FOR OFFICE USE ONLY:
Patient Number: _____
Doctor: _____
Insurance: _____
Emp. Initials: _____

CHIRO YEARLY 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

CHIEF COMPLAINT: Answer the questions as completely as possible. If a question does not apply, leave it blank.

Reason for today's appointment: ☐ Neck pain ☐ Upper back pain ☐ Low back pain ☐ Other: _____

Which side of your body is the complaint on? ☐ Right ☐ Left ☐ Both

How long have you had this problem?
Date: _____ or _____day(s) _____ week(s) _____ month(s) _____ year(s)

How do you think your problem began?
_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the time) ☐ Frequently (50-75%) ☐ Occasionally (26-49%) ☐ Intermittently (0-25%)

Rate the severity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe

How does this effect your movement?
☐ Stiffness ☐ Spasms ☐ Cramps

What makes the symptoms worse?
_____

What makes the symptoms better?
_____

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

*****Please list any ADDITIONAL complaints that you have: (Other areas of pain, etc.)*****
_____

If you are being RE-EVALUATED ONLY:
What percentage of improvement have you had from 0-100%: _____ %

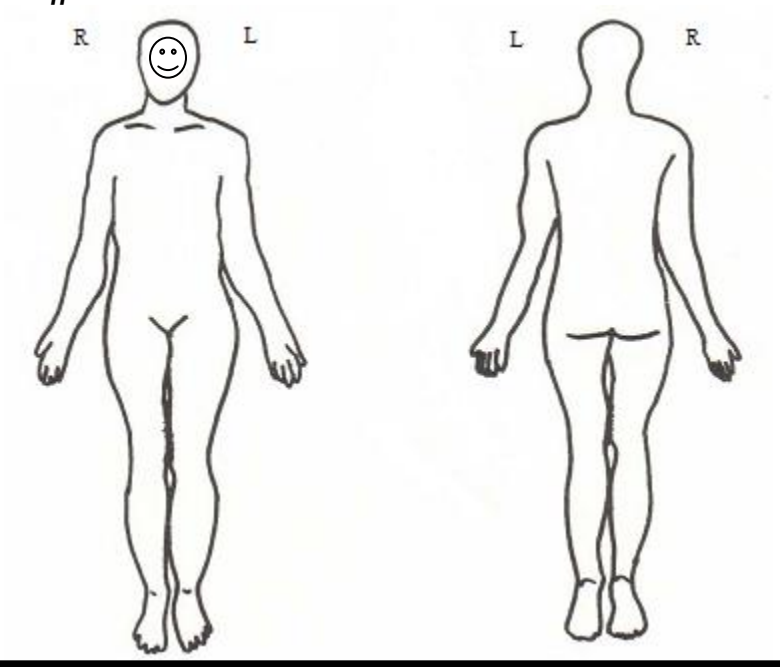
PATIENT'S INITIALS_____DATE_____

PAIN DRAWING:

INSTRUCTIONS: ***Mark the area on your body where you feel the described sensations:***

- ***Use the appropriate symbol***
- ***Mark the areas of spread***
- ***Include all affected areas***

KEY:	
Numbness / Tingling	=======
Pins & Needles	oooooooo
Burning pain	xxxxxxxx
Dull / achy pain	……
Sharp / Stabbing pain	///////////////



VISUAL PAIN SCALE

INSTRUCTIONS: ***Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate a score for each complaint. Please indicate your pain level right now, at its worst and at its best.***

Example:

Headache *Neck* *Low back*

No Pain ——— **Worst pain**

0 (1) 2 3 4 (5) 6 7 8 (9) 10

What is your pain RIGHT NOW?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its BEST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its WORST?

No Pain ——— **Worst pain**

0 1 2 3 4 5 6 7 8 9 10

PATIENT'S INITIALS_____DATE_____

REVIEW OF SYSTEMS: Please CIRCLE any condition that you CURRENTLY HAVE. Or check NONE ☐.

ALLERGIC/IMMUNOLOGIC: ☐ NONE
Food Allergies Hay fever Frequent sinus problems Hives

CONSTITUTIONAL: ☐ NONE
Fainting Poor appetite Sudden weight gain Weakness Difficulty concentrating Dizzy spells Nervousness
Low libido Fatigue Sudden weight loss Chills Difficulty sleeping Fever Night sweats

ENDOCRINE: ☐ NONE
Hypothyroid Type I Diabetes (juvenile) Frequent infections Being tired a lot Changes in hair growth Excessive hunger
Extreme thinness General weakness Heat intolerance Eat to relieve fatigue Unexplained weight loss Hyperthyroid
Type II Diabetes Loss of appetite Unusually jumpy/nervous Cold intolerance Excessive Thirst
Drowsy after eating Shaky if hungry Hoarseness Unexplained weight gain

GASTROINTESTINAL: ☐ NONE
Anorexia/Bulimia Food Sensitivities Constipation Nausea Abdominal gas Acid reflux Black /tarry stools
Frequent indigestion Ulcer Heartburn Diarrhea Vomiting Abdominal pain Belching after meals
Difficulty swallowing

HEMATOLOGIC/LYMPHATIC: ☐ NONE
Jaundice Bleeding/bruising Swollen glands Leukemia Lymphoma Liver problems Anemia Blood clots Hemophilia Myeloma

MUSCULOSKELETAL: ☐ NONE
Osteoporosis Arthritis Back pain Joint pain Muscle weakness Frequent foot/leg cramps Heel spurs Joint stiffness
Scoliosis Neck pain TMJ pain Muscle pain Back injuries General muscle tension Hot joints Joint swelling

PSYCHIATRIC: ☐ NONE
Alcoholism Emotional stress Extreme worry Feeling miserable/blue Hallucinations Recurrent bad dreams
Being timid/shy Crying often Eating when nervous Feeling angered/ irritable Insecurity Phobias Sleep walking

CARDIOVASCULAR: ☐ NONE
High blood pressure High Cholesterol Poor Circulation Unusually slow heart rate Bleeding problems Blue extremities
Light-headed when standing Heart problems Low blood pressure Chest pain Ankle swelling Angina
Blood clots Cold hands/feet Heart murmur Leg pain walking short distances

EARS, NOSE &THROAT: ☐ NONE
Ear noises/ringing Chronic ear infection Loss of taste Blisters/Cold sores Deviated Septum Dysphagia
Ear pain Frequent colds Hearing loss Loss of smell Bleeding gums Dental Problems
Dry mouth Ear discharge Excessive saliva Gum disease

EYES: ☐ NONE
Blurred vision Injury Crossed Eyed Far Sightedness Glaucoma Near sightedness Swelling
Vision Headaches Burning sensation Cataracts Dry/Gritty Feeling heartbeat in eyes Itchy Redness
Tearing/crusting

GENITOURINARY: ☐ NONE
Kidney stones Prostate issues Infertility PMS symptoms Bladder control problems Foul smelling urine
Discolored urine Frequent urination Kidney/Bladder infections Bedwetting Erectile dysfunction Discharge
Burning Difficulty starting stream Dribbling Getting up at night to urinate

INTEGUMENTARY/SKIN: ☐ NONE
Skin cancer Eczema Hair loss Boils Coarse/bumpy skin Dandruff Excessive perspiration Itching Psoriasis
Acne Rashes Bruising Corns Dryness Hair changes Nail bed changes

NEUROLOGICAL: ☐ NONE
Anxiety Headaches Pins/needles Seizures Confusion Difficulty of Speech Epilepsy Forgetfulness
Depression Dizziness/Vertigo Numbness/Tingling Memory loss Convulsions Double vision Fainting spells Hand Trembling

RESPIRATORY: ☐ NONE
Coughing Asthma Emphysema COPD Chronic cough Coughing up blood Non-productive/dry cough
Shortness of breath Apnea Pneumonia Hay fever Asbestos exposure Congestion Difficulty breathing

PATIENT'S INITIALS_____DATE_____

SOCIAL HISTORY: Please answer as completely as possible.

Marital Status: _____

Number of children: ____ Number of Pregnancies: ____ Number of miscarriages: ____ Number of abortions: ____

Highest level of education: _____

Do you feel that you eat a well-balanced diet? _____

How often do you exercise? _____ What types of exercises? _____

How often do you drink alcohol? _____

If you smoke cigarettes, how often? _____ If you chew tobacco, how often? _____

Have you ever used illegal drug? (circle) YES NO

If you use illegal drugs now, which ones? _____

Have you ever been treated for substance abuse? (circle) YES NO

Are your vaccinations up to date? (circle if known) YES NO

SURGICAL HISTORY:

Please list any surgeries that you have had in the past and the date if known. Also INCLUDE RIGHT OR LEFT side of body where applicable.

- □ **I have never had any previous surgery**

PROCEDURE:	DATE:	PROCEDURE:	DATE:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Enviromental: _____
Food: _____
Medication/Drug: _____

CURRENT MEDICATIONS:

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

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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.

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.

PATIENT'S INITIALS_____DATE_____