# CONFIDENTIAL PATIENT INFORMATION

Date _____

Who Referred You?_____ E-Mail _____
Name_____
Address _____ City _____ State ___ Zip _____
Home Phone (____) _____ Cell Phone (____) _____ Age _____ Birthdate_____
Social Security # _____Occupation _____ Employer _____
Employer's Address _____ City _____ State ____ Zip _____
Drivers Lic. # _____ Marital Status _____ Number of Children_____
Name of Spouse _____ Spouse Occupation _____ Employer _____
Emergency Contact Person _____ Phone Number _____

**Describe Your Condition/Complaint ?** _____
_____
How long have you had this complaint? _____ Have you experienced this before?_____
List other Doctor(s) seen for this condition _____
Is your health problem work related ? ☐YES ☐NO As a result of an auto accident ? ☐ YES ☐NO
*[ PLEASE FILL OUT THE FOLLOWING IF DUE TO WORK OR AUTO ACCIDENT]*

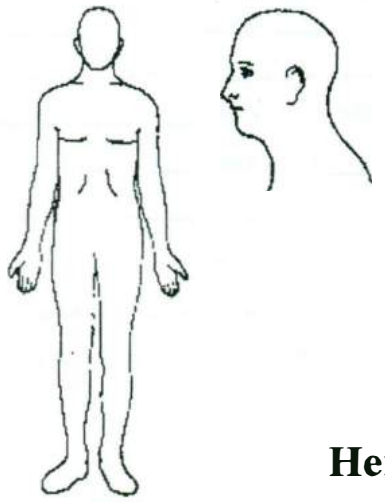
Date of accident _____ Hour of accident _____ AM PM

***WORK RELATED INJURY***
Was any equipment, machinery and or object(s) related to injury? ☐ YES ☐NO What kind ?_____
Was accident reported to supervisor and/or employer ? ☐YES ☐NO
Has a Worker's Compensation claim been filed ? ☐YES ☐NO

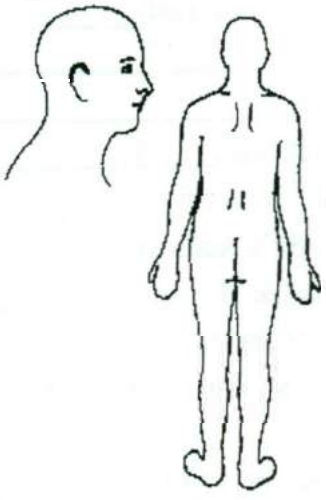
***TRAFFIC ACCIDENT***
What kind of vehicle was involved in accident ? ☐TRUCK ☐CAR ☐MOTORCYCLE ☐OTHER
Were you a ☐DRIVER ☐PASSENGER ☐PEDESTRIAN ?
Were there others involved in the vehicle with you ?☐YES ☐NO Who are they ? _____
Was your vehicle moving when the accident occurred ?☐YES ☐NO Approximate MPH ? _____
Did your vehicle hit other vehicle(s) ? ☐YES ☐NO Where ? _____
Did other vehicle(s) hit your vehicle(s) ? ☐YES ☐NO Where ? _____
Was accident reported to the POLICE DEPARTMENT ? ☐YES ☐NO
Were traffic citations issued? ☐YES ☐NO To whom ? _____
Describe accident including cause(s) and surrounding circumstance _____

## *PATIENT PAIN DRAWING*

Please place the symbol(s) on the body in the area(s)
that best describes your pain or discomfort you are experiencing.



| | |
|---|---|
| **Z =** | SHARP PAIN |
| **D =** | DULL PAIN |
| **B =** | BURNING PAIN |
| **N =** | NUMBNESS |
| **T =** | TINGLING |
| **A =** | ACHE |
| **P =** | PINS & NEEDLES |
| **X =** | THROBBING |



**Height**:_____ **Weight**:_____

SYMPTOMS: Check the box for the symptoms you are presently experiencing or have experienced recently.

**GENERAL**
- ☐ Headache
- ☐ Head seems too heavy
- ☐ Shoulders feel heavy
- ☐ Loss of memory
- ☐ Equilibrium Problems
- ☐ Dizziness
- ☐ Fainting
- ☐ Tremors
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Neck motion restricted
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Pins/needles in arm/legs
- ☐ Arm/leg numbness
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Extreme nervousness
- ☐ Tension
- ☐ Anxiety
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Loss of Sleep
- ☐ Allergies
- ☐ Nausea

**EAR,NOSE,THROAT**
- ☐ Failing vision
- ☐ Nearsightedness
- ☐ Far sightedness
- ☐ Blurred vision
- ☐ Deafness
- ☐ Earache
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Sinus infection
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Nasal drainage
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Gum disease
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Enlarged glands

**SKIN**
- ☐ Skin eruptions
- ☐ Itching
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Boils
- ☐ Moles
- ☐ Varicose veins
- ☐ Sensitive skin

**RESPIRATORY**
- ☐ Chronic cough
- ☐ Spitting phlegm
- ☐ Spitting blood
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Shortness of breath

**CARDIOVASCULAR**
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Previous heart problems
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke

**GENITOURINARY**
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection/stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostate problems
- ☐ Hernia

**GASTROINTEST.**
- ☐ Poor appetite
- ☐ Poor digestion
- ☐ Excessive thirst/hunger
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gall bladder problems

**FOR WOMEN**
- ☐ Painful menst. periods
- ☐ Cramps or backache
- ☐ Irregular cycle
- ☐ Excessive Flow
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Hot flashes
- ☐ Pregnant ☐ Yes ☐ No
- ☐ Breast implants

**DISEASE PROCESSES:** Please Check the Box if you have, or have had, any of the following:

| | | |
|---|---|---|
| ☐Cancer | ☐Multiple Sclerosis | ☐Immunity Disease |
| ☐Diabetes | ☐Measles | ☐Osteoporosis |
| ☐Heart Disease | ☐Epilepsy | ☐Transient Ischemia Attack |
| ☐Tuberculosis | ☐Convulsions | ☐Fractures |
| ☐Hepatitis | ☐Concussions | ☐Dislocations |
| ☐High Blood Pressure | ☐Rheumatism | ☐Asthma |
| ☐Stroke | ☐Rheumatic Fever | ☐Venereal Disease |
| ☐Muscular Dystrophy | ☐Scarlet Fever | ☐Meningitis |
| ☐Systemic Lupus Erythmetosis | ☐Scleraderma | ☐Psoriasis |
| ☐Diptheria | ☐Pneumonia | ☐Polio |
| ☐Typhoid Fever | ☐Anemia | ☐Alcoholism |

## PAST HEALTH HISTORY

**SURGERIES:** Please Check applicable items: ☐ Appendix ☐Rectal ☐ Tonsils ☐Hernia ☐Joints ☐Heart ☐Spine ☐Gall Bladder ☐Female Organs ☐Prostate ☐Implants

Other Surgical Procedures: _____

Other Injuries (slips, falls, auto, etc.): _____

List medications you are currently taking, prescription/over the counter: _____

Do you smoke? ☐YES ☐NO How much per day? _____

FEMALES: Are you taking Birth Control Pills? ☐YES ☐NO How long have you been on them? _____

## FINANCIAL ARRANGEMENTS

Will You Be Using Insurance? ☐YES ☐NO Primary Insurance Company _____

Secondary Insurance Company (Spouse's Insurance) _____

**Please present your insurance card(s) to us**

With my signature below, I voluntarily Consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the Doctor and it is the responsibility of the staff to carry out any instructions of the Doctor. I hereby authorize the doctor to treat my condition as he deems appropriate. Any x-rays taken at this office are property of this office, being on file where they may be seen at any time.

I understand that health and accident insurance policies are and arrangement between an insurance carrier and me, the patient. It is my responsibility to provide my insurance information (if applicable) and any other information needed to submit claims for my treatment. I understand that I am responsible for any services rendered to me, including deductibles, co-pays. Or non-covered services. Payment of services, co-pays, deductibles and non-covered services are expected at the time of service.

**I have read, understand and agree with the above policies.**

_____

***Print Patient Name***

_____ _____

***Patient signature*** ***Date***

# Back Index

Form BI100

rev 3/27/2003

***Patient Name*** _____ ***Date***

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## 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 moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is very severe and does not vary much.

## 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 sleep is reduced by less than 25%.
- ☐ Because of pain my normal sleep is reduced by less than 50%.
- ☐ Because of pain my normal sleep is reduced by less than 75%.
- ☐ Pain prevents me from sleeping at all.

## Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit 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 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

## Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while 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 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases pain immediately.

## Walking

- ☐ I have no pain while walking.
- ☐ I have some pain while walking but it doesn't increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

## Personal Care

- ☐ I do 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 increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases 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.

## Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes 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 off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

## 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 cause me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel except that done while lying down.
- ☐ Pain restricts all forms of travel.

## Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

## Changing degree 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 improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

# Neck Index

Form N1-100

rev 3/27/2003

**Patient Name** _____ **Date** _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ 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.

## Sleeping

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

## Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

## Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty concentrating when I want.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

## Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☐ I can only do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

## Personal Care

- ☐ 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 I 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.

## Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ 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 off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

## Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

## Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

## Headaches

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

*Neck Index Score* ☐