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: _____

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

Policy Holder's First Name MI Last Name DOB

Policy Holder's Social Security #_____

Policy 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 II ☐

Do you smoke? ☐ Never ☐ Former Smoker ☐ Current/Every Day Smoker ☐ Current Some Day(s) Smoker

Vitals (for office use only) Height_____ Weight_____ Blood Pressure_____

Medications

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

_____

_____

_____

_____

_____

Do you have allergies? ☐ **Food** ☐ **Environmental** ☐ **Medication**

List Type of Allergy and Reaction(s):

_____

_____

_____

_____

Thank You for your cooperation!

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 1 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:_____**%**

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

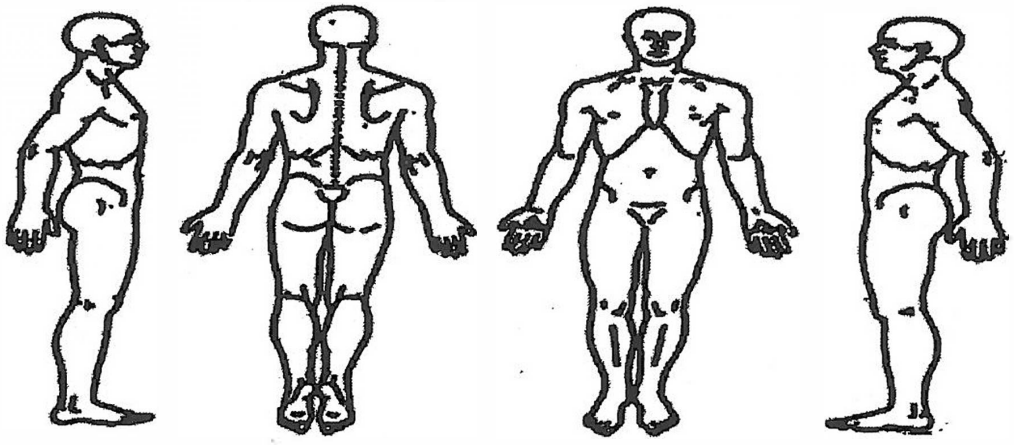
- ☐ A. I am able to engage in all my recreation activities with no neck pain at all.
- ☐ B. I am able to engage in all my recreation activities with some pain in my neck.
- ☐ C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ D. I am able to 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 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 (76-100% 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? _____

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	□	□	Smoking/Tobacco 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	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal 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 the 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_____ **Date:**_____

Name:_____

1. What was the date of the accident?_____
2. What time did the accident occur?_____
3. How many vehicles were involved in the accident?_____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occured? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? if yes, please describe

11. Where were you sitting in the vehicle during the accident?

12. Did you know the accident was coming?_____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)

- kept going straight	- spun around
- kept going straight hitting a car in front	- spun around and hit a stationary object
- was hit by another vehicle	- hit a stationary object

18. Did you lose consciousness during the accident? - yes - no
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? - no - yes, please describe_____
23. Did your face hit anything during the accident? - no - yes, please describe_____
24. Did your shoulders hit anything during the accident? - no - yes, please describe_____
25. Did your neck hit anything during the accident? - no - yes, please describe_____
26. Did your chest hit anything during the accident? - no - yes, please describe_____

27. Did your hips hit anything during the accident? -no - yes, please describe_____

28. Did your knees hit anything during the accident? -no - yes, please describe_____

29. Did your feet hit anything during the accident? -no - yes, please describe_____

30. What kind of headrest was in your vehicle?
    - movable fixed headrest
    - nonmovable fixed headrest
    - no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? - yes ☐ -no ☐

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

- windshield	- rear bumper	- mirror
- steering wheel	- front bumper	- knee bolster
- dashboard	- trunk	- back right door
- seat frame	- front left door	- completely totalled
- side window	- front right door	
- rear window	- back left door	

35. Choose the items that dented inward
    - floorboards - side door - dashboard

36. Choose the doors that would not open as a result of the accident
    - front left - front right
    - rear left - rear right

37. Did you go to the hospital? If no, why and do not answer 38-43

38. How did get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized over night? _____

41. Circle what you were prescribed at the hospital
    - pain medication - muscle relaxors - neck brace

42. Did you recieve any stitches for any cuts at the hospital? _____

43. Were x rays taken at the hosiptal? If yes, which area was taken?

AUTO INSURANCE VERIFICATION

PATIENT NAME: _____

CLAIM NO (PATIENT INSURANCE): _____

DATE OF ACCIDENT: _____

DEDUCTIBLE: _____

MED PAY: _____ **PIP LIMITS:** _____

ADJUSTER'S NAME: _____

PHONE NO: _____ **EXT:** _____

FAX NO: _____

EMAIL: _____

INSURANCE COMPANY BILLING INFORMATION:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

METHOD OF SUBMISSION: FAX ☐ **MAIL** ☐ **EMAIL** ☐ **EDI** ☐

NOTES REQUIRED? YES ☐ **NO** ☐

ONLINE CLAIM STATUS AVAILABLE? _____

AT FAULT? ☐ **YES** / ☐ **NO**

IF NO, AT FAULT INSURANCE CO: _____

CLAIM NO.: _____

ATTORNEY? ☐ **Y** / ☐ **N**

IF YES, ATTORNEY NAME: _____

PHONE: _____ **FAX:** _____

VERIFIED BY: _____ **DATE:** _____

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

☐ Initial ☐ Update

Please check all that apply to your WORK *because of the accident.*

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____

- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

Please check all that apply to your HOME/DOMESTIC duties *because of the accident.*

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____

- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

_____ _____

Signature Date