

# Confidential Patient Health Record

Today's Date: \_\_\_/\_\_\_/\_\_\_

**How did you hear about us?**  Family \_\_\_\_\_  Friend \_\_\_\_\_  
 Co-Worker \_\_\_\_\_  Close to home/work  Yellow pages  Drove by  Hospital  
 Dr. \_\_\_\_\_  Insurance Plan  Internet

## Personal Information

Title:  Mr.  Ms.  Mrs.

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Suffix:  Jr  Sr  II  III

Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female SSN: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Separated

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Email Address: \_\_\_\_\_ Spouses Name: \_\_\_\_\_

Children (Names and Ages): \_\_\_\_\_  
\_\_\_\_\_

## Emergency Contact

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

## Employment Information

Business Name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer's Email Address: \_\_\_\_\_

Occupation/Job Title: \_\_\_\_\_ Job Description \_\_\_\_\_

## Current Health Condition

Unwanted Condition (Why you are here today?): \_\_\_\_\_  
\_\_\_\_\_

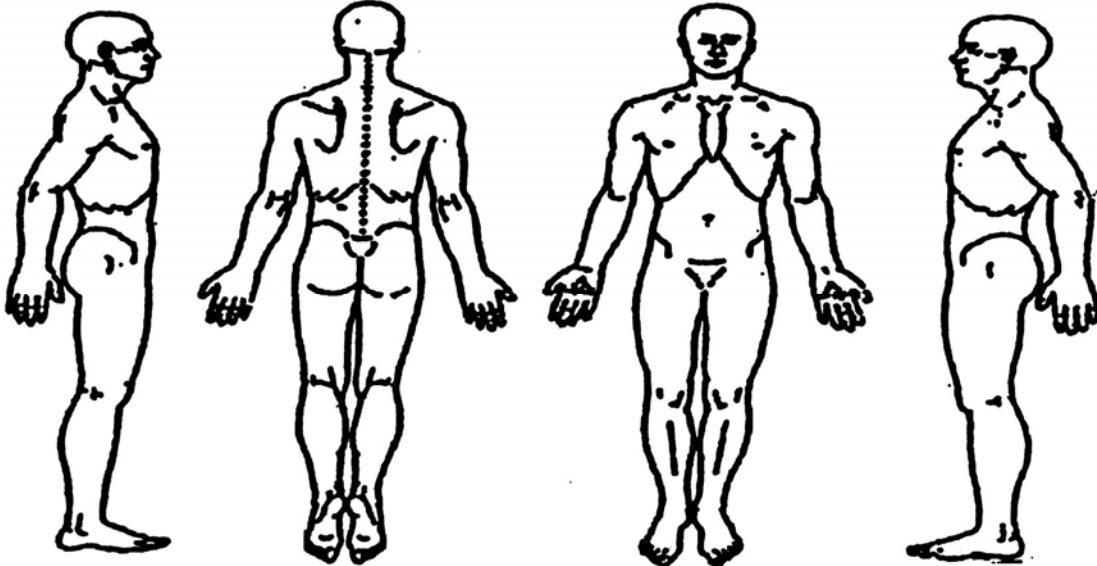
Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT INTAKE FORM

1. Is today's problem caused by:  Auto Accident     Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)     Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)     Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp     Numb  
 Dull     Tingly  
 Diffuse     Sharp with motion  
 Achy     Shooting with motion  
 Burning     Stabbing with motion  
 Shooting     Electric like with motion  
 Stiff     Other: \_\_\_\_\_

5. How are your symptoms changing with time?

- Getting Worse     Staying the Same     Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

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

7. How much has the problem interfered with your work?

- Not at all     A little bit     Moderately     Quite a bit     Extremely

8. How much has the problem interfered with your social activities?

- Not at all     A little bit     Moderately     Quite a bit     Extremely

9. Who else have you seen for your problem?

- Chiropractor     Neurologist     Primary Care Physician  
 ER physician     Orthopedist     Other: \_\_\_\_\_  
 Massage Therapist     Physical Therapist     No one

10. How long have you had this problem? \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**11. How do you think your problem began?**

**12. Do you consider this problem to be severe?**

- Yes
- Yes, at times
- No

**13. What aggravates your problem?**

What alleviates your problem?

**14. What concerns you the most about your problem; what does it prevent you from doing?**

**15. What is your:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_

**16. How would you rate your overall Health?**

- Excellent
- Very Good
- Good
- Fair
- Poor

**17. What type of exercise do you do?**

- Strenuous
- Moderate
- Light
- None

**18. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis
- Diabetes
- Lupus
- Heart Problems
- Cancer
- ALS

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**For Females Only**

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

20. List all prescription medications you are currently taking:

\_\_\_\_\_

21. List all of the over-the-counter medications you are currently taking:

\_\_\_\_\_

22. List all surgical procedures you have had:

\_\_\_\_\_

23. What activities do you do at work?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day    | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work?

\_\_\_\_\_

25. Have you ever been hospitalized?     No     Yes

if yes, why \_\_\_\_\_

26. Have you had significant past trauma?     No     Yes

27. Anything else pertinent to your visit today? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

## NECK DISABILITY INDEX

Name: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

### 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 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 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 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 not do any work at all.**

### 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.
- 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 8 – Driving

- I can 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 at all because of severe pain in my neck
- I can't drive my car at all.**

### SECTION 4 – Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- 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 due to pain.

### SECTION 9 – Sleeping

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

### SECTION 5 – Headaches

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

### 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 neck pain.
- 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.

## REVISED OSWESTRY INDEX

Name: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

### SECTION 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderately increasing
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

### SECTION 2 – Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

### 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.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. 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 only lift very light weights at the most.

### SECTION 4 – Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

### SECTION 5 – Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

### SECTION 6 – Standing

- I can stand as long as I want without pain.
- I have some pain standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

### SECTION 7 – Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼.
- Because of pain, my normal night's sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

### SECTION 8 – Social Life

- My social life is normal and gives me no 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 much.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

### SECTION 9 – Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it worse.
- I get extra pain while traveling, but it does not compel me to **seek alternative forms of travel.**
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain prevents all forms of travel except done lying down.
- Pain restricts all forms of travel.

### SECTION 10 – Changing Degrees 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 slowly improves.**
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.