Patient Health Questionnaire

Patient Number: _____

Patient Name _____ ***Date*** _____

1. ***When did your symptoms start:*** _____ ***Describe your symptoms and how they began:***

_____

_____

2. ***How often do you experience your symptoms?***

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

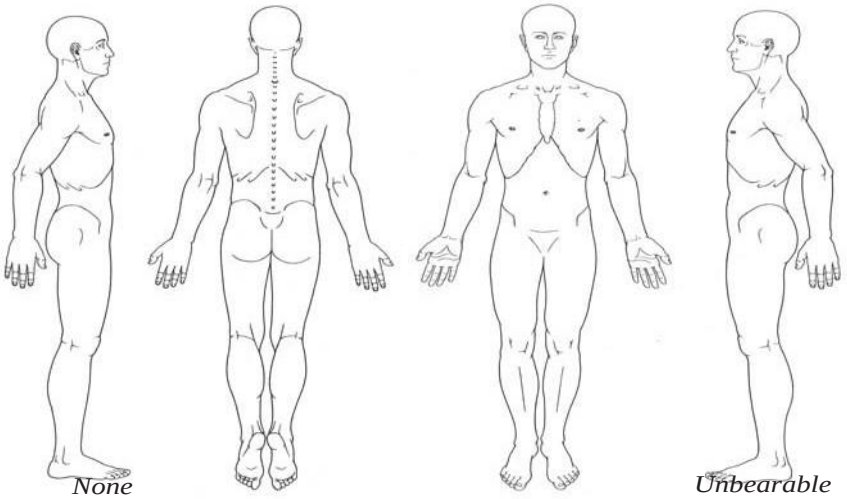
3. ***What describes the nature of your symptoms?***

① Sharp Dull ④ Shooting
② ache Numb ⑤ Burning
③ ⑥ Tingling

4. ***How are your symptoms changing?***

① Getting Better
② Not Changing
③ Getting Worse

Indicate where you have pain or other symptoms



5. ***How bad are your symptoms at their:***

None Unbearable

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. ***How do your symptoms affect your ability to perform daily activities?***

⓪ *No complaints*
① ② *Mild, forgotten with activity*
③ ④ *Moderate, interferes with activity*
⑤ ⑥ *Limiting, prevents full activity*
⑦ ⑧ *Intense, preoccupied with seeking relief*
⑨ ⑩ *Severe, no activity possible*

7. ***What activities make your symptoms worse:*** _____

8. ***What activities make your symptoms better:*** _____

9. ***Who have you seen for your symptoms?***

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. *When and what treatment?* _____

b. *What tests have you had for your symptoms and when were they performed?*

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. ***Have you had similar symptoms in the past?*** ① Yes ② No

a. *If you have received treatment in the past for the same or similar symptoms, who did you see?*

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. ***What is your occupation?***

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. *If you are not retired, a homemaker, or a student, what is your current work status?*

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. ***What do you hope to get from your visit/treatment*** *(select all that apply)**:***

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ ***Date*** _____

Complaints

Chart____

Head: (circle as many as apply)

A) **Headache** 1) Mild 2) Moderate 3) Severe Frequency: (**1 2 3 4 5 6 7**) times per (Day Week Month)
Are they: 1) Sharp **2**) Dull **3**) Constant **4)** Intermittent
Location: 1) Back of head **2**) Forehead **3**) Right Side **4**) Left Side **5**) Behind Eyes
B) Light Headed **C**) Dizziness **D**) Loss of Balance **E**) Blurred Vision **F**) Ringing in Ears **G**) Fainting
H) JAW Pain **I**) sensitivity to light

Neck: (circle as many as apply)

A) **Pain**: 1) Left Side 2) Right Side 3) Both **Pain Level** 1) Mild 2) Moderate 3) Severe

Pain Increased by: 1) Forward Bending 2) Backward Bending 3) Rotating Head to Left 4) Rotating Head to Right
5) Bending Neck to Left 6) Bending Neck to Right
B) Stiffness C) Muscle Spasm D) Grinding

Shoulders: (circle as many as apply)

A) Pain in Joint	Left	Right	Both
B) Limitation of Motion	Left	Right	Both
C) Tension	Left	Right	Both
D) Location	Front	Back	

Arms and Hands: (circle as many as apply**)**

A) Pain in upper arm	Left	Right	Both
B) Pain in elbow	Left	Right	Both
C) Pain in forearm	Left	Right	Both
D) Pain in wrist	Left	Right	Both
E) Numbness in arm	Left	Right	Both
F) Numbness in forearm	Left	Right	Both
G) Numbness- hand and fingers	Left	Right	Both

Low Back: (circle as many as apply)

A) Lumbar Pain	Left	Right	Both
B) Sacroiliac Pain	Left	Right	Both
C) Muscle Spasm	Left	Right	Both

Pain Level: 1) Mild 2) Moderate 3) Severe

Mid Back (circle as many as apply)

A) Pain	Left	Right	Both
B) Muscle Spasm	Left	Right	Both
C) Rib pain	Left	Right	Both

Pain Level: 1) Mild 2) Moderate 3) Severe

Hips and Legs: (circle as many as apply)

A) Pain in Buttocks	Left	Right	Both
B) Pain in Hips	Left	Right	Both
C) Pain in Down Leg	Left	Right	Both
Radiates to:	1) sole of foot 2) top of foot 3) calf 4) back of leg 5) hamstring 6) thigh		
D) Numbness down Leg	Left	Right	Both
E) Numbness in Foot/Toes	Left	Right	Both
F) Knee pain	Left	Right	Both

Foot and Ankle: (circle as many as apply)

A) Ankle Pain	Left	Right	Both
B) Swollen Ankle	Left	Right	Both
C) Foot Pain	Left	Right	Both

Name (Print)_____**Signature**_____**Date**_____

History

Chart_____

Personal Health History(circle as many as apply**)**

AIDS/HIV	Cataracts	Hernia	Osteoporosis	Stroke
Alcoholism	Chemical Dependency	Herniated Disc	Pacemaker	Suicide attempt
Allergies	Chickenpox	Herpes	Parkinson's disease	Thyroid Problems
Anemia	Depression	High Blood Pressure	Pinched Nerve	Tonsillitis
Anorexia	Diabetes	High Cholesterol	Pneumonia	Tuberculosis
Appendicitis	Emphysema	Kidney Diseases	Polio	Tumors
Arthritis	Epilepsy	Liver Disease	Prostate Problems	Ulcers
Asthma	Fractures	Measles	Prosthesis	Vaginal Infections
Bleeding disorder	Glaucoma	Migraines	Psoriasis	Venereal disease
Blocked arteries	Goiter	Miscarriage	Psychiatric Care	Whooping Cough
Breast lump	Gout	Mononucleosis	Rheumatoid Arthritis	Other_____
Bronchitis	Heart Disease	Multiple Sclerosis	Rheumatic Fever	_____
Cancer	Hepatitis	Mumps	Scarlet fever	_____

Name of Primary Care Physician_____

Date of Last Exam _____

Women: Are you pregnant Y N Nursing? Y N Taking Birth Control Pills? Y N

List any surgeries you have had and the dates:

_____

_____

Family Health History:
Associated health problems of relatives:

_____

_____

Deaths in immediate family:

Cause of parent's or sibling's death	Age of Death
_____	_____
_____	_____
_____	_____

Name(print)_____**Signature**_____**Date** _____

Patient's Name: _____ Number: _____ Date: _____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to hour your neck pain as affected your ability to manage in everyday life. **Please answer every section and mark in each section ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your pain.**

Section 1 – Pain Intensity
- o I have no pain at the moment
- o The pain is very mild at the moment
- o The pain is moderate at the moment
- o The pain is fairly severe at the moment
- o The pain is very severe at the moment
- o The pain is the worst imaginable at the moment

Section 2 – Personal Care (Washing, Dressing Etc.)
- o I can look after myself normally without causing extra pain
- o I can look after myself normally but it causes extra pain
- o It is painful to look after myself and I am slow and careful
- o I need some help but manage most of my personal care
- o I need help every day in most aspects of self-care
- o I do not get dressed, I was with difficulty and stay in bed

Section 3 – Lifting
- o I can lift heavy weights without extra pain
- o I can lift heavy weights but it gives extra pain
- o Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned i.e. on a table.
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- o I can lift very light weights
- o I cannot lift or carry anything at all

Section 4 – Reading
- o I can read as much as I want to with no pain in my neck
- o I can read as much as I want to with slight pain in my neck
- o I can read as much as I want to with moderate pain
- o I cannot read as much as I want because of moderate pain in my neck
- o I can hardly read at all because of severe pain in my neck
- o I cannot read at all

Section 5 – Headaches
- o I have no headaches at all
- o I have slight headaches which come infrequently
- o I have slight headaches w come frequently
- o I have moderate headaches which come infrequently
- o I have moderate headaches which come frequently
- o I have headaches almost all the time

Signature: _____

Score: _____

Section 6 – Concentration
- o I can concentrate fully when I want to with no difficulty
- o I can concentrate fully when I want to with slight difficulty
- o I have a fair degree of difficulty in concentrating when I want to
- o I have a lot of difficulty in concentrating when I want to
- o I have a great deal of difficulty in concentrating when I want to
- o I cannot concentrate at all

Section 7 – Work
- o I can do as much as I want to
- o I can only do my usual work, but no more
- o I can do most of my usual work, but no more
- o I cannot do my usual work
- o I can hardly do any work at all
- o I cannot do any work at all

Section 8 – Driving
- o I drive my car without any neck pain
- o I can drive my car as long as I want with slight pain in my neck
- o I can drive my car as long as I want with moderate pain in my neck
- o I cannot drive my car as long as I want because of moderate pain in my neck
- o I can hardly drive my car at all because of severe pain in my neck
- o I cannot drive my care at all

Section 9 – Sleeping
- o I have no trouble sleeping
- o My sleep is slightly disturbed (less than 1 hr. sleepless)
- o My sleep is moderately disturbed (1-2 hrs. sleepless)
- o My sleep is moderately disturbed (2-3 hrs. sleepless)
- o My sleep is greatly disturbed (3-4 hrs. sleepless)
- o My sleep is completely disturbed (5-7 hrs. sleepless)

Section 10 – Recreation
- o I am able to engage in all my recreation activities with no neck pain at all
- o I am able to engage in all my recreation activities, with some pain in my neck
- o I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- o I am able to engage in few of my usual recreating activities because of pain in my neck
- o I can hardly do any recreation activities because of pain in my neck
- o I cannot do any recreation activities at all

Patient's Name: _____ Number: _____ Date: _____

Oswestry Low Back Pain Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. **Please answer by checking ONE box** in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but **please just mark the box that indicates the statement which most clearly describes your problem.**

Section 1 – Pain Intensity
- o I have no pain at the moment
- o The pain is very mild at the moment
- o The pain is moderate at the moment
- o The pain is fairly severe at the moment
- o The pain is very severe at the moment
- o The pain is the worst imaginable at the moment

Section 2 – Personal Care (Washing, Dressing Etc.)
- o I can look after myself normally without causing extra pain
- o I can look after myself normally but it causes extra pain
- o It is painful to look after myself and I am slow and careful
- o I need some help but manage most of my personal care
- o I need help every day in most aspects of selfcare
- o I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting
- o I can lift heavy weights without extra pain
- o I can lift heavy weights but it gives extra pain
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed on a table
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- o I can lift very light weights
- o I cannot lift or carry anything at all

Section 4 – Walking
- o Pain does not prevent me walking any distance
- o Pain prevents me from walking more than 1 mile
- o Pain prevents me from walking more than ½ mile
- o Pain prevents me from walking more than 100 yards
- o I can only walk using a stick or crutches
- o I am in bed most of the time

Section 5 – Sitting
- o I can sit in any chair as long as I like
- o I can only sit in my favorite chair as long as I like
- o Pain prevents me from sitting more than one hour
- o Pain prevents me from sitting more than 30 minutes
- o Pain prevents me from sitting more than 10 minutes
- o Pain prevents me from sitting at all

Signature:_____

Section 6 – Standing
- o I can stand as long as I want without extra pain
- o I can stand as long as I want but it gives me extra pain
- o Pain prevents me from standing for more than 1 hour
- o Pain prevents me from standing for more than 30 minutes
- o Pain prevents me from standing for more than 10 minutes
- o Pain prevents me from standing at all

Section 7 – Sleeping
- o My sleep is never disturbed by pain
- o My sleep is occasionally disturbed by pain
- o Because of pain I have less than 6 hours sleep
- o Because of pain I have less than 4 hours sleep
- o Because of pain I have less than 2 hours sleep
- o Pain prevents me from sleeping at all

Section 8 – Sex Life (If applicable)
- o My sex life is normal and causes no extra pain
- o My sex life is normal but causes some extra pain
- o My sex life is nearly normal but is very painful
- o My sex life is severely restricted by pain
- o My sex life is nearly absent because of pain
- o Pain prevents any sex life at all

Section 9 – Social Life
- o My social life is normal and gives me no extra pain
- o My social life is normal but increases the degree of pain
- o Pain has no significant effect on my social life apart from limiting my more energetic interests eg. sports
- o Pain has restricted my social life and I do not go out as often
- o Pain has restricted my social life to my home
- o I have no social life because of pain

Section 10 – Traveling
- o I can travel anywhere without pain
- o I can travel anywhere but it gives me extra pain
- o Pain is bad but I manage journeys over two hours
- o Pain restricts me to journeys of less than one hour
- o Pain restricts me to short necessary journeys under 30 minutes
- o Pain prevents me from traveling except to receive treatment

Score:_

VEHICLE ACCIDENT REPORT

Chart _____

Name: _____ Date: _____

1) Date of Accident _____ / _____ / _____ 2) Time of Accident _____ : _____ (AM / PM)

3) Were you: A) Driver B) Passenger (Front) C) Passenger (Rear) D) Pedestrian

4) Were you wearing seatbelts? (Y / N)

5) Type of Vehicle: A) Auto B) Truck C) Van D) Motorcycle E) Motorhome F) Bicycle

6) How accident occurred: A) Struck by another vehicle B) Struck another vehicle C) Struck a stationary object D) Other

7) Where was your vehicle hit? A) Front B) Rear C) Rt. Side D) Lft. Side E) Rt. Front F) Lft. Front G) Rt. Rear H) Lft. Rear

8) Where was other vehicle hit? A) Front B) Rear C) Rt. Side D) Lft. Side E) Rt. Front F) Lft. Front G) Rt. Rear H) Lft. Rear

9) Your approximate speed _____ MPH 10) Other vehicle approximate speed _____ MPH

11) What occurred at the moment of impact? (Circle as many as apply)

A) Tensed body BEFORE impact B) Neck whipped forward & back C) Spine torqued and twisted D) Thrown over seat
E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side H) Cut and bruised

12) Did you strike your: (Circle as many as apply)

A) Head Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

B) Shoulder (Lft./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

C) Arm (Lft./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

D) Elbow (Lft./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

E) Wrist (Lft./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

F) Hip (Lft./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

G) Knee (Lft./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

H) Ankle (Lft./Rt.) - Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

13) Were you rendered unconscious? (Y / N) 14) Did you receive medical attention at the scene of the accident? (Y / N)

15) Where did you go immediately following the accident? A) Hospital B) Home C) Personal Doctor D) To the office E) Resumed activities

16) Were you: (Circle as many as apply) A) Shaken B) Disoriented C) Confused

Did you have any physical complaints before the accident? (Y / N) If "YES" please describe: _____

_____

_____

In your own words, please describe accident: _____

_____

_____

_____

How did you feel immediately after the accident? _____

_____

_____

PATIENT SIGNATURE: _____ DATE: _____

Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely.