

Patient Health History

Today's Date / Signature of Patient _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check all that apply)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email Text Message

Date of Birth / Age _____ Gender (check one) Male Female Unspecified

Marital Status (check one) Single Married Other SSN _____

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Place of Employment: _____

Insured's Name (if not self) _____ Insured's DOB /

Insured's Place of employment _____ Insured's SSN _____

Family Physician _____ Referred by: _____

Race (check one)

- | | | | |
|-----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Filipino |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Native Hawaiian or other Pacific Island |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I choose not to specify |

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

- | | | | | | |
|----------------------------------|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Chinese | <input type="checkbox"/> French | <input type="checkbox"/> German |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Italian | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Japanese | <input type="checkbox"/> French Creole | <input type="checkbox"/> Greek | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Persian | <input type="checkbox"/> Urdu | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Armenian | <input type="checkbox"/> I choose not to specify | |

Patient Health Questionnaire - PHQ

Patient Name _____ Date _____

1. Describe your symptoms _____

- a. When did your symptoms start? _____
- b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- a. Constantly (76-100% of the day)
- b. Frequently (51-75% of the day)
- c. Occasionally (26-50% of the day)
- d. Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?

- a. Sharp
- b. Dull ache
- c. Numb
- d. Shooting
- e. Burning
- f. Tingling

4. How are your symptoms changing?

- a. Getting Better
- b. Not Changing
- c. Getting Worse

5. During the past 4 weeks:

- a. Indicate the average intensity of your symptoms
None _____ Unbearable
0 1 2 3 4 5 6 7 8 9 10
- b. How much has pain interfered with your normal work (including both work outside the home and housework):
Not at all A little bit Moderately Quite a bit Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (Like visiting with friends, relatives, etc)

All of the time Most of the time Some of the time A little of the time None of the time

7. In general would you say your overall health right now is...

Excellent Very Good Good Fair Poor

8. Who have you seen for your symptoms? 1. No One 2. Other Chiropractor 3. Medical Doctor

4. Other 5. Physical Therapist

a. What treatment did you receive and when? _____

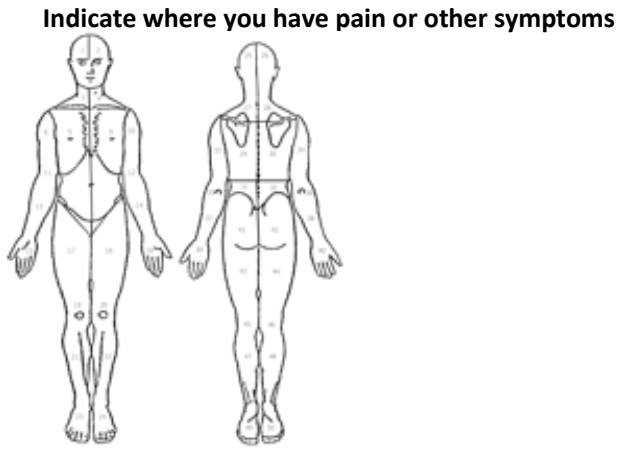
b. What tests have you had for your symptoms and when were they performed?
1. Xrays date: _____ 3. CT Scan date: _____
2. MRI date: _____ 4. Other date: _____

9. Have you had similar symptoms in the past? 1. Yes 2. No

- a. If you have received treatment in the past for the same or similar symptoms, who did you see?
1. This Office 2. Other Chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other _____

10. List all of the surgical procedures you have had and times you have been hospitalized: _____

Patient Signature _____ Date _____



Cardiovascular:	Present	Past	No
Poor Circulation	0	0	0
High Blood Pressure	0	0	0
Aortic Aneurysm	0	0	0
Heart Disease	0	0	0
Vascular Disease	0	0	0
Heart Attack	0	0	0
Chest Pain	0	0	0
High Cholesterol	0	0	0
Pace Maker	0	0	0
Jaw Pain	0	0	0
Irregular Heart Beat	0	0	0
Swelling of Legs	0	0	0

Genitourinary:	Present	Past	No
Bladder Infection	0	0	0
Kidney Disease	0	0	0
Lower Side Pain	0	0	0
Burning Urination	0	0	0
Frequent Urination	0	0	0
Blood in Urine	0	0	0
Kidney Stone	0	0	0
Loss of Bladder Control	0	0	0
Prostate Problem	0	0	0

Hematologic/Lymph:	Present	Past	No
Hepatitis	0	0	0
Blood Clots	0	0	0
Easy Bleeding	0	0	0
Easy Bruising	0	0	0
Cancer	0	0	0
Fever/Chills/Sweats	0	0	0

Respiratory:	Present	Past	No
Tuberculosis	0	0	0
Asthma	0	0	0
Emphysema	0	0	0
Shortness of Breath	0	0	0
Cold/Flu	0	0	0
Cough/Wheezing	0	0	0

Ear/Nose/Throat:	Present	Past	No
Dizziness	0	0	0
Hearing Loss	0	0	0
Sinus Infection	0	0	0
Nosebleed	0	0	0
Sore Throat	0	0	0
Difficulty Swallowing	0	0	0
Bleeding Gums	0	0	0
Chronic Sinusitis	0	0	0

Eyes:	Present	Past	No
Glasses/Contacts	0	0	0
Glaucoma	0	0	0
Double vision	0	0	0
Blurred Vision	0	0	0

Integumentary:	Present	Past	No
Skin Lesions	0	0	0
Skin Ulcers	0	0	0
Skin Disease	0	0	0
Eczema	0	0	0
Psoriasis	0	0	0
Rashes	0	0	0

Allergic/Immune:	Present	Past	No
Hives	0	0	0
Immune Disorder	0	0	0
HIV/AIDS	0	0	0
Cortisone Use	0	0	0

Gastrointestinal	Present	Past	No
Acid Relfux	0	0	0
Gallbladder Problems	0	0	0
Bowel Problems	0	0	0
Constipation	0	0	0
Liver Problems	0	0	0
Ulcers	0	0	0
Diarrhea	0	0	0
Nausea/Vomiting	0	0	0
Bloody Stools	0	0	0
Poor Appetite	0	0	0

Muskuloskeletal:	Present	Past	No
Gout	0	0	0
Arthritis	0	0	0

Muskuloskeletal:	Present	Past	No
Joint Stiffness	0	0	0
Muscle Weakness	0	0	0
Osteoporosis	0	0	0
Broken Bones	0	0	0
Joints replaced	0	0	0
Disc Herniation	0	0	0

Endocrine:	Present	Past	No
Thyroid Disease	0	0	0
Diabetes	0	0	0
Hair Loss	0	0	0
Menopausal	0	0	0
Menstrual Problems	0	0	0

Psychiatric:	Present	Past	No
Depression	0	0	0
Anxiety Disorder	0	0	0
Unusual Stress	0	0	0

Constitutional:	Present	Past	No
Abnormal Weight Loss	0	0	0
Abnormal Weight Gain	0	0	0
Energy Level Problem	0	0	0
Difficulty Sleeping	0	0	0

Neurological:	Present	Past	No
Stroke	0	0	0
Seizure	0	0	0
Head Injury	0	0	0
Brain Aneurysm	0	0	0
Numbness	0	0	0
Headaches	0	0	0
Severe Headaches	0	0	0
Pinched Nerves	0	0	0
Parkinson's Disease	0	0	0
Carpal Tunnel	0	0	0
Spinning/Balance	0	0	0

Females Only	Present	Past	No
Birth Control Pills	0	0	0
Hormonal Replacement	0	0	0
Pregnancy	0	0	0

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<p>SECTION 1 - Pain Intensity</p> <ul style="list-style-type: none"> <input type="radio"/> I have no pain at the moment <input type="radio"/> The pain is very mild at the moment. <input type="radio"/> The pain is moderate at the moment. <input type="radio"/> The pain is fairly severe at the moment. <input type="radio"/> The pain is very severe at the moment. <input type="radio"/> The pain is the worst imaginable at the moment. 	<p>SECTION 6 - Concentration</p> <ul style="list-style-type: none"> <input type="radio"/> I can concentrate fully when I want to with no difficulty. <input type="radio"/> I can concentrate fully when I want to with slight difficulty. <input type="radio"/> I have a fair degree of difficulty in concentrating when I want to. <input type="radio"/> I have a lot of difficulty in concentrating when I want to. <input type="radio"/> I have a great deal of difficulty in concentrating when I want to. <input type="radio"/> I cannot concentrate at all.
<p>SECTION 2 - Personal Care (Washing, Dressing, etc.)</p> <ul style="list-style-type: none"> <input type="radio"/> I can look after myself normally without causing extra pain. <input type="radio"/> I can look after myself normally, but it causes extra pain. <input type="radio"/> It is painful to look after myself and I am slow and careful. <input type="radio"/> I need some help, but manage most of my personal care. <input type="radio"/> I need help every day in most aspects of self care. <input type="radio"/> I do not get dressed, I wash with difficulty and stay in bed. 	<p>SECTION 7 - Work</p> <ul style="list-style-type: none"> <input type="radio"/> I can do as much work as I want to. <input type="radio"/> I can only do my usual work, but no more. <input type="radio"/> I can do most of my usual work, but no more. <input type="radio"/> I cannot do my usual work. <input type="radio"/> I can hardly do any work at all. <input type="radio"/> I cannot do any work at all.
<p>SECTION 3 - Lifting</p> <ul style="list-style-type: none"> <input type="radio"/> I can lift heavy weights without extra pain. <input type="radio"/> I can lift heavy weights, but it gives extra pain. <input type="radio"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. <input type="radio"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="radio"/> I can lift very light weights. <input type="radio"/> I cannot lift or carry anything at all. 	<p>SECTION 8 - Driving</p> <ul style="list-style-type: none"> <input type="radio"/> I can drive without any neck pain. <input type="radio"/> I can drive as long as I want with slight pain in my neck. <input type="radio"/> I can drive as long as I want with moderate pain in my neck. <input type="radio"/> I cannot drive as long as I want because of moderate pain in my neck. <input type="radio"/> I can hardly drive at all because of severe pain in my neck. <input type="radio"/> I cannot drive my car at all.
<p>SECTION 4 - Reading</p> <ul style="list-style-type: none"> <input type="radio"/> I can read as much as I want to with no pain in my neck. <input type="radio"/> I can read as much as I want to with slight pain in my neck. <input type="radio"/> I can read as much as I want to with moderate pain in my neck. <input type="radio"/> I cannot read as much as I want because of moderate pain in my neck. <input type="radio"/> I can hardly read at all because of severe pain in my neck. <input type="radio"/> I cannot read at all. 	<p>SECTION 9 - Sleeping</p> <ul style="list-style-type: none"> <input type="radio"/> I have no trouble sleeping. <input type="radio"/> My sleep is slightly disturbed (less than 1 hour sleepless). <input type="radio"/> My sleep is mildly disturbed (1-2 hours sleepless). <input type="radio"/> My sleep is moderately disturbed (2-3 hours sleepless). <input type="radio"/> My sleep is greatly disturbed (3-5 hours sleepless). <input type="radio"/> My sleep is completely disturbed (5-7 hours)
<p>SECTION 5 - Headaches</p> <ul style="list-style-type: none"> <input type="radio"/> I have no headaches at all. <input type="radio"/> I have slight headaches which come infrequently. <input type="radio"/> I have moderate headaches which come infrequently. <input type="radio"/> I have moderate headaches which come frequently. <input type="radio"/> I have severe headaches which come frequently. <input type="radio"/> I have headaches almost all the time. 	<p>SECTION 10 - Recreation</p> <ul style="list-style-type: none"> <input type="radio"/> I am able to engage in all of my recreational activities with no neck pain at all. <input type="radio"/> I am able to engage in all of my recreational activities with some pain in my neck. <input type="radio"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck. <input type="radio"/> I have neck pain with most recreational activities. <input type="radio"/> I can hardly do any recreational activities because of pain in my neck. <input type="radio"/> I cannot do any recreational activities at all.

COMMENTS: _____

NAME: _____ **DATE:** _____ **SCORE:** _____

Back PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

<p>Section 1: Pain Intensity</p> <ul style="list-style-type: none"> <input type="radio"/> The pain comes and goes and is very mild. <input type="radio"/> The pain is mild and does not vary much. <input type="radio"/> The pain is moderate and comes and goes. <input type="radio"/> The pain is moderate and does not vary much. <input type="radio"/> The pain comes and goes and is very severe. <input type="radio"/> The pain is severe and does not vary much. 	<p>Section 6: Standing</p> <ul style="list-style-type: none"> <input type="radio"/> I can stand as long as I want without pain. <input type="radio"/> I have some pain while standing, but it does not increase with time. <input type="radio"/> I cannot stand for longer than one hour without increasing pain. <input type="radio"/> I cannot stand for longer than 1/2 hour without increasing pain. <input type="radio"/> I cannot stand for longer than 10 minutes without increasing pain. <input type="radio"/> Pain prevents me from standing at all.
<p>Section 2: Personal Care</p> <ul style="list-style-type: none"> <input type="radio"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="radio"/> I do not normally change my way of washing or dressing even though it causes some pain. <input type="radio"/> Washing and dressing increases the pain, but I manage not to change my way of doing it. <input type="radio"/> Washing and dressing increases the pain and I find it necessary to change my way of doing it. <input type="radio"/> Because of the pain, I am unable to do some washing and dressing without help. <input type="radio"/> Because of the pain, I am unable to do any washing and dressing without help. 	<p>Section 7: Sleeping</p> <ul style="list-style-type: none"> <input type="radio"/> I get no pain in bed. <input type="radio"/> I get pain in bed, but it does not prevent me from sleeping well. <input type="radio"/> Because of pain, my normal night's sleep is reduced by less than 1/4. <input type="radio"/> Because of pain, my normal night's sleep is reduced by less than 1/2. <input type="radio"/> Because of pain, my normal night's sleep is reduced by less than 3/4. <input type="radio"/> Pain prevents me from sleeping at all.
<p>Section 3: Lifting</p> <ul style="list-style-type: none"> <input type="radio"/> I can lift heavy weights without extra pain. <input type="radio"/> I can lift heavy weights, but it causes extra pain. <input type="radio"/> Pain prevents me from lifting heavy weights off the floor. <input type="radio"/> Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table). <input type="radio"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="radio"/> I can only lift very light weights at the most 	<p>Section 8: Social Life</p> <ul style="list-style-type: none"> <input type="radio"/> My social life is normal and gives me no pain. <input type="radio"/> My social life is normal, but increases the degree of my pain. <input type="radio"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc. <input type="radio"/> Pain has restricted my social life and I do not go out very often. <input type="radio"/> Pain has restricted my social life to my home. <input type="radio"/> I have hardly any social life because of the pain.
<p>Section 4: Walking*</p> <ul style="list-style-type: none"> <input type="radio"/> I have no pain on walking. <input type="radio"/> Pain prevents me from walking more than one mile. <input type="radio"/> Pain prevents me from walking more than 1/2 mile. <input type="radio"/> Pain prevents me from walking more than 1/4 mile. <input type="radio"/> I can only walk using a cane or crutches. <input type="radio"/> I am in bed most of the time and have to crawl to the toilet. 	<p>Section 9: Traveling</p> <ul style="list-style-type: none"> <input type="radio"/> I get no pain while travelling. <input type="radio"/> I get some pain while travelling, but none of my usual forms of travel makes it any worse. <input type="radio"/> I get extra pain while travelling, but it does not compel me to seek alternative forms of travel. <input type="radio"/> I get extra pain while travelling, which compels me to seek alternative forms of travel. <input type="radio"/> Pain restricts all forms of travel. <input type="radio"/> Pain prevents all forms of travel except that done lying down
<p>Section 5: Sitting</p> <ul style="list-style-type: none"> <input type="radio"/> I can sit in any chair as long as I like. <input type="radio"/> I can only sit in my favorite chair as long as I like. <input type="radio"/> Pain prevents me from sitting more than one hour. <input type="radio"/> Pain prevents me from sitting more than 1/2 hour. <input type="radio"/> Pain prevents me from sitting more 10 minutes. <input type="radio"/> Pain prevents me from sitting at all. 	<p>Section 10: Changing Degree of Pain</p> <ul style="list-style-type: none"> <input type="radio"/> My pain is rapidly getting better. <input type="radio"/> My pain fluctuates, but is definitively getting better. <input type="radio"/> My pain seems to be getting better, but improvement is slow at present. <input type="radio"/> My pain is neither getting better nor worse. <input type="radio"/> My pain is gradually worsening. <input type="radio"/> My pain is rapidly worsening.

COMMENTS: _____

NAME: _____ **DATE:** _____ **SCORE:** _____