| Patient Information | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | | | Date: | |
| SS / SIN Number: | | | | Male: | Female: |
| Address: | | | City: | State: | Zip: |
| Driver's License Number: | | | | Date of Birth: | |
| Cell Phone: | | | Home Phone: | | |
| Work Phone: | | | Email: | | |
| Whom may we thank for referring you? | | | | | |
| **Preferred Method of Contact (please check one)** | | | | | |
| Email: | Text: | Phone: | Cell Phone Carrier: | | |
| **Race (please check one)** | | | | | |
| American Indian: ☐ | Asian: ☐ | Black or African American: ☐ | Pacific Islander: ☐ | Hispanic: ☐ | White: ☐ |
| **Ethnicity (please check one)** | | Hispanic: ☐ | | Non-Hispanic: ☐ | |
| **Patient Status (please check appropriate box from selection below)** | | | | | |
| Minor: ☐ | Single: ☐ | Married: ☐ | Divorced: ☐ | Widowed: ☐ | Separated: ☐ |
| Employer: | | | | | |
| Employer Address: | | | City: | State: | Zip: |
| Spouse or Parent / Guardian's Name: | | | | | |
| Spouse / Guardian's Employer: | | | | Work Phone: | |
| Person to Contact in Case of Emergency: | | | | Phone: | |
| **If Patient is a Student** | | | | | |
| Name of School or College: | | | | City: | State: |
| **If Patient is of School Age, 15+, it is OK to treat in my Absence** | | | | | |
| Parent or Guardian Signature: | | | | Date: | |

| Insurance of Primary Card Holder (if different from above) | | | | |
|---|---|---|---|---|
| Name of the Insured: | | Relationship to Patient: | | |
| Date of Birth: | SS / SIN Number: | | Date Employed: | |
| Name of Employer: | | Work Phone: | | |
| Address of Employer: | | City: | State: | Zip: |
| Insurance Company: | | Group No.: | Member ID: | |
| Ins. Co. Address: | | City: | State: | Zip: |
| **If Known** | How much is your deductible: | How much have you used: | | |
| **Insurance Primary Card Holder (only fill out if different from above)** | | | | |
| Name of Person Responsible for Account: | | Relationship to Patient: | | |
| Address: | | City: | State: | Zip: |
| Employer: | | Work Phone: | | |
| Cell Phone: | | Email: | | |
| Is the Person Currently a Patient at our Office? | | Yes: | No: | |

| Please Fill Out the Following Information Based on your PRESENT SYMPTOMS | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Check all that Apply | | Which Side? | | Pain Scale for Each 1 = Discomfort | | | | | 10 = Severe Pain | | | | | Percentage of Time you Notice your Symptoms | | | | |
| ✓ | Symptom | L | R | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 0 | 25 | 50 | 75 | 100 |
| | Headaches | | | | | | | | | | | | | | | | | |
| | Neck Pain | | | | | | | | | | | | | | | | | |
| | Upper Back Pain | | | | | | | | | | | | | | | | | |
| | Mid Back Pain | | | | | | | | | | | | | | | | | |
| | Lower Back Pain | | | | | | | | | | | | | | | | | |
| | Shoulder Joint Pain | | | | | | | | | | | | | | | | | |
| | Arm Pain / Numbness | | | | | | | | | | | | | | | | | |
| | Elbow Pain | | | | | | | | | | | | | | | | | |
| | Hand / Wrist Pain | | | | | | | | | | | | | | | | | |
| | Leg Pain / Numbness | | | | | | | | | | | | | | | | | |
| | Hip Pain | | | | | | | | | | | | | | | | | |
| | Knee Pain | | | | | | | | | | | | | | | | | |
| | Ankle / Foot Pain | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |

| Past Medical History | | | | | | | |
|---|---|---|---|---|---|---|---|
| Have you ever had the following: (check if yes, leave blank if you are uncertain) | | | | | | | |
| Symptom | ✓ | Symptom | ✓ | Symptom | ✓ | Symptom | ✓ |
| Measles | | Anemia | | Back Trouble | | Hepatitis | |
| Mumps | | Bladder Infection | | High Blood Pressure | | Ulcer | |
| Chicken Pox | | Epilepsy | | Low Blood Pressure | | Kidney Disease | |
| Whooping Cough | | Migraine Headaches | | Hemorrhoids | | Thyroid Disease | |
| Scarlet Fever | | Tuberculosis | | Asthma | | Bleeding Tendency | |
| Diphtheria | | Diabetes | | Hives of Eczema | | **Any Other Disease** | |
| Small Pox | | Cancer | | AIDS & HIV | | | |
| Pneumonia | | Polio | | Infectious Mono | | | |
| Rheumatic Fever | | Glaucoma | | Bronchitis | | | |
| Arthritis | | Hernia | | Mitral Valve Prolepses | | **Date of Last Chest X-Ray** | |
| Venereal Disease | | Blood or Plasma Transfusion | | Stroke | | | |

| Previous Hospitalizations/Surgeries/Serious Illness | When | Hospital, City, State |
|---|---|---|
| | | |
| | | |
| | | |

| Medications (Include Non-prescription) | | |
|---|---|---|
| | | |
| | | |

| Family Medical History | | |
|---|---|---|
| **Relation** | **Disease** | **If Deceased, Cause of Death** |
| Father | | |
| Mother | | |
| Sister | | |
| Brother | | |
| | | |
| Spouse | | |
| Children | | |
| | | |
| | | |

| Recent Medical History | | | | |
|---|---|---|---|---|
| Indicate which of the below you have Experienced in the Last 1-2 Months | | | | |
| 1 = Never | 2 = Rarely | 3 = Occasionally | 4 = Frequently | 5 = Constantly |

| **Symptom** | **1** | **2** | **3** | **4** | **5** | **Symptom** | **1** | **2** | **3** | **4** | **5** | **Symptom** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Asthma | | | | | | Hoarseness | | | | | | Shoulder Pain | | | | | |
| Stuffy Nose | | | | | | Shortness of Breath | | | | | | Hip Pain | | | | | |
| Hay Fever | | | | | | Wheezing | | | | | | Knee Pain | | | | | |
| Sore Throat | | | | | | Muscle Aches | | | | | | Ankle / Foot Pain | | | | | |
| Chronic Cough | | | | | | Fibromyalgia | | | | | | Pain Between Shoulder Blades | | | | | |
| Chest Congestion | | | | | | Arthritis | | | | | | Headaches | | | | | |
| Frequent Sneezing | | | | | | Joint Pain | | | | | | Migraines | | | | | |
| Itchy/Watery Eyes | | | | | | Low Back Pain | | | | | | Dizziness | | | | | |
| Drainage | | | | | | Neck Pain | | | | | | Numbness | | | | | |
| Earache or Ear Infection | | | | | | Wrist / Hand Pain | | | | | | Tingling | | | | | |
| Itching | | | | | | Elbow Pain | | | | | | Other: | | | | | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the Arizona Pain Relief staff to perform the necessary services I may need.

| | |
|---|---|
| Patient Signature: | Date: |
| Signature of Parent or Guardian (if applicable): | Date: |
| Signature of Doctor (doctor's review): | Date: |

## Revised Oswestry Pain Disability Questionnaire

Name:_______________________________________________ Date: _____/_____/______

**Please Read:**

This questionnaire has been designed to give your doctor/therapist information as to how your pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

**Section 1 – Pain Intensity**

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad, but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain

**Section 2 – Personal Care (Washing, Dressing, etc.)**

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally, but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help, but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

**Section 3 – Lifting**

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

**Section 4 - Walking**

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

**Section 5 - Sitting**

- ☐ I can it in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

**Section 6 – Standing**

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

**Section 7 – Sleeping**

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all

**Section 8 – Social Life**

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

**Section 9 – Traveling**

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

**Section 10 – Employment/Homemaking**

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.

Patient Signature ______________________________ Medical Provider______________________________

Patient Name ______________________________ Supervising Physician______________________________

Chiropractor______________________________

Please fill out form in its entirety to the best of your knowledge:

| Patient Intake - Personal Injury | |
|---|---|
| **Patient's Name:** | **Date of Birth:** |
| **Date of Injury:** | **Date of Exam:** |
| **Do you have an attorney?** □ NO □ YES<br>If yes- Name of attorney: _______________________________________________________ | **Type of Injury:** |
| **Treatment for Current Accident Injuries:** | |
| Have you seen any other medical providers for your injuries after the current accident? **(including ER / Hospital Visits)** If so, who did you see? **(Please Provide Providers Name and Phone Number)** | |
| **What types of treatments did you receive?** | |
| **Have you had any medical imaging:** □ None □ X-Ray □ MRI □ CT<br>**Please provide the name and phone number of facility where imaging was completed:** | |
| **Accident Details:** | |
| **What type of vehicle were you driving?**<br>□ Car □ Truck □ SUV | **Where was your vehicle impacted?**<br>□ Front □ Rear □ Driver Side □ Passanger |
| **What type of vehicle was the other vehicle in the accident?**<br>□ Car □ Truck □ SUV | **Did the airbags deploy?**<br>□ YES □ NO |
| **Did you hit your head?** □ NO □ YES<br>□ Headrest □ Window □ Windshield □ Steering Wheel □ Door | **Did you hit your face?** □ NO □ YES<br>□ Airbag □ Steering Wheel |
| **Did you hit your body?** □ NO □ YES<br>□ Upper Body: ________________________________________<br>□ Lower Body: ________________________________________ | **Did you lose consciousness:** □ NO □ YES (□ Brief or □ Extended)<br>-Regained Consciousness: **Where**: ___________________ |
| **After the collision, were you:**<br>□ Dazed / Confused □ Scared □ Shaky / Nervous<br>□ In Pain Dizzy □ Nauseated □ Shocked □ Upset | **After the accident. did you go to:**<br>□ **Hospital** (Ambulance □ NO □ YES) (if YES did they use a board/collar for transport? □ NO □ Yes)<br>□ **Urgent Care** □ **Home / Work** |
| **Current Work Status:** | |
| **Employed:** □ NO □ YES (□ FT □ PT) □ Retired / **Student:** □ NO □ YES ( □ FT □ PT) | **Missed Work:** _______ **days, due to collision** |
| **Employer Name:** | |
| **Type of Labor:** □ Light □ Moderate □ Heavy / **Pain at Work:** □ No □ YES | **Returned to Work?** □ NO □ YES Returned Due To Finances: □ NO □ YES |
| **Previous Accident History :** | |
| **Previous Motor Vehicle Accident:** □ NO □ YES, If YES, When? | |
| **What injuries did you have?** | |
| **What types of treatments did you receive?** | |
| **Past Motor Vehicle Accident W/ Injury?** □ NO □ YES **What was the injury?** | **Past Work Injury (Workers Comp)?** □ NO □ YES **What was the injury?** |
| **Past Slip and Fall Injury?** □ NO □ YES **What was the injury?** | **Past Sports Injury?** □ NO □ YES **What was the injury?** |
| **Past Military Injury?** □ NO □ YES **What was the injury?**<br>- Time in the Military: __________________________ | |

# Personal Injury - Provider Recommendation

☐ Reviewed Patient Intake Form

**Accident Details:**

**Current Work Status:**

**Recommendations:**

| **Imaging:** | **Continue Treatment:** |
| --- | --- |
| ☐ X-Ray ☐ CT ☐ MRI | ☐ Chiropractic ☐ PCP |
| **DME:** | **Referral For:** |
| ☐ Tens/EMS ☐ SI Belt ☐ LSO ☐ TLSO<br>☐ Other Bracing ___________________ | ☐ Neurologist ☐ Pain Management ☐ Surgeon |

**Additional Notes:**

**Provider Print:** ___________________________________

**Provider Signature:** ______________________________________________ **Date:** ____________________