BROWN CHIROPRACTIC CENTER

YOUR HEALTH IS OUR MISSION

Patient Name_____ Birthdate _____ Age _____ Sex: M / F

Address _____ City _____ State _____ Zip _____

Occupation_____ Employer_____

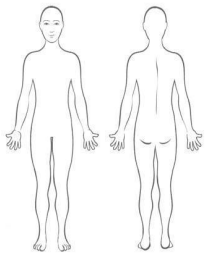
Phone # _____ Cell # _____ Height ____ ' ____" Weight _____

Insurance _____ SS#_____ *Marital Status* ____ *Spouse's Name* _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN: ***{Circle Pain Area}***

○ Headache ○ Neck Pain ○ Mid-Back Pain ○ Low Back Pain

○ Other _____



Is this? ○ Work Related ○ Auto Related ○ N/A

Date Problem Began _____ How Problem Began_____

What describes the nature of your symptoms?

○ Sharp ○ Dull ache ○ Numb ○ Shooting ○ Burning ○ Tingling

How often are your symptoms present?

(Occasional) ○ 0 - 25% ○ 26 - 50% ○ 51 - 75% ○ 76 - 100% (Constant)

In general would you say your overall health right now is:

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? NO YES

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

◯ Alcohol/Drug Dependence
◯ Recent Fever
◯ Diabetes
◯ High Blood Pressure
◯ Stroke (Date) _____
◯ Corticosteroid Use (Cortisone, Prednisone, etc.)
◯ Taking Birth Control Pills
◯ Dizziness/Fainting
◯ Numbness in Groin/Buttocks
◯ Cancer/Tumor (Explain) _____
_____
◯ Osteoporosis
◯ Epilepsy/Seizures
◯ Other Health Problems (Explain) _____

◯ Prostate Problems
◯ Menstrual Problems
◯ Urinary Problems
◯ Currently Pregnant, # Weeks _____
◯ Abnormal Weight ○ Gain ○ Loss
◯ Marked Morning Pain/Stiffness
◯ Pain Unrelieved by Position or Rest
◯ Pain at Night
◯ Visual Disturbances
◯ Surgeries _____
_____
◯ Tobacco Use - Type _____
◯ Frequency _____/Day
◯ Medications _____

Family History: ○ Cancer ○ Diabetes ○ High Blood Pressure
○ Heart Problems/Stroke ○ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my Physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ **Date** _____

REVIEW OF SYSTEMS: Circle Yes (Y) or No (N):

Constitutional			**Respiratory**			**Gastrointestinal**			**Dermatology**		
Recent weight loss	Y	N	Cough	Y	N	Abdominal pain	Y	N	Rashes	Y	N
Fever	Y	N	Wheezing	Y	N	Heartburn	Y	N	Sores	Y	N
Chills	Y	N	Short of breath	Y	N	Bloody stool	Y	N	Blisters	Y	N
									Dry or sensitive skin	Y	N
Endocrine			**Allergy**			**Psychology**			Hives	Y	N
Excessive thirst	Y	N	Runny nose	Y	N	Depression	Y	N	Suspicious moles	Y	N
Excessive sweating	Y	N	Itchy eyes	Y	N	Mood swings	Y	N	Suspicious lesions	Y	N
Excessive urination	Y	N	Stuffy nose	Y	N	Anxiety	Y	N	Itching	Y	N

Urology			**ENT**			**Genitourinary (Female)**			**Hematologic/Lymphatic**		
Frequent urination	Y	N	Nose bleeds	Y	N	Pelvic pain	Y	N	Easy bruising	Y	N
Difficulty urinating	Y	N	Sore throat	Y	N	Irregular periods	Y	N	Swollen glands	Y	N
Blood in urine	Y	N	Change in voice	Y	N	Recurrent infections	Y	N	Fatigue	Y	N

Cardiology			**Ophthalmology**			**Musculoskeletal**			**Neurology**		
Palpitations	Y	N	Eye irritation	Y	N	Muscle aches	Y	N	Dizziness	Y	N
Chest pains/tightness	Y	N	Blurred vision	Y	N	Joint pain	Y	N	Headaches	Y	N
High blood pressure	Y	N	Eye drainage	Y	N	Joint swelling	Y	N	Seizures	Y	N
Varicose veins	Y	N	Visual changes	Y	N	Joint stiffness	Y	N	Weakness	Y	N

FAMILY HISTORY: Does anyone in your family have a history of diabetes, rheumatoid arthritis, heart problems, stroke, cancer or multiple sclerosis? If Yes, please specify_____

_____

Has anyone in your family ever had a spine problem similar to the one you are currently experiencing? Please circle

Mother Father Sister Brother Grandmother Grandfather

List **ALL** prescription and over-the-counter medications you are currently taking_____

_____

Past surgeries_____

Past fractures/dislocations_____

Past car accidents_____

Past traumas_____

List **ALL** allergies_____

EXERCISE	**WORK ACTIVITY**	**HABITS**	
None	Sitting	Smoking/Snuff	Packs or cans/day_____
1-3 x / wk	Standing	Alcohol	Drinks/wk_____
4-6 x / wk	Light Labor	Coffee/Caffeine Drinks	Cups/Day_____
Daily	Heavy Labor	High Stress Level	Reason_____

I authorize payment to the Brown Chiropractic Center. Brown Chiropractic Center may use and share your health information without your written authorization, for activities relating to treatment, payment, and health care operations. I have received a copy of the Notice of Privacy & Patient Rights for the Brown Chiropractic Center.

*Signature*_____ *Date*_____

Doctor comments/notes: _____

_____

_____

_____

BCBS BCBS State UHC Aetna Cigna Medicare/Supp Humana(Medicare) Medicare/COB

Medicaid/Ambetter/Magnolia/UHC Medicare/Medicaid CHIPS Self Pay Other_____

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

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. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

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