APPLICATION FOR TREATMENT

Date ______________________________

Name ____ Age _______ Birthdate ____________
Address ____ City ______________ State _____ ZIP Code __________
Home Phone Number ________________ Phone at Work ________________ Referred to our office by ________________
Check if you are: Married____ Single____ Widowed____ Divorced____ Separated____
Employer ____ Occupation ______________________________
Please describe the principal health problems for which you came to this office. ______________________________

____

____

____

How and when did symptoms first occur? ____
List any other doctors seen for these problems ____
List diagnosis(es) and type of treatment(s) ____

____

____

Does this interfere with your normal living and work? Yes____ No____ In what way? ______________________
Have you lost any days of work? Yes____ No____ Dates ____
Have you had similar symptoms or injuries before? Yes____ No____ If yes, explain __________________________

____

List the names of any relatives that have or have had a similar problem ____

____

Who is responsible for your bill? Self ____ Spouse____ Employer____ Insurance____ Other____________
How payment will be made: Type of Insurance:

__________ Cash __________ Worker's Compensation __________ Health Insurance
__________ Check __________ Credit Card __________ Automobile Ins. Policy

Name of Company and Address ____

____

PAST HISTORY

Have you been treated for any health condition by a physician in the last year? Yes____ No____
If yes, explain: ____

____

Have you or any relative received Chiropractic treatment previously? Yes____ No____ If yes, explain ______________

____

List the approximate dates of any operations, unusal diseases, serious illnesses or accidents you have had (include any broken bones)

____

____

List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.) ______________

____

____

FAMILY HISTORY

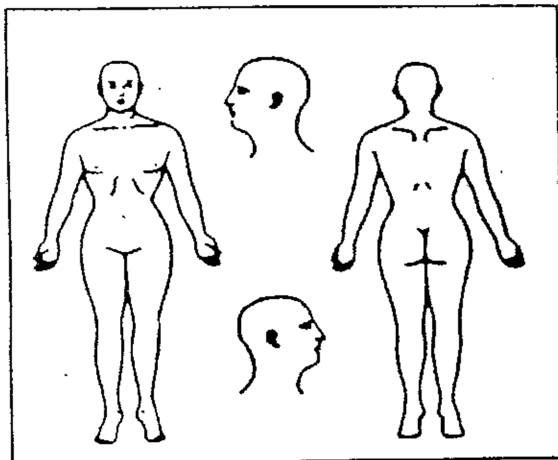
Name of wife or husband ______________________ Ages of children ______________

Spouse's Employer ______________________ Business Phone ______________

Your nearest Relative ______________________

Relative's Address ______________________

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. ______________________
2. ______________________
3. ______________________
4. ______________________

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient ______________________ Social Security Number ______________

Neck Index

Form N1-100

rev 3/27/2003

Patient Name ______________________________ ***Date*** ______________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
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.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

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 cannot 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 neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

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 only 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 cannot do any work at all.

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 I 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.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

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 cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name ______________________________ ***Date*** ____________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Sitting

⓪ I can sit in any chair 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 I avoid sitting because it increases pain immediately.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score ______

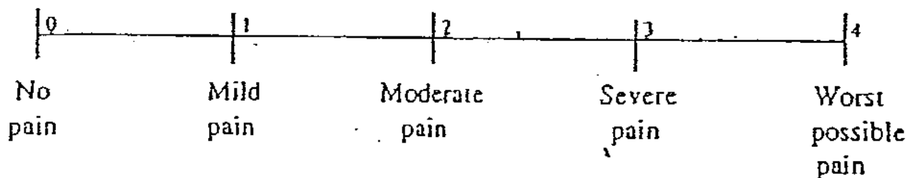
■ Appendix

Functional Rating Index

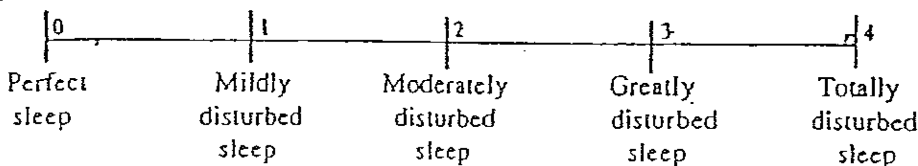
For use with <u>Neck and/or Back Problems</u> only.

In order to properly assess your condition, we must understand how much your <u>neck and/or back problems</u> have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

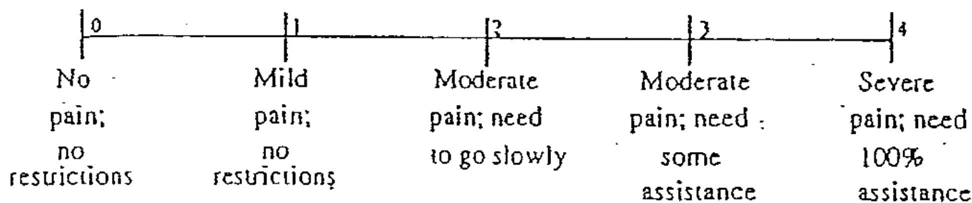
1. Pain Intensity



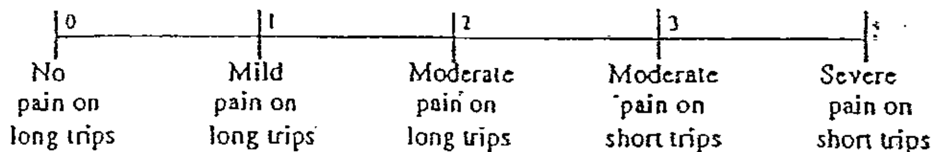
2. Sleeping



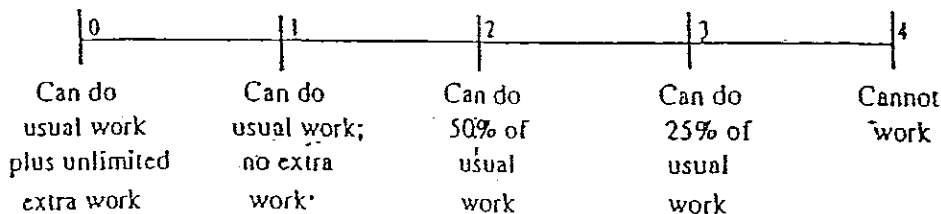
3. Personal Care (washing, dressing, etc.)



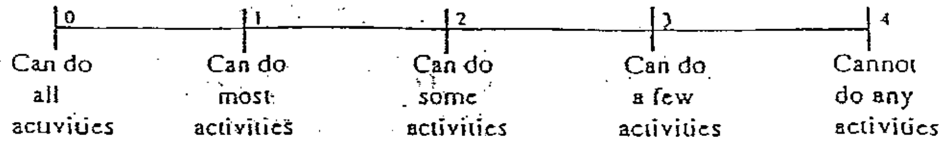
4. Travel (driving, etc.)



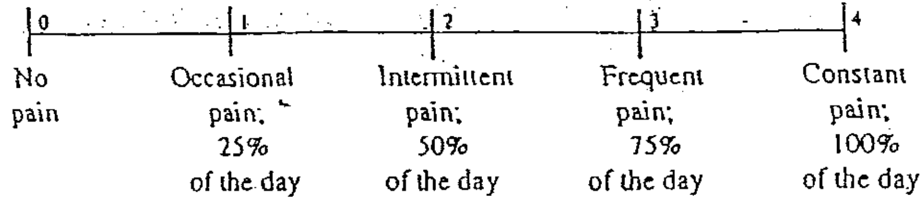
5. Work



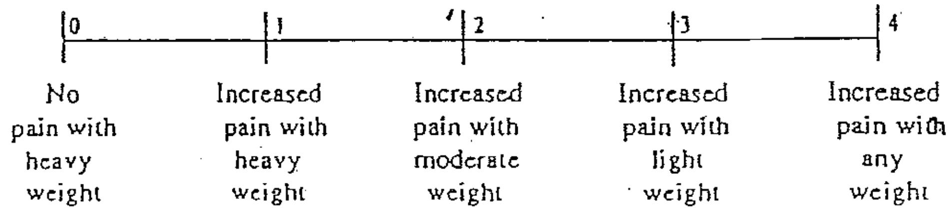
6. Recreation



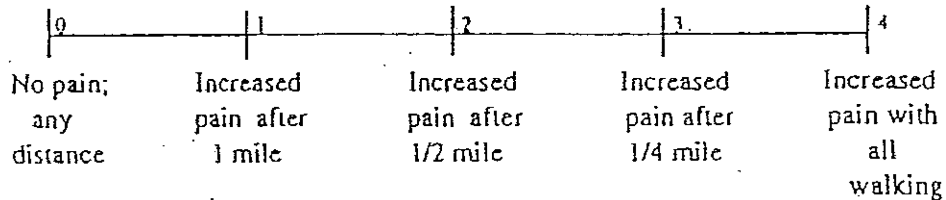
7. Frequency of pain



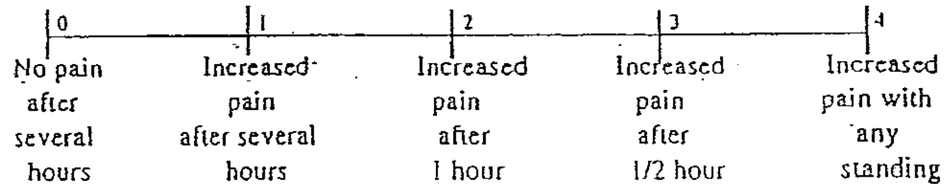
8. Lifting



9. Walking



10. Standing



Patient's Signature

Date

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PATIE NUMBER________________

PATIENT NAME________________

CONFIDENTIAL HEALTH HISTORY

The items below may relate to your current condition. In the space in front of each item enter (Y) if you have **EVER HAD** the problem or enter (N) if you have **NEVER HAD** the problem.

GENERAL
_____ Fever
_____ Chills
_____ Night Sweats
_____ Loss of Sleep
_____ Fatigue
Nervousness
_____ Weight Loss or Gain
_____ Allergies
_____ Bleeding Problem
_____ Anemia
_____ Diabetes
_____ Cancer
_____ Thyroid Disease/Goiter
_____ Alcoholism
_____ Drug Abuse
_____ Any Surgeries
_____ Any Medications
_____ Any Supplements/Vitamin

EYE EAR NOSE THROAT
____ Poor Vision
____ Pain in Eyes
____ Deafness/Difficulty Hearing
____ Nose Bleeds
____ Nose Problems
____ Sinus Trouble
____ Dental Problems
____ Hoarseness
____ Tonsillectomy

GASTROINTESTINAL
____ Poor Appetite/Digestion
____ Difficulty Swallowing
____ Belching or Gas
____ Frequent Nausea
____ Vomiting
____ Vomiting Blood
____ Pain over Abdomen
____ Ulcer
____ Black or Bloody Stools
____ Liver Problems
____ Gall Bladder Problems
____ Jaundice
____ Hernia
____ Diarrhea
____ Constipation
____ Hemorrhoids
____ Appendicitis

MEN ONLY
____ Testicular Swelling/Pain
____ Prostate Problems

RESPIRATORY
___ Difficulty Breathing
____ Chronic Cough
____ Spitting Phlegm
____ Spitting Blood
____ Wheezing/Asthma
____ Pneumonia
____ Tuberculosis

CARDIOVASCULAR
____ Irregular Heartbeat
____ High Blood Pressure
____ Pain over Heart
____ Ankle Swelling
____ Varicose Veins
____ Rheumatic Fever
____ Stroke

GENITOUINARY
____ Frequent urination
____ Painful urination
____ Blood in Urine
____ Kidney disease
____ Inability to control urination
____ Difficulty Staring Urine Flow
____ Get up _______ times per night to urinate
____ Breast Lump or Pain
____ Venereal Infection
____ Sexual Difficulties

WOMEN ONLY
____ Painful Periods
____ Excessive Flow
____ Irregular Cycle
____ Vaginal burning or itching
____ Hot Flashes
____ Date Last Period Began
____ Date of Last Pap Test

SKIN
____ Itching
____ Bruising easily
____ Change in Mole(S)
____ Skin Cancer

NERUOLOGIC
___ Weakness
Twitching
____ Tremors
____ Headache
____ Fainting
____ Dizziness
____ Convulsions
____ Epilepsy
____ Numbness/tingling
____ Arm/Leg Pain
____ Mental Disorder

MUSCULOSKETAL
___ Neck Stiffness/Pain
____ Pain Between Shoulders
____ Low Back Pain
____ Swollen Joints
____ Painful Joints
____ Muscle Aches/Soreness
____ spinal Curvature
____ Arthritis
____ Any Fractures

HABITS
____ Smoking _____ packs per day
____ Drinking
____ Recreational Drug Use

EXERCISE
____ None
____ 1-2 times per week
____ 3-5 times per week
____ 6-7 times per week

FAMILY HISTORY
____ Diabetes
____ Thyroid Disease
____ Tuberculosis
____ Kidney Disease
____ High blood Pressure
____ Heart Disease
____ Cancer
____ Muscle, bone or Nerve Disease