**Patient Name**_____ **Date**_____ File#_____

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

**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 severe.
- ☐ F. The pain is severe and does not vary much.

**SECTION 2 - Personal Care**

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

**SECTION 3 - Lifting**

- ☐ A. I can lift heavy weights without extra pain.
- ☐ B. I can lift heavy weights, but it causes extra pain.
- ☐ C. Pain prevents me from lifting heavy weights off the floor.
- ☐ D. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned , e.g. on a table.
- ☐ E. Pain prevents me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
- ☐ F. I can only lift very light weights at the most.

**SECTION 4 - Walking**

- ☐ A. Pain does not prevent me from walking any distance.
- ☐ B. Pain prevents me from walking more than 1 mile
- ☐ C. Pain prevents me from walking more than 1/2 mile.
- ☐ D. Pain prevents me from walking 1/4 mile.
- ☐ E. I can only walk while using a cane or on crutches.
- ☐ F. I am in bed most of the time and have to crawl to the toilet.

**SECTION 5 - Sitting**

- ☐ A. I can sit in any chair as long as I like without pain.
- ☐ B. I can only sit in my favorite chair as long as I like.
- ☐ C. Pain prevents me from sitting more than I hour.
- ☐ D. Pain prevents me from sitting more than a 1/2 hour.
- ☐ E. Pain prevents me from sitting more than 10 minutes.
- ☐ F. Pain prevents me from sitting at all.

**SECTION 6 - Standing**

- ☐ A. I can stand as long as I want without pain.
- ☐ B. I have some pain while standing, but it does not increase with time.
- ☐ C. I cannot stand for longer than 1 hour without increasing pain.
- ☐ D. I cannot stand for longer than a 1/2 hour without increasing pain.
- ☐ E. I cannot stand for longer than 10 minutes without increasing pain.
- ☐ F. I avoid standing, because it increases the pain right away.

**SECTION 7 - Sleeping**

- ☐ A. I have no pain in bed.
- ☐ B. I have pain in bed, but it does not prevent me from sleeping well.
- ☐ C. Because of pain, my normal nights sleep is reduced by less than one-quarter.
- ☐ D. Because if pain, my normal nights sleep is reduced by less than one-half.
- ☐ E. Because of pain, my normal nights sleep is reduced by less than three-quarters.
- ☐ F. Pain prevents me from sleeping at all.

**SECTION 8 - 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 has no significant effect on my social life apart from limiting 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 9 - Traveling**

- ☐ A. I have no pain while traveling.
- ☐ B. I have some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ C. I have extra pain while traveling, which compels me to seek alternative forms of travel.
- ☐ D. Pain prevents all forms of travel except that done lying down.
- ☐ E. Pain restricts all forms of travel

**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 at present.
- ☐ D. My pain is neither getting better or worse.
- ☐ E. My pain is gradually worsening.
- ☐ F. My pain is rapidly worsening.

**Disability Index Score:**_____ **%**

# NECK

**Patient Name**_____ **Date**_____ **File#**_____

*Please read carefully:*

*This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only* ***ONE CHOICE*** *which applies to you. We realize you may consider that two of the statements in any section relate to you, but please just mark* ***the one box which most closely describes your problem right now.***

## 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 9washing dressing, etc.)

- ☐ A I can look after myself 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, wash with difficulty and stay in bed.

## SECTION 3 - Lifting

- ☐ A I can lift heavy weights without extra pain.
- ☐ B. I can lift heavy weights but it gives extra pain.
- ☐ C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ D. Pain prevents me from lifting heavy weights but I can manage light to 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 cannot read as much as I want 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 which come almost all the time.

## SECTION 6 - Concentration

- ☐ A. I can concentrate fully when I want to with no difficulty.
- ☐ B. I can concentrate fully when I want to with slight difficulty.
- ☐ C. I have a fair degree of difficulty in concentrating when I want to.
- ☐ D. I have a lot of difficulty concentrating when I want to.
- ☐ E. I cannot concentrate at all.

## SECTION 7 - Work

- ☐ A I can do as much work as I want to.
- ☐ 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 cannot do my usual work.
- ☐ E. I can hardly do any work at all.
- ☐ F. I cannot do any work at all.

## SECTION 8 - Driving

- ☐ A I can drive without any neck pain.
- ☐ B. I can drive as long as I want with slight pain in my neck.
- ☐ C. I can drive as long as I want with moderate pain in my neck.
- ☐ D. I cannot drive as long as I want because of moderate pain in my neck.
- ☐ E. I can hardly drive at all because of severe pain in my neck.
- ☐ F. I cannot drive my car at all.

## SECTION 9 - Sleeping

- ☐ A. I have no trouble sleeping.
- ☐ B. My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ C. My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ D. My sleep is moderately disturbed (2-5 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 my recreation activities with no neck pain at all.
- ☐ B. I am able to engage in all my recreation activities with some pain in my neck.
- ☐ C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ E. I can hardly do any recreation activities because of pain in my neck
- ☐ F. I cannot do any recreation activities at all.

# PATIENT HISTORY

Date: _____

(Legal) First Name (Legal) MI (Legal) Last Name DOB Age.

Street._____ -----'Apt._____

City _____ State._____ Zip_____

Social Security# _____ Marital Status ☐ S ☐ M ☐ W ☐ D Spouse:._____

**Language:**

☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian

Other:_____

**Race/Ethnicity:**

☐White ☐American Indian or Alaskan Native ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐
☐Black or African American ☐Hispanic or Latino ☐Decline to Answer

**Contact Info:** Home Phone:_____ Work Phone:._____ Cell:._____

Cell Carrier: _____ Email Home:._____

Email Work:_____

Contact Preference: ☐ **Home Ph** ☐ **Work Ph** ☐ **Cell Ph** ☐ **Email Hm** ☐ **Email Wk** ☐ **Postal Mail**

**Emergency Contact:**_____ Phone:._____

Who referred you to our office?_____ Phone:._____

**Occupation:.**_____ Employer:._____

Employer Address:_____

City Street State ZIP

**Insurance Information:** *A copy of your insurance card(s) will be made, in addition, please complete the information requested below:*

Are you the policy holder? ☐ **Y** ☐ **N** if No, who is? ☐Spouse ☐ Parent ☐Employer ☐Other_____

Policy Holder's First Name MI Last Name DOB

Policy Holder's Social Security#_____

Policy Holder's Employer: _____

)o you have secondary insurance? ☐ **Y** ☐ **N** if Yes, please complete the following:

>olicy Holder's First Name **MI** Last Name DOB

>olicy Holder's Social Security#_____

)olicy Holder's Employer:._____

Date:

First Name MI Last Name

## Patient History

Please give a brief description of the problem(s) you are experiencing:

Is/Are the problem(s) getting better? ☐ Y ☐ N When did the problem(s) start? _____

What appears to be the initial cause? _____

Are you seeing any other providers for other problems or health conditions? ☐ Y ☐ N

Please list the problem(s), date problem(s) began and Provider(s) treating you for the condition(s):

## Past History

Have you: If yes, please list the date and name of the treating provider.

ever been diagnosed with. Hypertension? ☐ Y ☐ N
been hospitalized in the last 5 years? ☐ Y ☐ N
been diagnosed with Diabetes? ☐ Y ☐ N
Type I ☐ Type 2 ☐

Do you smoke? ☐ Never ☐ Former Smoker ☐ currenVEvery Dai s:moker ☐ .Current Some Day(s) Smoker

**Vitals** {for office use only) Height;_____ Weight._____ Blood Pressure_____

## Medications

Nhat medications are you currently taking? (Please include all non-prescription and over the counter vitamins, herbs, minerals, etc.):
_ist Date, Brand Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by:
=>tease be as specific as possible.

**)o you have allergies?** ☐ **Food** ☐ **Environmental** ☐ **Medicatio11**

List Type of Allergy and Reaction(s):

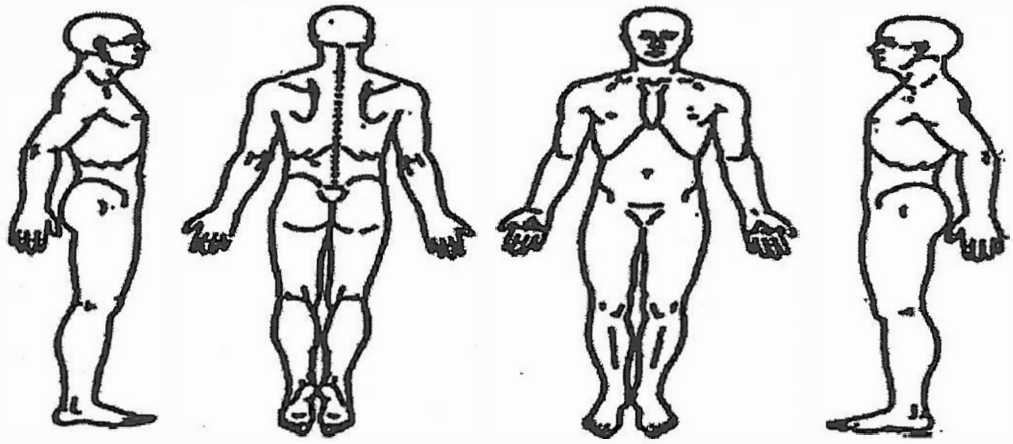
*Thank You for your cooperation!*

# PATIENT INTAKE FORM

Patient Name: _____ Date: _____

**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 (76-1 00% 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 ☐ Noone

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

**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?**

_____

**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?**
□ Stenuous □ 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 |
|---|---|---|---|---|---|
| □ | □ Headaches | □ | □ High Blood Pressure | □ | □ Diabetes |
| □ | □ Neck Pain | □ | □ Heart Attack | □ | □ Excessive Thirst |
| □ | □ Upper Back Pain | □ | □ Chest Pains | □ | □ Frequent Urination |
| □ | □ Mid Back Pain | □ | □ Stroke | □ | □ SmokingfTobacco Use |
| □ | □ Low Back Pain | □ | □ Angina | □ | □ Drug/Alcohol Dependance |
| □ | □ Shoulder Pain | □ | □ Kidney Stones | □ | □ Allergies |
| □ | □ Elbow/Upper Arm Pain | □ | □ Kidney Disorders | □ | □ Depression |
| □ | □ Wrist Pain | □ | □ Bladder Infection | □ | □ Systemic Lupus |
| □ | □ Hand Pain | □ | □ Painful Urination | □ | □ Epilepsy |
| □ | □ Hip Pain | □ | □ Loss of Bladder Control | □ | □ Dennatitis/Eczema/Rash |
| □ | □ Upper Leg Pain | □ | □ Prostate Problems | □ | □ HIV/AIDS |
| □ | □ Knee Pain | □ | □ Abnonnal Weight Gain/Loss | | |
| □ | □ Ankle/Foot Pain | □ | □ Loss of Appetite | **For Females Only** | |
| □ | □ Jaw Pain | □ | □ Abdominal Pain | □ | □ Birth Control Pills |
| □ | □ Joint Pain/Stiffness | □ | □ Ulcer | □ | □ Homional Replacement |
| □ | □ Arthritis | □ | □ Hepatitis | □ | □ Pregnancy |
| □ | □ Rheumatoid Arthritis | □ | □ Liver/Gall Bladder Disorder | | |
| □ | □ Cancer | □ | □ General Fatigue | | |
| □ | □ Tumor | □ | □ Muscular Incoordination | | |
| □ | □ Asthma | □ | □ Visual Disturbances | | |
| □ | □ Chronic Sinusitis | □ | □ Dizziness | | |
| □ | □ Other:_____ | | | | |

**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?**

| | | | |
|---|---|---|---|
| □ **Sit:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **Stand:** | □ Most of thEi day | □ ,Half the, day | □ A little of the day |
| □ **Computer work:** | □ Most of the day | □ Half the day | □ A little of the day |
| □ **On the phone:** | □ Most of the day | □ Half of the, day | □ 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**_____ **bate:**_____