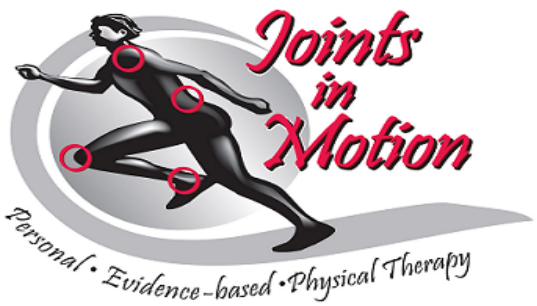
Patient Name:_____
DOB:_____
Height:_____Weight: _____




## Please fill out completely.

## FACTORS OF COMPLAINT

**How and when did your problem begin?**

- ❑ I don't know how it began
- ❑ It comes and goes.
- ❑ I've had it a long time (_____years)
- ❑ Injury (date of injury_____) On the job? Yes No

Please explain how the injury happened. _____

**What are your expectations of this visit?** _____

_____

**Are you experiencing any of the following?**

| | | |
|---|---|---|
| Is your pain worse at night? | ☐ Yes | ☐ No |
| Does your pain awaken you from sleep? | ☐ Yes | ☐ No |
| Does coughing affect your pain? | ☐ Yes | ☐ No |

**What makes your symptoms better?** (Select all that apply.)

☐Sitting ☐ Standing ☐Walking ☐Other: _____

**What makes your symptoms worse?** (Select all that apply.)

☐ Sitting ☐ Standing ☐ Walking ☐ Other: _____

_____

**Has your pain affected your ability to do your job or any other daily actvities?** ☐ Yes ☐ No

If yes, please explain: _____

**Is there anything else you feel we should know? If yes, please explain:** _____

_____



Patient's initials_____Date:_____

Patient Name:_____
DOB:_____

## PREVIOUS TREATMENT

Have you received any of the following treatments for your current pain? If YES, did it make it better or worse?(Check your answer)

| | | |
|---|---|---|
| Chiropractic Care | ☐ Better | ☐ Worse |
| Physical Therapy | ☐ Better | ☐ Worse |
| Injections | ☐ Better | ☐ Worse |
| Psychological Consultation | ☐ Better | ☐ Worse |

For your current pain, please mark the box for the correct time frame any tests were done.

| | <6 months | <12 months |
|---|---|---|
| X-Rays | ☐ | ☐ |
| MRI Scans | ☐ | ☐ |
| CT Scan | ☐ | ☐ |
| Myelogram | ☐ | ☐ |
| Discogram | ☐ | ☐ |
| EMG/NCV(nerve test) | ☐ | ☐ |

Results: _____

## GENERAL MEDICAL INFORMATION

**Check all past and present conditions.** **If NONE check ☐**

- ❑ Heart Attack
- ❑Heart Murmur
- ❑Angina
- ❑High Blood Pressure
- ❑Stroke
- ❑Varicose Veins
- ❑Bleeding Disorder
- ❑Gastro-Intestinal Disease
- ❑Diabetes
- ❑Liver/Kidney Disease
- ❑Degenerative Arthritis
- ❑Rheumatoid Arthritis
- ❑Anxiety
- ❑Depression
- ❑Lung Disease
- ❑Asthma
- ❑Sexual Difficulty
- ❑Osteporosis
- ❑Cancer:_____
- ❑Other: _____
  _____

Have you used :
☐ Immuno-suppression ☐ Corticosteriods ☐ Other:_____

List any major surgeries:

| | Type | Year |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |

Do you have any allergies to medications, food or envioronmental substances?
☐ No ☐ Yes If yes, list the medications.

_____
_____

Please list all current medications including prescriptions, over-the-counter and herbal remedies.

| Medication | Dosage | Frequency | Administrative Method/Route |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |



Patient's initials_____Date_____

# SOCIAL HISTORY

**Marital Status**
- ❑ Married
- ❑ Separated
- ❑ Divorced
- ❑ Single
- ❑ Widow/Widower

**Education**
Check the highest level completed.
- ❑ Grammer School
- ❑ High School
- ❑ College
- ❑ Post Graduate

**Alcohol Use**
☐ Yes ☐ No
Frequency: _____

**Tobacco Use**
☐ Yes ☐ No
Frequency: _____

**Impact of pain on your lifestyle.**

| | |
|---|---|
| I describe my home setting as supportive of me during this time. | ☐ Yes ☐ No |
| I describe my work setting as supportive of me during this time. | ☐ Yes ☐ No |
| My pain has affected my interactions with my family and friends. | ☐ Yes ☐ No |
| The changes in my lifestyle due to my problem have been difficult for me. | ☐ Yes ☐ No |

What is your ability to enjoy life? ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Please indicate your <u>current</u> work status.
- ❑ Working Full Time
- ❑ Working Part Time
- ❑ Seeking Employment
- ❑ Not working by choice. (Retired, homemaker, student, etc.)
- ❑ Physically unable to work due to problem

<u>Before</u> having this pain, did you normally work: ☐ Full Time ☐ Part Time ☐ Neither

What is your usual occupation? _____

Do you like your current work situation? ☐ Yes ☐ No ☐ N/A

Are you currently in litigation with regards to your injury? ☐ Yes ☐ No

Have you been laid off from your job? ☐ Yes ☐ No

**<u>Consent:</u>** I understand that my diagnosis and treatment plan will be discussed during my appointment and I have the right to question and /or refuse any treatment offered.

_____ Signature of Patient (or parent if patient is a minor)



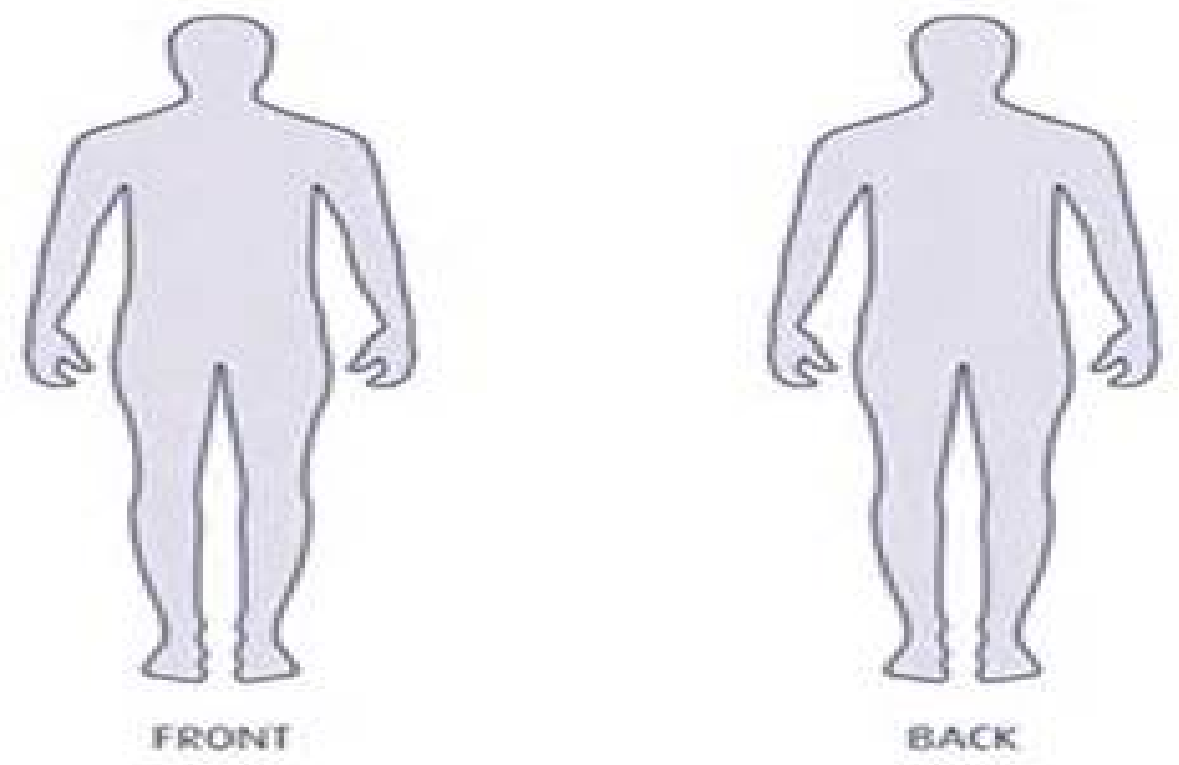
Patient initials _____ Date_____

# Pain Questionaire

Name:_____DOB: _____Date: _____

Where is your pain now?
Mark the areas on your body where you feel pain.
Mark areas where the pain radiates.

| Aching | Numbness | Pins and Needles | Burning | Stabbing |
|---|---|---|---|---|
| ▲▲▲ | = = = | ○ ○ ○ | x x x | / / / |




Pain at **LOWEST**: Rate pain level in the last 24 hours

| No pain | | | | | | | | | | Worst Pain Imaginable |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Pain **CURRENTLY**: Rate pain level in the last 24 hours

| No pain | | | | | | | | | | Worst Pain Imaginable |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Pain at **WORST**: Rate pain level in the last 24 hours

| No pain | | | | | | | | | | Worst Pain Imaginable |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| add columns | | + | + | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* TOTAL:

**10.** If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____



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