□ NO	□ MILD	□ MODERATE	□ SEVERE
Recreation	□ NO	□ MILD	□ MODERATE	□ SEVERE

Does your condition interfere with any of the following:

□ Computer Use	□ Cleaning	□ Shopping
□ Sports	□ Cooking	□ Gardening
□ Reading	□ Watching Kids	□ School
□ Exercise	□ Yard Work	□ Self Care
□ Vacuuming	□ Driving	□ Other: _____
□ Social Life	□ Relationship	

Health History (Check if you have now or have had in the past:)

- ☐ Abdominal Aortic Aneurysm
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Bleeding Disorders
- ☐ Bulimia
- ☐ Buzzing/Ringing in Ears
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Chronic Bronchitis
- ☐ Chronic Fatigue
- ☐ Chronic Tonsillitis
- ☐ Constipation
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Digestive Problems
- ☐ Dysmenorrhea
- ☐ Eczema
- ☐ Emphysema
- ☐ Erectile Dysfunction
- ☐ Eye Troubles
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Issues
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Hypertension/ HBP
- ☐ Indigestion
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Measles
- ☐ Menstrual Problems
- ☐ Mid Back Pain
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Swollen Ankles
- ☐ Throat Conditions
- ☐ Thyroid Conditions
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Unexplained Memory Loss
- ☐ Unexplained Weight Loss
- ☐ Unexplained Weight Gain
- ☐ UTI
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other:_____

Family History (please list all known conditions/illnesses that may apply):

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial conditions: _____

List of Current Medications/Supplements:

_____

_____

_____

_____

_____

_____

List other doctors consulted for condition:

1: _____ 2: _____

3: _____ 4: _____

Concerns:

We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Please circle all that apply, **star your top 3** and add any others that are important to you.

Is it going to hurt?	I don't want to be cracked
Do I have to come forever?	Is it addictive?
Are the X-rays dangerous?	Is it safe for children?
Is it expensive?	What if insurance does not cover chiropractic?
What do I do if NUCCA does not work?	Can this be fixed?

Habits:

Strong habits are key to health. It helps us understand how you will heal when we know your health habits. Please circle all that apply, **star your top 3** and add any others that you may have.

Stretch 3-5 times a week	Exercise 3-5 times a week
Drink ½ my body weight in ounces of water	Take supplements for health
Have a positive attitude	Sleep 6-8 hours a night
Drink or eat something green every day	Get maintenance chiropractic 2-4 times a year
Do activities to minimize stress regularly	Non-smoker

Goals:

We want to make sure you get lasting relief and help you in every way possible. Please circle any functional goals that you have, **star your top 3** and add any others that are important to you.

Sleep through the night	Exercise again
Continue working/get back to work	Avoid future flare ups
Play with kids/grandkids normally	Get off pain medications
Be ready for an upcoming event	Have a better attitude
Have some moments of relief	Sit/stand comfortably for an extended period

List of Previous Hospital Stays/Surgeries: (What and When?)

List of Any Childhood Traumas / Accidents / Falls / Auto Injuries: (What happened and When?)

Is there anything else you think we should know about or that you would like to discuss? (Explain):

Are you interested in Nutritional Services? (i.e, Nutritional Consultation, Hair Mineral Analysis, or Nutrient Analysis)

☐ YES ☐ NO

How would you like our office to communicate with you? Text_____ Phone_____ Email_____

Patient's Signature: _____ Date: _____

Notice: Not all patients require x-rays to determine or verify a diagnosis, type and length of care.
If your examination warrants x-ray analysis, the following office policy prevails:
All first visit charges are to be paid when services are rendered.
The fee paid for x-rays is for analysis only.
The film itself is the property of this office and cannot be released.

*** If you have insurance please give your card to the front desk staff***

Outcome Assessment

In order to properly access your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

Only fill out for conditions that apply to you.

For use with neck pain only

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score _____

For use with back pain only

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score _____

Name _____

PRINTED

_____

Signature

_____

Date

HEADACHE DISABILITY INDEX

NAME:_____ DATE: _____ AGE:_____ Score Total:_____:E___: F_____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headaches: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than one per week
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", OR "NO" to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.			
F2. Because of my headaches I feel restricted in performing my routine daily activities.			
E3. No one understands the effect my headaches have on my life.			
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.			
E5. My headaches make me angry.			
E6. Sometimes I feel that I am going to lose control because of my headaches.			
F7. Because of my headaches I am less likely to socialize.			
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.			
E9. My headaches are so bad that I feel I am going to go insane.			
E10. My outlook on the world is affected by my headaches.			
E11. I am afraid to go outside when I feel that a headache is starting.			
E12. I feel desperate because of my headaches.			
F13. I am concerned that I am paying penalties at work or at home because of my headaches.			
E14. My headaches place stress on my relationships with family or friends.			
F15. I avoid being around people when I have a headache.			
F16. I believe my headaches are making it difficult for me to achieve my goals in life.			
F17. I am unable to think clearly because of my headaches.			
F18. I get tense (e.g. muscle tension) because of my headaches.			
F19. I do not enjoy social gatherings because of my headaches.			
E20. I feel irritable because of my headaches.			
F21. I avoid traveling because of my headaches.			
E22. My headaches make me feel confused.			
E23. My headaches make me feel frustrated.			
F24. I find it difficult to read because of my headaches.			
F25. I find it difficult to focus my attention away from my headaches and on other things.			

Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital headache disability inventory (HDI). Neurology 1994; 44:837-842.