Patient Information Update

Welcome. We are delighted to see you again. Thank you for taking a few minutes to help us update your record.

Name: ____ Today's date: _____________
First Middle Last

1. Has your name changed since your last visit here? _____ Yes _____ No

   If yes, what was the old name? _____________________________________

   What name do you use for health insurance? _____________________________________

2. If you have a new or different address since your initial visit here, please write it below:

   ____

   ____

   ____

3. Has your marital status changed? _____ Yes _____ No
4. Has your telephone number changed? _____ Yes _____ No

   Please write your correct telephone number: _____________________________________

5. Has your employment changed? _____ Yes _____ No

   Please tell us your new employer name and address:

   ____

   ____

   ____

6. New employer telephone number: _____________________
7. Have you changed health insurance companies? _____ Yes _____ No

   If yes, please write your new health insurance carrier and address. Provide us with the new card to copy.

   Primary ______________________________ Secondary ____________________________

   _____________________________________ _____________________________________

   _____________________________________ _____________________________________

   Subscriber #: __________________________ Subscriber #: __________________________

   Group #: _____________________________ Group #: _____________________________

8. Who is responsible for this bill? ____
9. Please note any changes in your health since your last visit:

   Illness: ____

   Accident: ____

   Allergies: ____

   Medications being taken: ____

   ____

   Other: ____

   ____

   ____

Patient Signature: ____

Name: ____ Date: ____________________

√ Check each of your health problems.	√ Check which side of your body it is located.	At its worst, how severe is your health problem? (10 is the most severe) *Circle the number.*	What percentage of your waking day do you feel your health problems? (100% is constant)
HEAD PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 1. Headaches or Migraines	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 2. TMJ (jaw) Pain/Clicking	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
SPINAL PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 3. Neck □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 4. Upper Shoulder (trapezius) Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 5. Upper Back (Shoulder blades) Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 6. Middle Back □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 7. Low Back □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 8. Pelvis/Buttock Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
UPPER EXTREMITY (ARM) PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 9. Shoulder Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 10. Elbow Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 11. Wrist Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 12. Hand □Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 13. Arm □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
LOWER EXTREMITY (LEG) PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 14. Hip Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 15. Knee Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 16. Ankle Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 17. Foot □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 18. Leg □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
CHEST, ABDOMINAL OR PELVIC PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 19. Chest Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 20. Abdominal Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 21. Pelvic Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%

Answer the following questions regarding your health problems:

Which health problem concerns you the most? ____

Describe your health problem: □ sharp □ dull ache □ burning □ radiating/spreading □ throbbing □ pinching □ twinge

Explain: ____

How many days out of the week do you experience you health problem? □ daily □ 6 □ 5 □ 4 □ 3 □ 2 □ 1 day (s)

What time of the day is your health problem the worst? □ morning □ afternoon □ evening □ sleeping □ all day □ varies

How long have you been experiencing your health problem? □ ___ day(s) □ ___ week(s) □ ___ month(s) □ ___year(s)

Have you experienced your current health problem in the past? □ No □ Yes, the last time was _________________ ago.

What do you feel caused your health problem? □ I don't know □ injury □ auto accident □ stress □ developed over time

Explain: ____

What aggravates or makes you health problem worse? ____

What relieves or makes your health problems better? ____

Who have you seen previously for this health problem? □ No one □ Chiropractor □ Medical □ Physical Therapist

What treatment did you receive? ____

Which of the following activities of daily life are being adversely affected by your current health problem?

□ Sitting	□ Walking	□ Climbing stairs	□ Housework	□ Job/Work
□ Standing up	□ Running	□ Bending over	□ Cooking	□ Computer work
□ Standing	□ Exercising	□ Sleeping	□ Laundry	□ Social life
□ Laying on side L R	□ Sports activities	□ Lifting children	□ Yard work	□ Relationships
□ Laying on back	□ Relaxation	□ Playing with kids	□ Driving	□ Finances

Other activities not listed: ____

Name: ____ Date: ___________________

This questionnaire will give Family Chiropractic 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. Circle the number that corresponds to your answer.

PLEASE ANSWER THESE QUESTIONS SPECIFIC TO YOUR BACK.

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.

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.

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 ½ hour.
4 Pain prevents me from sitting more than 10 minutes.
5 I avoid sitting because it increases the pain immediately.

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 ½ 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.

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 ½ mile without increasing pain.
4 I cannot walk more than ¼ mile without increasing pain.
5 I cannot walk at all without increasing pain.

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.

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 if they are conveniently positioned.
5 I can only lift very light weights.

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.

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.

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.

Name: ____ Date: ____________________

This questionnaire will give Family Chiropractic 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. Circle the number that corresponds to your answer.

PLEASE ANSWER THESE QUESTIONS SPECIFIC TO YOUR NECK.

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 prevent 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.