

**Initial Health Profile:**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ M/ F (Circle) Social Security# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

(No P.O. Boxes)

Home Telephone( ) \_\_\_\_\_ Work Telephone( ) \_\_\_\_\_ Cell/Pager ( ) \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_ Single / Married / Divorced / Widowed (Circle)

Health Insurance: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_ Cardholder's Birth Date: \_\_\_\_\_

Referral source? (Circle) Yellow Pages / Internet/ Insurance Website/ Sign / Friend/ Family/ Other \_\_\_\_\_

If referred by friend or family, who? \_\_\_\_\_

Have you been to a chiropractor before? Y/N If YES, who and when? \_\_\_\_\_

**Present and past health history:**

1. Describe your problem: \_\_\_\_\_

2. The cause of your problem is: \_\_\_\_\_

3. How long have you had your problem? \_\_\_\_\_

4. How did your symptoms begin? \_\_\_\_\_

5. Have you had this problem before? Yes No IF YES, WHEN? \_\_\_\_\_

6. How are your symptoms changing? (circle)

Improving Getting worse Staying the same

7. How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (0-25% of the time)

8. When and what other treatment have you received for this problem?

- Medical Doctor \_\_\_\_\_
- Physical Therapist \_\_\_\_\_
- Other \_\_\_\_\_

9. What other tests have you had for this problem? \* Include approximate date\*

- Xrays Results: \_\_\_\_\_
- MRI Results: \_\_\_\_\_
- Other Results: \_\_\_\_\_

10. Who is your Primary Care Physician? \_\_\_\_\_

Would you like for us to send over a report of our findings? YES NO

11. Circle the condition of your overall current health: Excellent Good Fair Poor

12. Circle any previously diagnosed conditions: Cancer Diabetes Heart Disease Thyroid

Arthritis Mental Disorders Autoimmune Asthma OTHER: \_\_\_\_\_

13. Any family members with similar conditions? \_\_\_\_\_

14. List medications: \_\_\_\_\_

15. List known allergies: \_\_\_\_\_

16. List previous surgeries: \_\_\_\_\_

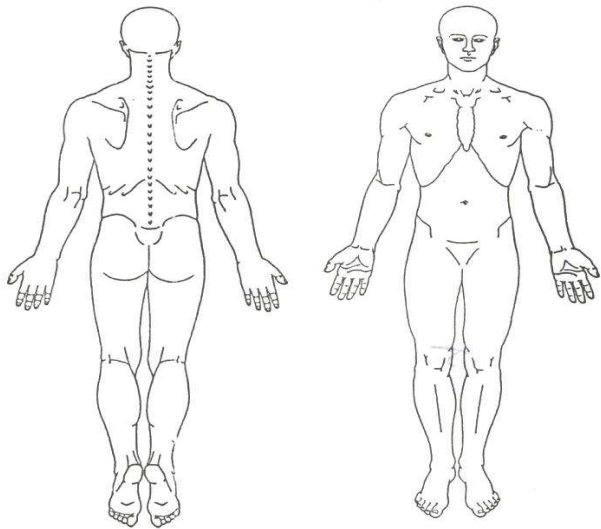
17. List previous hospitalizations: \_\_\_\_\_

18. Previous trauma history: (please include details) \_\_\_\_\_

- Car accidents \_\_\_\_\_
- Falls \_\_\_\_\_
- Impact/rough sports \_\_\_\_\_
- Childhood injuries \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Name: \_\_\_\_\_  
 Date: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Signature: \_\_\_\_\_



**Indicate where you have pain or other symptoms:**

**XXX** PAIN  
**OOO** SPASM  
**+++** NUMB  
**---** OTHER

NONE                      Circle your average severity of symptoms:                      Unbearable  
 0     1     2     3     4     5     6     7     8                      9     10

**Check off all that apply in each section:**

<p><b><u>1. Movement Complaints</u></b>  <input type="checkbox"/> Inflexibility  <input type="checkbox"/> Restricted Movement  <input type="checkbox"/> Stiffness  <input type="checkbox"/> Spasms  <input type="checkbox"/> Cramps  <input type="checkbox"/> Other: _____</p>	<p><b><u>2. Sensation Complaints:</u></b>  <input type="checkbox"/> Numb  <input type="checkbox"/> Pins and needles  <input type="checkbox"/> Prickly  <input type="checkbox"/> Tingling  <input type="checkbox"/> Other: _____        _____</p>	<p><b><u>3. Pain Types</u></b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Achey</td> <td><input type="checkbox"/> Shooting</td> </tr> <tr> <td><input type="checkbox"/> Burning</td> <td><input type="checkbox"/> Stabbing</td> </tr> <tr> <td><input type="checkbox"/> Dull</td> <td><input type="checkbox"/> Hurting</td> </tr> <tr> <td><input type="checkbox"/> Excruciating</td> <td><input type="checkbox"/> Sore</td> </tr> <tr> <td><input type="checkbox"/> Numb Ache</td> <td><input type="checkbox"/> Throbbing _____</td> </tr> <tr> <td><input type="checkbox"/> Sharp</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Achey	<input type="checkbox"/> Shooting	<input type="checkbox"/> Burning	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Dull	<input type="checkbox"/> Hurting	<input type="checkbox"/> Excruciating	<input type="checkbox"/> Sore	<input type="checkbox"/> Numb Ache	<input type="checkbox"/> Throbbing _____	<input type="checkbox"/> Sharp	<input type="checkbox"/> Other _____
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<p><b><u>4. What aggravates your problem?</u></b>  <input type="checkbox"/> Computer work  <input type="checkbox"/> Coughing or sneezing  <input type="checkbox"/> Arising from a chair  <input type="checkbox"/> Bending at the waist  <input type="checkbox"/> Carrying  <input type="checkbox"/> Climbing stairs  <input type="checkbox"/> Driving  <input type="checkbox"/> Exercising  <input type="checkbox"/> Getting in and out of bed  <input type="checkbox"/> Getting in and out of a car  <input type="checkbox"/> Lifting  <input type="checkbox"/> Looking up/down/left/right  <input type="checkbox"/> Pushing/Pulling  <input type="checkbox"/> Reclining  <input type="checkbox"/> Repetitious movements  <input type="checkbox"/> Sitting  <input type="checkbox"/> Sleeping  <input type="checkbox"/> Standing  <input type="checkbox"/> Stooping  <input type="checkbox"/> Walking  <input type="checkbox"/> Other _____        _____</p>	<p><b><u>5. What helps your problem?</u></b>  <input type="checkbox"/> Nothing  <input type="checkbox"/> Pain medication  <input type="checkbox"/> List: _____  <input type="checkbox"/> Exercising  <input type="checkbox"/> Reclining  <input type="checkbox"/> Resting  <input type="checkbox"/> Sitting  <input type="checkbox"/> Cold or Ice  <input type="checkbox"/> Heat or hot packs  <input type="checkbox"/> Stretching  <input type="checkbox"/> Massage  <input type="checkbox"/> Other _____</p>	<p><b><u>7. Which have you had in the past six months? 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<p><b><u>6. Lifestyle factors: DO YOU?</u></b>  <input type="checkbox"/> Exercise _____  <input type="checkbox"/> Sit for long hours  <input type="checkbox"/> Sleep on a good mattress  <input type="checkbox"/> Sleep on a cervical pillow          What is your sleep position?              Back   Stomach   Side          Do you wake up in pain?              Yes   No   Sometimes</p>																																																		

# Back Index

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.*

## **1. Pain Intensity**

- 0A The pain comes and goes and is very mild.
- 1B The pain is mild and does not vary much.
- 2C The pain comes and goes and is moderate.
- 3D The pain is moderate and does not vary much.
- 4E The pain comes and goes and is very severe.
- 5F The pain is severe and does not vary much.

## **2. Personal Care**

- 0A I do not have to change my way of washing or dressing in order to avoid pain.
- 1B I do not normally change my way of washing or dressing even though it causes some pain.
- 2C Washing and dressing increases the pain but I manage not to change my way of doing it.
- 3D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- 4E Because of the pain I am unable to do some washing and dressing with out help.
- 5F Because of the pain I am unable to do any washing and dressing with out help.

## **3. Lifting**

- 0A I can lift heavy weights without extra pain.
- 1B I can lift heavy weights but it causes extra pain.
- 2C Pain prevents me from lifting heavy weights off the floor.
- 3D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- 4E Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- 5F I can only lift very light weights.

## **4. Walking**

- 0A I have no pain while walking.
- 1B I have some pain while walking but it doesn't increase with distance.
- 2C I cannot walk more than 1 mile without increasing the pain.
- 3D I cannot walk more than 1/2 mile without increasing the pain.
- 4E I cannot walk more than 1/4 mile without increasing the pain.
- 5F I cannot walk at all without increasing pain.

## **5. Sitting**

- 0A I can sit in any chair as long as I like.
- 1B I can only sit in my favorite chair as long as I like.
- 2C Pain prevents me from sitting more than 1 hour.
- 3D Pain prevents me from sitting more than 1/2 hour.
- 4E Pain prevents me from sitting more than 10 minutes.
- 5F I avoid sitting because it increases pain immediately.

## **6. Standing**

- 0A I can stand as long as I want without pain.
- 1B I have some pain while standing but it does not increase with time.
- 2C I cannot stand for longer than 1 hour without increasing the pain.
- 3D I cannot stand for longer than 1/2 hour without increasing the pain.
- 4E I cannot stand for longer than 10 minutes without increasing the pain.
- 5F I avoid standing because it increases pain immediately.

## **7. Sleeping**

- 0A I get no pain at all in bed.
- 1B I get pain in bed but it does not prevent me from sleeping well.
- 2C Because of pain my normal sleep is reduced by less than 25%.
- 3D Because of pain my normal sleep is reduced by less than 50%.
- 4E Because of pain my normal sleep is reduced by 75%.
- 5F Pain prevents me from sleeping at all.

## **8. Traveling**

- 0A I get no pain while traveling.
- 1B I get some pain while traveling but none of my usual forms of travel make it worse.
- 2C I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- 3D I get extra pain while traveling which causes me to seek alternate forms of travel.
- 4E Pain restricts all forms of travel except that done while lying down.
- 5F Pain restricts all forms of travel.

## **9. Social Life**

- 0A My social life is normal and gives me no extra pain.
- 1B My social life is normal but increases the degree of pain.
- 2C Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing).
- 3D Pain has restricted my social life and I do not go out very often.
- 4E Pain has restricted my social life to my home.
- 5F I have hardly any social life because of the pain.

## **10. Changing degree of pain**

- 0A My pain is rapidly getting better.
- 1B My pain fluctuates but overall is definitely getting better.
- 2C My pain seems to be getting better but improvement is slow.
- 3D My pain is neither getting better or worse.
- 4E My pain is gradually worsening.
- 5F My pain is rapidly worsening.

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score

# Neck Index

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.*

## **1. Pain Intensity**

- 0A I have no pain at the moment.
- 1B The pain is very mild at the moment.
- 2C The pain comes and goes and is moderate.
- 3D The pain is fairly severe at the moment.
- 4E The pain is very severe at the moment.
- 5F The pain is the worst imaginable at the moment.

## **2. Personal Care**

- 0A I can look after myself normally without causing extra pain.
- 1B I can look after myself normally but it causes extra pain.
- 2C It is painful to look after myself and I am slow and careful.
- 3D I need some help but I manage most of my personal care.
- 4E I need help every day in most aspects of self care.
- 5F I do not get dressed, I wash with difficulty and stay in bed.

## **3. Lifting**

- 0A I can lift heavy weights without extra pain.
- 1B I can lift heavy weights but it causes extra pain.
- 2C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- 3D Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- 4E I can only lift very light weights.
- 5F I cannot lift or carry anything at all.

## **4. Reading**

- 0A I can read as much as I want with no neck pain.
- 1B I can read as much as I want with slight neck pain.
- 2C I can read as much as I want with moderate neck pain.
- 3D I cannot read as I want because of moderate neck pain.
- 4E I can hardly read at all because of severe neck pain.
- 5F I cannot read at all because of neck pain.

## **5. Headaches**

- 0A I have no headaches at all.
- 1B I have slight headaches which come infrequently.
- 2C I have moderate headaches which come infrequently.
- 3D I have moderate headaches which come frequently.
- 4E I have severe headaches which come frequently.
- 5F I have headaches almost all the time.

## **6. Concentration**

- 0A I can concentrate fully when I want with no difficulty.
- 1B I can concentrate fully when I want with slight difficulty.
- 2C I have a fair degree of difficulty concentrating when I want.
- 3D I have a lot of difficulty concentrating when I want.
- 4E I have a great deal of difficulty concentrating when I want.
- 5F I cannot concentrate at all.

## **7. Work**

- 0A I can do as much as I want.
- 1B I can only do my usual work but no more.
- 2C I can only do most of my usual work but no more.
- 3D I cannot do my usual work.
- 4E I can hardly do any work at all.
- 5F I cannot do any work at all.

## **8. Driving**

- 0A I can drive my car without any neck pain.
- 1B I can drive my car as long as I want with slight neck pain.
- 2C I can drive my car as long as I want with moderate neck pain.
- 3D I cannot drive my car as long as I want because of moderate neck pain.
- 4E I can hardly drive at all because of severe neck pain.
- 5F I cannot drive my car at all because of neck pain.

## **9. Sleeping**

- 0A I have no trouble sleeping.
- 1B My sleep is slightly disturbed (less than 1 hour sleepless).
- 2C My sleep is mildly disturbed (1-2 hours sleepless).
- 3D My sleep is moderately disturbed (2-3 hours sleepless).
- 4E My sleep is greatly disturbed (3-5 hours sleepless).
- 5F My sleep is completely disturbed (5-7 hours sleepless).

## **10. Recreation**

- 0A I am able to engage in all my recreation activities without neck pain.
- 1B I am able to engage in all my usual recreation activities with some neck pain.
- 2C I am able to engage in most but not all my usual recreation activities because of neck pain.
- 3D I am only able to engage in a few of my usual activities because of neck pain.
- 4E I can hardly do any recreation activities because of neck pain.
- 5F I cannot do any recreation activities at all.

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