FOR OFFICE USE ONLY:
Patient Number: ______________
Doctor: ______________________
Insurance: ___________________
Emp. Initials: _________________

10th VISIT CHIRO REVAL:
PATIENT INFORMATION:

Please give your Driver's License and insurance card to the front desk to copy for your records.

Patient Name: Last __________________________ **First** _________________________ **Date** _____ / _____ / _____
Address: __________________________________ **City** ______________________ **State** _____ **Zip** ____________
Cell Phone: (_____) _____ - _____ **Home Phone** (_____) ____ - _______ **Birth date** ____ / ____ / ____ **Age** ____
Sex: ____**M** ____**F** **Driver's License:** _____________________________ **Patient Soc. Sec. #** _____ - _____ - _____
Marital Status: S M D W **Spouse's Name:** _______________________ **Referred by:** _______________________
Person responsible for payment: ________________ **Patient Employed by:** _________________________________
Occupation: _____________________ **Work Phone:** (____) ____ - ______
Email: ____
Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email
Have you ever been to a Chiropractor before?: YES NO
Have you filed a legal claim at this time (circle if yes): Auto accident / Personal injury / Workman's Compensation

CAUSATION:

The cause for your visit today was from (Select one):

- □ Unknown factors
- □ auto accident
- □ work injury
- □ other accident
- □ trauma
- □ illness
- □ aggravation of a congenital problem

Date of onset (if known): ____ /____ / ____

OR (Select one):

- □ few days ago
- □ week ago
- □ couple of weeks ago
- □ month ago
- □ several months ago
- □ more than a year ago

Have you ever had this complaint before this onset? (circle one): Y N

If you circled yes, select the number of times:

- □ one
- □ two
- □ three
- □ four
- □ more than four times
- □ multiple times

Since the onset of this complaint, it has been (circle one):

- □ improving
- □ getting worse
- □ staying the same
- □ intermittent

Please add any other information about the primary complaint that may be helpful:

____

PATIENT'S INITIALS_________DATE_________

CHIEF COMPLAINT:

Please select the answers that best describe your primary complaint for today's visit. Choose MORE than one answer if appropriate.

WHERE is your WORST pain?

- □ back of the head
- □ forehead
- □ area behind the eye
- □ face
- □ neck
- □ shoulder
- □ arm
- □ hand
- □ fingers
- □ upper back
- □ chest
- □ low back and buttock region
- □ abdomen
- □ groin
- □ "tailbone"
- □ hip
- □ knee
- □ leg
- □ foot

What word(s) BEST describe(s) you pain?

- □ constant
- □ intermittent
- □ mostly on the right side
- □ mostly on the left side
- □ about equal on both sides
- □ radiating from the neck into the back of the head
- □ radiating from the neck into the shoulder
- □ radiating from the neck into the arm and hand
- □ radiating into the chest
- □ radiating into the abdomen
- □ radiating into the groin
- □ radiating into the buttock and thigh
- □ radiating into the entire leg and foot
- □ "shooting"
- □ "burning"
- □ "stinging"
- □ "crawling"
- □ "aching"
- □ "throbbing"

PAIN PROFILE:

For the following questions, please rate your pain from 1 to 10. With zero(0) being NO pain to ten(10) being maximal pain.

My pain today is: _____

The best my pain has been in last 30 days: _____

The worst my pain has been in the last 30 days: _____

Since I started coming here, my pain is (circle one): resolved much improved less severe the same more severe

PATIENT'S INITIALS_________DATE_________

REVIEW OF SYSTEMS:

If you have an issue in a section below, select your issue from the list. If you have no problems for a particular question, select the "No symptoms" box.

Do you have any ill feelings?
- ◻ No symptoms
- ◻ Decreased activity level
- ◻ Fever
- ◻ Chills
- ◻ Fatigue
- ◻ Night sweats
- ◻ Loss of appetite
- ◻ Weight loss
- ◻ Weight gain
- ◻ Loss of energy
- ◻ Uncontrolled sweating

Do you have any mental health problems?
- ◻ No symptoms
- ◻ Irritability
- ◻ Depression
- ◻ Disturbed sleep
- ◻ Suicidal thoughts
- ◻ Anxiety
- ◻ Nervousness

Do you have any trouble urinating?
- ◻ No symptoms
- ◻ Frequent urination
- ◻ Urgency
- ◻ Trouble stopping or starting stream
- ◻ Erectile dysfunction
- ◻ Nocturia
- ◻ Burning with urination
- ◻ Losing control/incontinence
- ◻ Bowel dysfunction
- ◻ Sexual dysfunction
- ◻ Hesitancy

Do you have trouble with your vision?
- ◻ No symptoms
- ◻ Blurred vision
- ◻ Double vision
- ◻ Vision loss
- ◻ Work glasses/contacts

Do you have any symptoms of heart trouble?
- ◻ No symptoms
- ◻ Chest pain
- ◻ Palpitations
- ◻ Fainting
- ◻ Shortness of breath
- ◻ Ankle swelling

Do you have any breathing problems?
- ◻ No symptoms
- ◻ Coughing
- ◻ Wheezing
- ◻ Shortness of breath

Do you have stomach problems?
- ◻ No symptoms
- ◻ Nausea
- ◻ Vomiting
- ◻ Diarrhea
- ◻ Constipation
- ◻ Loss of bowel control

Do you have muscle or joint problems?
- ◻ No symptoms
- ◻ Joint pain
- ◻ Joint weakness
- ◻ Muscle weakness

Do you have any skin problems?
- ◻ No symptoms
- ◻ Rash
- ◻ Itching
- ◻ Dryness
- ◻ Lesions
- ◻ Open wounds/infection
- ◻ Hair/nail changes

Do you have any immunity problems?
- ◻ No symptoms
- ◻ Enlarged lymph nodes
- ◻ Hives
- ◻ Hay fever
- ◻ Persistent infections

Do you have any endocrine problems?
- ◻ No symptoms
- ◻ Diabetes
- ◻ Thyroid disorder

Do you have any neurological problems?
- ◻ No symptoms
- ◻ Seizures
- ◻ Abnormal sensory feelings in extremity
- ◻ Loss of memory

Do you have any bruising or bleeding problems?
- ◻ No symptoms
- ◻ History of anemia
- ◻ Abnormal bleeding
- ◻ Bruising
- ◻ Heat intolerance
- ◻ Cold intolerance

PATIENT'S INITIALS_________DATE_________

CURRENT MEDICATIONS:

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
____________________	__________	____________	____________________	__________	____________
____________________	__________	____________	____________________	__________	____________
____________________	__________	____________	____________________	__________	____________
____________________	__________	____________	____________________	__________	____________
____________________	__________	____________	____________________	__________	____________
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____________________	__________	____________	____________________	__________	____________
____________________	__________	____________	____________________	__________	____________
____________________	__________	____________	____________________	__________	____________

ALLERGIES:

Please list any allergies as well as your reaction to the allergen if known.

Environmental Allergies: ____

Food Allergies: ____

Medication/Drug Allergies: ____

PATIENT'S INITIALS_________DATE_________

Neck Pain and Disability Index

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your **neck pain** has affected your ability to manage in everyday life. In each section, please fill in **ONE** box only which **most closely** describes your problem.

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 2 Personal Care

- ☐ **A**. I can look after myself normally without causing extra pain.
- ☐ **B**. I can look after myself normally but it causes extra pain.
- ☐ **C**. It is painful to look after myself and I am slow and careful.
- ☐ **D**. I need some 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, I wash with difficulty and stay in bed.

Section 3 Lifting

- ☐ **A**. I can lift heavy weight without extra pain.
- ☐ **B**. I can lift heavy weight but it gives extra pain.
- ☐ **C**. Pain prevents me from lifting heavy weights off the floor, but I can manage it they are conveniently positioned.
- ☐ **D**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ☐ **E**. I can lift very light weights.
- ☐ **F**. I cannot lift or carry anything at all.

Section 4 Reading

- ☐ **A**. I can read as much as I want with no pain in my neck
- ☐ **B**. I can read as much as I want with slight pain in my neck.
- ☐ **C**. I can read as much as I want with moderate pain in my neck.
- ☐ **D**. I can't read as much because of moderate pain in my neck.
- ☐ **E**. I can hardly read at all because of severe pain in my neck.
- ☐ **F**. I cannot read at all.

Section 5 Headaches

- ☐ **A**. I have no headaches at all.
- ☐ **B**. I have slight headaches which come infrequently.
- ☐ **C**. I have moderate headaches which come infrequently.
- ☐ **D**. I have moderate headaches which come frequently.
- ☐ **E**. I have severe headaches which come frequently.
- ☐ **F**. I have headaches almost all of the time.

Section 6 Concentration

- ☐ **A**. I can concentrate fully when I want with no difficulty.
- ☐ **B**. I can concentrate fully when I want with slight difficulty.
- ☐ **C**. I have a fair degree of difficulty in concentrating when I want.
- ☐ **D**. I have a lot of difficulty in concentrating when I want.
- ☐ **E**. I have a great degree of difficulty in concentrating when I want.
- ☐ **F**. I cannot concentrate at all.

Section 7 Work

- ☐ **A**. I can do as much work as I want.
- ☐ **B**. I can only do my usual work, but no more.
- ☐ **C**. I can do most of my usual work, but no more.
- ☐ **D**. I can hardly do any work at all.
- ☐ **E**. I cannot do my usual work.
- ☐ **F**. I can't do any work at all.

Section 8 Driving

- ☐ **A**. I can drive my car without any neck pain.
- ☐ **B**. I can drive my car as long as I want with slight pain in my neck.
- ☐ **C**. I can drive my car as long as I want with moderate pain.
- ☐ **D**. I can't drive my car as long as I want because of moderate pain.
- ☐ **E**. I can hardly drive at all because of severe pain in my neck.
- ☐ **F**. I can't drive my car at all.

Section 9 Sleeping

- ☐ **A**. I have no trouble sleeping.
- ☐ **B**. My sleep is slightly disturbed (less then 1hr. sleepless).
- ☐ **C**. My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ **D**. My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ **E**. My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ **F**. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 Recreation

- ☐ **A**. I am able to engage in all recreational activities with no neck pain.
- ☐ **B**. I am able to engage in all my recreational activities, with some pain in my neck.
- ☐ **C**. I am able to engage in most, but not all of my usual recreational activities because of my neck pain.
- ☐ **D**. I am able to engage in a few of my usual recreational activities because of my neck pain.
- ☐ **E**. I can hardly do any recreational activities because of pain.
- ☐ **F**. I can't do any recreational activities at all.

Office Use Only **Score:______**

PATIENT'S INITIALS_________DATE_________

Low Back Pain and Disability Index

Please Read Instructions:
This questionnaire has been designed to give the doctor information as to how your **low back pain** has affected your ability to manage in everyday life. In each section, please fill in **ONE** box only which **most closely** describes your problem.

Section 1 Pain Intensity
☐ **A**. The pain comes and goes and is very mild.
☐ **B**. The pain is mild and does not vary much.
☐ **C**. The pain comes and goes and is moderate.
☐ **D**. The pain is moderate and does not vary much.
☐ **E**. The pain comes and goes and is very severe.
☐ **F**. The pain is very severe and doesn't vary much.

Section 2 Personal Care
☐ **A**. I can look after myself normally without causing extra pain.
☐ **B**. I can look after myself normally but it causes extra pain.
☐ **C**. It is painful to look after myself and I am slow and careful.
☐ **D**. I need some help but manage most of my personal care.
☐ **E**. I need help every day in most aspects of self care.
☐ **F**. I can't dress myself. I wash with difficulty and stay in bed.

Section 3 Lifting
☐ **A**. I can lift heavy weight without extra pain.
☐ **B**. I can lift heavy weight but it gives extra pain.
☐ **C**. Pain prevents me from lifting heavy weights off the floor.
☐ **D**. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
☐ **E**. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
☐ **F**. I can only lift very light weights at the most.

Section 4 Walking
☐ **A**. I have no pain while walking.
☐ **B**. I cannot walk more than one mile without increasing pain.
☐ **C**. I cannot walk more than ½ mile without increasing pain.
☐ **D**. I cannot walk more than ¼ mile without increasing pain.
☐ **E**. I can walk with crutches.
☐ **F**. I cannot walk at all without increasing 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 one hour.
☐ **D**. Pain prevents me from sitting more than a half hour.
☐ **E**. Pain prevents me from sitting more than 10 minutes.
☐ **F**. I avoid sitting because it increases pain straight away.

Section 6 Standing
☐ **A**. I can stand as long as I want without pain.
☐ **B**. I have some pain on standing but it does not increase with time.
☐ **C**. I cannot stand for longer than one hour without increasing pain.
☐ **D**. I cannot stand for longer than a ½ hour without increasing pain.
☐ **E**. I can't stand for longer than 10 minutes without increasing pain.
☐ **F**. I avoid standing because it increases the pain straight away.

Section 7 Sleeping
☐ **A**. I get no pain in bed.
☐ **B**. I get pain in bed but it doesn't prevent me from sleeping well.
☐ **C**. Because of pain my normal night's sleep is reduced by < 1/4.
☐ **D**. Because of pain my normal night's sleep is reduced by < 1/2.
☐ **E**. Because of pain my normal night's sleep is reduced by < 3/4.
☐ **F**. Pain prevents me from sleeping at all.

Section 8 Traveling
☐ **A**. I get no pain while traveling.
☐ **B**. I get some pain while traveling but none of my usual forms of travel make it any worse.
☐ **C**. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
☐ **D**. I get extra pain while traveling which compels me to seek alternative forms of travel.
☐ **E**. Pain restricts all forms of travel.
☐ **F**. Pain prevents all forms of travel except that done lying down

Section 9 Social life
☐ **A**. My social life is normal and gives me no pain.
☐ **B**. My social life is normal but increases the degree of pain.
☐ **C**. Pain limits my more energetic interests, e.g. dancing, etc.
☐ **D**. Pain has restricted my social life and I do not go out very often.
☐ **E**. Pain has restricted my social life to my home.
☐ **F**. I have hardly any social life because of the pain.

Section 10 Changing Degree of Pain
☐ **A**. My pain is rapidly getting better.
☐ **B**. My pain fluctuates but overall is definitely getting better.
☐ **C**. My pain seems to be getting better but improvement is slow.
☐ **D**. My pain is neither getting better nor worse.
☐ **E**. My pain is gradually worsening.
☐ **F**. My pain is rapidly worsening.

Office Use Only **Score:______**

PATIENT'S INITIALS_________DATE_________