Initial Health Profile:

Name: _____Today's Date:_____ Date of Birth _____

Height _____ Weight _____ Age _____ M/ F **(Circle)** Social Security# _____

Address: _____ City _____ State _____ Zip Code _____

(No P.O. Boxes)

Home Telephone( )_____ Work Telephone( )_____ Cell/Pager ( ) _____

Occupation/Employer:_____ Single / Married / Divorced / Widowed **(Circle)**

Health Insurance: _____

Cardholder's Name:_____ Cardholder's Birth Date: _____

Referral source? **(Circle)** Yellow Pages / Internet/ Insurance Website/ Sign / Friend/ Family/ Other_____

If referred by friend or family, who? _____

Have you been to a chiropractor before? Y/N If YES, who and when?_____

Present and past health history:

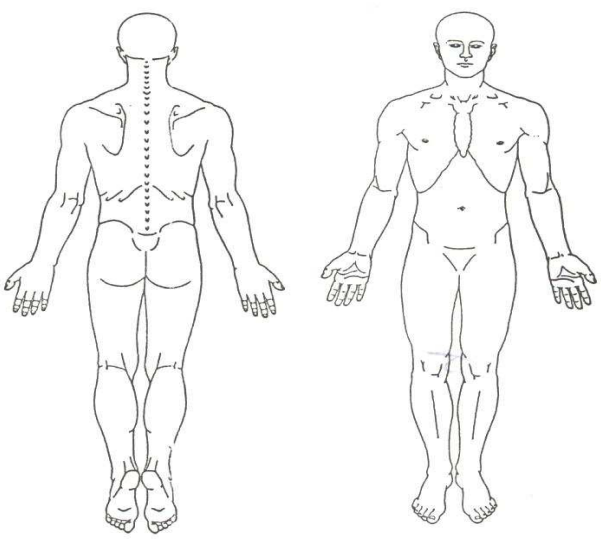
1. Describe your problem: _____

_____

2. The cause of your problem is:_____
3. How long have you had your problem?_____
4. How did your symptoms begin?_____
5. Have you had this problem before? Yes No IF YES, WHEN?_____
6. How are your symptoms changing? **(circle)**
   Improving Getting worse Staying the same
7. How often do you experience your symptoms?
   - ☐ Constantly (76-100% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Occasionally (26-50% of the time)
   - ☐ Intermittently (0-25% of the time)
8. When and what other treatment have you received for this problem?
   - ☐ Medical Doctor_____
   - ☐ Physical Therapist _____
   - ☐ Other_____
9. What other tests have you had for this problem? * Include approximate date*
   - ☐ Xrays Results:_____
   - ☐ MRI Results:_____
   - ☐ Other Results:_____
10. Who is your Primary Care Physician? _____
    Would you like for us to send over a report of our findings? YES NO
11. Circle the condition of your overall current health: Excellent Good Fair Poor
12. Circle any previously diagnosed conditions: Cancer Diabetes Heart Disease Thyroid
    Arthritis Mental Disorders Autoimmune Asthma **OTHER**:_____
13. Any family members with similar conditions?_____
14. List medications:_____
15. List known allergies:_____
16. List previous surgeries:_____
17. List previous hospitalizations:_____
18. Previous trauma history: (please include details)_____
    - ☐ Car accidents_____
    - ☐ Falls_____
    - ☐ Impact/rough sports_____
    - ☐ Childhood injuries_____

SIGNATURE:_____ **DATE:**_____

Name:_____
Date:_____ **DOB:**_____
Signature:_____



Indicate where you have pain or other symptoms:

XXX	PAIN
OOO	SPASM
+++	NUMB
- - -	OTHER

NONE			Circle your average severity of symptoms:							Unbearable
0	1	2	3	4	5	6	7	8	9	10

Check off all that apply in each section:

1. Movement Complaints
__Inflexibility
__Restricted Movement
__Stiffness
__Spasms
__Cramps
__Other:_____

2. Sensation Complaints:
__Numb
__Pins and needles
__Prickly
__Tingling
__Other**:**_____
_____

3. Pain Types
__Achey
__Burning
__Dull
__Excruciating
__Numb Ache
__Sharp
__Shooting
__Stabbing
__Hurting
__Sore
__Throbbing_____
__Other_____

4. What aggravates your problem?
__Computer work
__Coughing or sneezing
__Arising from a chair
__Bending at the waist
__Carrying
__Climbing stairs
__Driving
__Exercising
__Getting in and out of bed
__Getting in and out of a car
__Lifting
__Looking up/down/left/right
__Pushing/Pulling
__Reclining
__Repititious movements
__Sitting
__Sleeping
__Standing
__Stooping
__Walking
__Other_____
_____

5. What helps your problem?
__Nothing
__Pain medication
List:_____
__Exercising
__Reclining
__Resting
__Sitting
__Cold or Ice
__Heat or hot packs
__Stretching
__Massage
__Other_____

6. Lifestyle factors: DO YOU?
__Exercise_____
__Sit for long hours
__Sleep on a good mattress
__Sleep on a cervical pillow
What is your sleep position?
Back Stomach Side
Do you wake up in pain?
Yes No Sometimes

7. Which have you had in the past six months? UNDERLINE

Recent accident
Recent injury
Dizziness
Fatigue
Nausea
Nervousness
Weight up or down
Skin changes
Joint pain
Joint swelling
Muscle cramps
Muscle tension
Muscle weakness
Shoulder pain
Carpal Tunnel
Arm pain
Confusion
Depression
Hand trembling
Headache/migraine
Jaw pain
Incoordination
Numbness/Tingling
Weak grip
Disc problems
Sleep trouble
Heart problems
High or Low Blood pressure
Swollen ankles
Chronic chest Condition
Chest pain
Breathing problem
Short breath
Ear pain
Sore throat
Sinus problems
Vision problems
Lost appetite
Excessive thirst
Abdominal pain
Acid reflux
Constipation
Diarrhea
Bladder trouble
Bowel trouble
Sexual dysfunction

Back Index

*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.

1. Pain Intensity

0A The pain comes and goes and is very mild.
1B The pain is mild and does not vary much.
2C The pain comes and goes and is moderate.
3D The pain is moderate and does not vary much.
4E The pain comes and goes and is very severe.
5F The pain is severe and does not vary much.

2. Personal Care

0A I do not have to change my way of washing or dressing in order to avoid pain.
1B I do not normally change my way of washing or dressing even though it causes some pain.
2C Washing and dressing increases the pain but I manage not to change my way of doing it.
3D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4E Because of the pain I am unable to do some washing and dressing with out help.
5F Because of the pain I am unable to do any washing and dressing with out help.

3. Lifting

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

4. Walking

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

5. Sitting

0A I can sit in any chair as long as I like.
1B I can only sit in my favorite chair as long as I like.
2C Pain prevents me from sitting more than 1 hour.
3D Pain prevents me from sitting more than 1/2 hour.
4E Pain prevents me from sitting more than 10 minutes.
5F I avoid sitting because it increases pain immediately.

6. Standing

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

7. Sleeping

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

8. Traveling

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

9. Social Life

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

10. Changing degree of pain

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

Back index score

Neck Index

*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.

1. Pain Intensity

0A I have no pain at the moment.
1B The pain is very mild at the moment.
2C The pain comes and goes and is moderate.
3D The pain is fairly severe at the moment.
4E The pain is very severe at the moment.
5F The pain is the worst imaginable at the moment.

2. Personal Care

0A I can look after myself normally without causing extra pain.
1B I can look after myself normally but it causes extra pain.
2C It is painful to look after myself and I am slow and careful.
3D I need some help but I manage most of my personal care.
4E I need help every day in most aspects of self care.
5F I do not get dressed, I wash with difficulty and stay in bed.

3. Lifting

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

4. Reading

0A I can read as much as I want with no neck pain.
1B I can read as much as I want with slight neck pain.
2C I can read as much as I want with moderate neck pain.
3D I cannot read as I want because of moderate neck pain.
4E I can hardly read at all because of severe neck pain.
5F I cannot read at all because of neck pain.

5. Headaches

0A I have no headaches at all..
1B I have slight headaches which come infrequently.
2C I have moderate headaches which come infrequently.
3D I have moderate headaches which come frequently.
4E I have severe headaches which come frequently.
5F I have headaches almost all the time.

6. Concentration

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

7. Work

0A I can do as much as I want.
1B I can only do my usual work but no more.
2C I can only do most of my usual work but no more.
3D I cannot do my usual work.
4E I can hardly do any work at all.
5F I cannot do any work at all.

8. Driving

0A I can drive my car without any neck pain.
1B I can drive my car as long as I want with slight neck pain.
2C I can drive my car as long as I want with moderate neck pain.
3D I cannot drive my car as long as I want because of moderate neck pain.
4E I can hardly drive at all because of severe neck pain.
5F I cannot drive my car at all because of neck pain.

9. Sleeping

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

10. Recreation

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

Neck index score