PATIENT INFORMATION

A. Name _____Date _____Birthdate _____

Address _____City _____State_____Zip _____

Home # _____Cell# _____Work # _____SS# _____

E-mail Address _____ Sex *M F* Marital Status *S M W D* # Children ____

Referred By _____ Insurance Company _____

Employer _____ Job Title _____Job Description _____

B. Medications: _____

Vitamins: _____

Allergies to Medications: _____

Prev. Chiro. Care: _____ Prev. x-rays: _____

Name of Primary Care Physician: _____

May we send a report to them? Y N Your current weight: _____ Height _____ Shoe size _____

Previous car accidents or falls:_____

Surgeries: _____

Broken bones: _____

Other traumas? _____ Previous Stroke or TIA?_____

Sleeping posture ❑ side ❑ stomach ❑ back **Posture** ❑ good ❑ fair ❑ poor

Current Hobbies, Sports, Activities: _____

Is there a chance that you could be pregnant? Y N

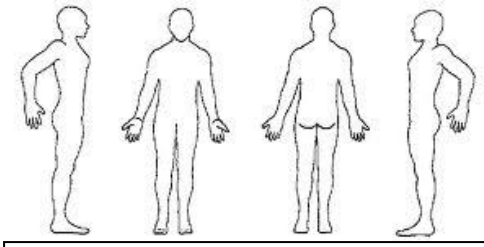
What brings you to the office today? PS-Pain Scale 1-10

1._____ PS____

2._____ PS____

3._____ PS____

4._____PS____



Circle on the body any area you're currently having pain

Date First Noticed _____ Ever had it before? Y N

It was caused by _____ Missed work due to this? Y N

What have you done to treat this? _____

Other professionals seen for this? _____

Is this a car or work accident? Y N Date and time of accident _____

Hurts more when: Sitting / Bending / Lifting / Twisting / Riding in car / Working / Sleeping / Standing / House Work / Walking / Straining / Constant / Other: _____

Hurts less when: ❑ OTC meds ❑ Prescription ❑ Rest ❑ Lay down ❑ Sleep ❑ Sit ❑ Stretch ❑ More active ❑ With ice ❑ With heat ❑ Massage ❑ Other _____

Description: ❑ Sharp ❑ Dull ❑ Throb ❑ Radiating ❑ Shooting ❑ Numb ❑ Tingling ❑ Stiff

My goals for my care here: _____

Caffeine ❑ None ❑ Some ❑ Much
Cigarettes ❑ None ❑ Some ❑ Much
Alcohol ❑ None ❑ Some ❑ Much

Energy Level:	No Energy	1	2	3	4	5	6	7	8	9	10	Energetic
Flexibility:	Can't Move	1	2	3	4	5	6	7	8	9	10	Very Flexible
Stress Level:	No Stress	1	2	3	4	5	6	7	8	9	10	Much Stress
Spiritual Interest:	No Interest	1	2	3	4	5	6	7	8	9	10	Very Interested

Overall State __ Fever __ Chills __ Fatigue __ Loss of appetite __ Weight loss or gain __ None	**Emotional Issues** __Irritability __ Depression __ Poor Sleep __ Anxiety __ None	**Urinary System Issues** __ Frequent urination __ Urgency __ Burning __ Loss of control __ None
Vision Issues __ Blurred __ Double __ None	**Heart Issues** __ Chest pains __ Palpitations __ Fainting __ None	**Breathing Issues** __ Coughing __ Wheezing __ Shortness of breath __ Asthma
Digestion Issues __ Nausea __ Vomiting __ Diarrhea __ Less than 2 Bowel Movements Daily __ None	**Joint Issues** __ Joint pains __ Joint weakness __ Muscle cramps __ None	**Skin Issues** __ Rash / Itchiness __ Dryness __ Open wounds __ None
Immune System Issues __ Lymph nodes enlarged __ Allergies __ Frequent infections __ None	**Endocrine Issues** __ Diabetes / Low blood sugar __ Thyroid issues __ Weak spells, tiredness __ Shakiness before meals __ None	**Neurological Issues** __ Seizures __ Headaches __ Tingling __ Numbness __ Poor coordination __ Migraines
Circulation Issues __ Anemia __ Bleeding __ Bruising __ Cold extremities __ None	**Skeletal Issues** __ Osteoporosis __ Osteopenia __ Neck pain __ Back pain __ None	**Do you:** __ Eat only few vegetables? __ Eat fast foods?

Family History of:
__ Arthritis
__ High Cholesterol
__ High Blood Pressure
__ Diabetes
__ Heart Disease
__ Cancer

INITIALS: _____

Low Back (Oswestry) Questionaire

NAME_____ **DATE**_____

Please answer ***every section***. Mark ***one letter only*** in each section.

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 6 - Standing*** **A__ I can stand as long as I want without extra pain.** **B__ I can stand as long as I want but it gives me extra pain.** **C__ Pain prevents me from standing for more than 1 hour.** **D__ Pain prevents me from standing for over 1/2 hour.** **E__ Pain prevents me from standing for over 10 minutes.** **F__ Pain prevents me from standing at all.**
SECTION 2 - Personal Care (washing, dressing, etc.) **A__ I can look after myself normally without causing extra pain.** **B__ I can look after myself normally but it is very painful.** **C__ It is painful to care for myself and I am slow and careful.** **D__ I need 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, wash with difficulty, and stay in bed.**	***SECTION 7 - Sleeping*** **A__ My sleep is never disturbed by pain.** **B__ My sleep is occasionally disturbed by pain.** **C__ Because of pain I have less than 6 hours' sleep.** **D__ Because of pain I have less than 4 hours' sleep.** **E__ Because of pain I have less than 2 hours' sleep.** **F__ Pain prevents me from sleeping at all.**
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, but I can manage if they are conveniently positioned, e.g. on a table.** **D__ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.** **E__ I can only lift very light weights, at the most.** **F__ I cannot lift or carry anything at all.**	***SECTION 8 - Traveling*** **A__ I can travel anywhere without pain.** **B__ I can travel anywhere but it gives extra pain.** **C__ Pain is bad but I manage journeys over 2 hours.** **D__ Pain restricts me to journeys of less than 1 hour.** **E__ Pain restricts me to short necessary journeys under 30 minutes.** **F__ Pain prevents me from traveling except to receive treatment.**
SECTION 4 - Walking **A__ Pain does not prevent me from walking any distance.** **B__ Pain prevents me from walking more than one mile.** **C__ Pain prevents me from walking more than 1/4 mile.** **D__ Pain prevents me from walking more than 100 yards.** **E__ I can only walk while using a stick or crutches.** **F__ I am in bed most of the time and have to crawl to the toilet.**	***SECTION 9 - Recreation*** **A__ My social life is normal and causes me no extra pain.** **B__ My social activities increase the degree of pain.** **C__ Pain limits my more energetic interests, e.g., sport, etc.** **D__ Pain has restricted my social life and I do not go out as often.** **E__ Pain has restricted my social life to my home.** **F__ I have no social life because of the pain.**
***SECTION 5 -* Sitting** **A__ I can sit in any chair as long as I like.** **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 1/2 hour.** **E__ Pain prevents me from sitting more than ten minutes.** **F__ Pain prevents me from sitting at all.**	**SECTION 10 – Changing degree of pain** **A__ Level of pain is rapidly improving.** **B__ Level of pain fluctuates but is improving.** **C__ Level of pain is slowing improving.** **D__ Level of pain is unchanging.** **E__ Pain level is gradually worsening.** **F__ Pain level is rapidly worsening.**

COMMENTS:

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Delta Chiropractic Center – Neck Disability Index

NAME_____ **DATE**_____

Please answer ***every section***. Mark ***one letter only*** in each section.

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 6 - Concentration*** A__ I can concentrate fully when I want to with no difficulty. B__ I can concentrate when I want to with slight difficulty. C__ I have a fair degree of difficulty in concentrating. D__ I have a lot of difficulty in concentrating. E__ I have a great deal of difficulty in concentrating. F__ Pain prevents me from concentrating at all.
SECTION 2 - Personal Care (washing, dressing, etc.) A__ I can look after myself normally without causing extra pain. B__ I can look after myself normally but it is painful. C__ It is painful to care for myself and I am slow and cautious. D__ I need 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, wash with difficulty, and stay in bed.	***SECTION 7 - Work*** A__ Pain does not prevent me from working at all. B__ Pain prevents me from working extra hours or duties. C__ Pain prevents me from doing some of my work. D__ Pain prevents me from half of my usual work. E__ I can hardly work at all. F__ I cannot work at all.
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,but I can manage if they are conveniently positioned, e.g. on a table. D__ Pain prevents me from lifting heavy weights, but I can manage **light** weights if they are conveniently positioned. E__ I can only lift very light weights, at the most. F__ I cannot lift or carry anything at all.	***SECTION 8 - Traveling*** A__ I can ride in a car anywhere without pain. B__ I can ride anywhere but it gives extra pain. C__ Traveling causes moderate pain in my neck. D__ Pain restricts me to journeys of less than 2 hours. E__ Pain restricts me to short necessary journeys under 30 minutes. F__ Pain prevents me from driving completely.
SECTION 4 - Reading A__ I can read as long as I like with no pain. B__ I can read with slight neck pain. C__ I can read with moderate neck pain. D__ I must limit my reading due to moderate neck pain. E__ Pain prevents me from reading more than 10 minutes. F__ Pain prevents me from reading at all.	***SECTION 9 - Sleeping*** A__ My sleep is never disturbed by pain. B__ My sleep is occasionally disturbed by pain. C__ Because of pain I have less than 6 hours' sleep. D__ Because of pain I have less than 4 hours' sleep. E__ Because of pain I have less than 2 hours' sleep. F__ Pain prevents me from sleeping at all.
SECTION 5 – ***Headaches*** A__ I have no headaches at all. B__ I experience slight, infrequent headaches C__ I have moderate, infrequent headaches. D__ I have moderate, frequent headaches. E__ I have severe, frequent headaches. F__ I have almost constant headaches.	***SECTION 10 - Recreation*** A__ My social life is normal and causes me no extra pain. B__ My social activities increase the degree of neck pain. C__ Pain limits my more energetic interests, e.g., sport, etc. D__ Pain has restricted my social life and I do not go out as often. E__ Neck pain has restricted my social life to my home. F__ I cannot do recreational activities due to neck pain.

COMMENTS:

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*Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine **25**(24): 3115-24.*

CONSENT TO RELEASE INFORMATION

As a patient of Delta Chiropractic Center, who do you authorize us to release scheduling and/or care and progress information to?

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

If our office needs to contact you, where may we leave a message?

Phone #: _____

_____
Printed Name

_____ _____
Signature Date

Patient Privacy Policies

To Contact Us

If you would like further information about our privacy policies, a copy is available upon request at our office.

By signing below, I acknowledge that I have been offered a copy of the Patient Privacy Policies.

This notice will expire seven years after the date upon which the record was created.

_____	_____
Patient Name Printed	Date
_____	_____
Patient Signature	Provider Representative
_____	_____
Guardian Printed Name	Guardian Signature

_____

Guardian's relationship to, or other authority to act for, the patient