DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ Age_____

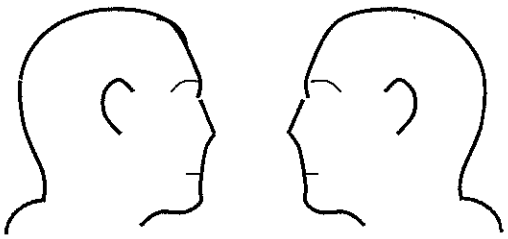
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

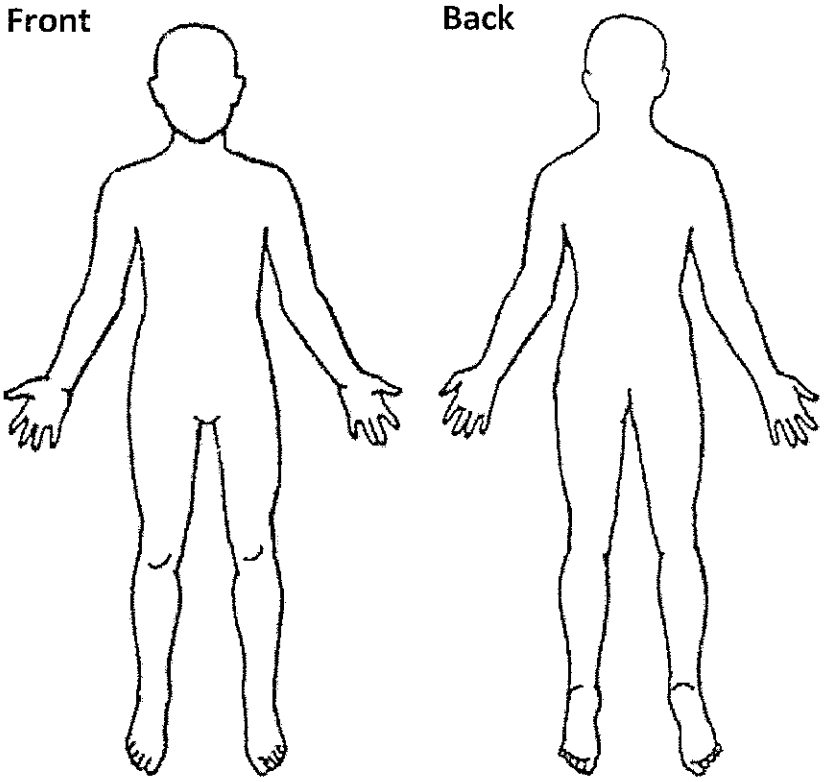
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE		MEDIUM			SEVERE				EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

_____ _____

Chiropractic Case History/Patient Information

Date:_____ Patient #_____ Doctor:_____

Name:_____ Social Security #_____

Age:_____ DOB:_____ Race:_____Marital: M S W D

Home Ph#: _____ Cell Ph#_____ Wrk#_____

Address:_____ City:_____

State:_____ Zip:_____ E-mail address:_____Fax #_____

Occupation:_____ Employer_____

Employer's Address:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

Nearest Relative:_____Address:_____Phone:_____

Family Medical Doctor/ph#/address: _____

When doctors work together it benefits you~may we have your permission to update your medical doctor regarding your care at this office?_____Date of Last Physical Exam:_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint / Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to?: Auto___Work____Other _____Any Work Days Lost:_____

Have you ever had the same or a similar condition? NO___ YES___If yes, when and describe:

_____

PAST MEDICAL HISTORY

Have you ever been diagnosed with or have suffered from?(check conditions that apply to you)

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Excessive Bleeding
__High/Low Blood Pressure
__Osteoarthritis
__Epilepsy
__Pace Maker
__Strokes
__Cancer
__Ruptures
__Coughing Blood
__Eating Disorder
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Depression
__Ulcers
__Hypertension

Have you had any major illnesses, injuries, falls, auto accidents or surgeries?

_____

[Women, please include information about childbirth (include dates)]:

_____

Have you been treated for any health condition by a physician in the last year?: NO___YES___
If yes, describe:_____

What medications or drugs are you taking?: _____

Do you have any allergies to any medications?NO__YES__describe: _____

Please list any other health problems you have, no matter how insignificant they may be:

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list: _____
Do you consume caffeine?____ If so, how much per day: _____
Do you exercise?_____ If yes, frequency and type of exercise: _____
What are your hobbies?: _____
How much time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents: Father: Age if Living_____ Deceased/Cause of and age at death:_____

Mother: Age if Living_____Deceased/Cause of and age at death:_____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:

_____

FAMILY DISEASES: (indicate whether family member is Father, Mother, Sister, Brother):
Tuberculosis____ Cancer____ Mental Illness____ Diabetes ____ Asthma____
Heart Disease____ Stroke _____ Kidney Disease____ Lung Disease____
Arthritis_____ Liver Disease ____ Other _____
Please check any and all insurance coverage that may be applicable in this case: Major Medical
Worker's Compensation Medicaid Medicare Auto Accident Medical
Savings Account & Flex Plans Other
Primary Insurance Company:

_____

Name of Secondary Insurance Company (if any):

_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____Date:_____

Guardian's Signature Authorizing Care:_____Date:_____

NAME_____ case#_____

SUMMARY

1. What is your major symptom?_____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___
   Gradually Worse_____ If yes, when and how?_____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____
   Night Only ___How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? NO ____ YES____ If yes, describe: _____
   _____
6. Describe the pain: Sharp _____Dull_____Numbness _____ Tingling _____Aching _____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? NO ___ YES ___ If yes, describe:
   _____
   If no, what have you tried that has not helped:_____
   8. What makes the problem worse? Standing ___Sitting ___Lying __Bending___
   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above:
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO EXTREME

SYMPTOMS __ 0 1 2 3 4 5 6 7 8 9 10 __ SYMPTOMS

(Circle the number above to indicate level of problem)

Doctor's Signature _____ Date _____

Lokey Chiropractic Clinic
Review of Systems

Patient Name: _____ Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

Name: _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE CHOICE 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 (Washing, Dressing, etc.)

A I can look after myself normally 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, I 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 weights off the floor, but I can manage if they are conveniently positioned.
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 to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want 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 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.
D I have a lot of difficulty in concentrating.
E I have a great deal of difficulty in concentrating.
F 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 neck pain.
C I can drive as long as I want, with moderate neck pain.
D I cannot drive as long as I want due to moderate neck pain.
E I can hardly drive at all, because of severe neck pain.
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 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours).

SECTION 10 - Recreation

A I am able to engage in all activities, without neck pain.
B I am able to engage in all activities, with some neck pain.
C I am able to engage in most, not all due to neck pain.
D I am able to engage in a few activities, due to neck pain.
E I can hardly do any activities, due to neck pain.
F I cannot do any recreational activities at all.

COMMENTS:

Name: _____ **Date:** _____

OSWESTRY DISABILITY INDEX QUESTIONNAIRE

Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is severe.
5 The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

0 I do not have to change my way of washing or dressing in order to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes some pain.
2 Washing and dressing increases the pain, but I manage not to change my way of doing it.
3 Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
4 Because of the pain, I am unable to do some washing and dressing without help.
5 Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights, but it gives extra pain.
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4 I can lift very light weights.
5 I cannot lift or carry anything at all.

SECTION 4 - Walking

0 Pain does not prevent me walking any distance.
1 Pain prevents me from walking more than 1 mile.
2 Pain prevents me from walking more than 1/2 mile.
3 Pain prevents me from walking more than 1/4 mile.
4 I can only walk while using a cane or crutches.
5 I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting

1 I can sit in my chair as long as I like without pain.
2 I can sit in my favorite chair as long as I like.
3 Pain prevents me from sitting more than one hour.
4 Pain prevents me from sitting more than 1/2 hour.
5 Pain prevents me from sitting more than 10 minutes.
6 Pain prevents me from sitting at all.

SECTION 6 - Standing

0 I can stand as long as I want without pain.
1 I have some pain, but it does not increase with time.
2 I can't stand for longer than 1 hr without increasing pain.
3 I can't stand for longer than 1/2 hr without increasing pain.
4 I can't stand for longer than 10 min without increasing pain.
5 I avoid standing, because it immediately increases the pain.

SECTION 7 - Sleeping

1 I have no pain in bed.
2 I get some pain laying in bed, but it does not prevent me from sleeping well.
3 My night's sleep is reduced by less than one quarter.
4 My night's sleep is reduced by less than one-half.
5 My night's sleep is reduced by less than three-quarters.
6 Pain prevents me from sleeping at all.

Section 8 - Social Life

1 My social life is normal and gives me no pain.
2 I can sit in my favorite chair as long as I like.
3 Pain has no significant affect on my social life apart from limiting my more energetic interactions.
4 Pain has restricted my social life and I do not go out very often.
5 Pain has restricted my social life to my home.
6 I have hardly any social life because of the pain.

SECTION 9 - Traveling

0 I have no pain while traveling.
1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
2 I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3 I get extra pain while traveling, which compels me to seek alternative forms of travel.
4 Pain restricts me from all forms of travel.
5 Pain prevents travel except that are done laying down.

SECTION 10 - Changing Degrees of Pain

0 My pain is rapidly getting better.
1 My pain fluctuates but overall is definitely getting better.
2 My pain seems to be getting better, but improvement is slow at present.
3 My pain is neither getting better nor worse.
4 My pain is gradually worsening.
5 My pain is rapidly worsening.

Headache Disability Index

Date _____

Patient Name: _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO	
_____	_____	_____	Because of my headaches I feel disabled.
_____	_____	_____	Because of my headaches I feel restricted in performing my routine daily activities.
_____	_____	_____	No one understands the effect my headaches have on my life.
_____	_____	_____	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	_____	_____	My headaches make me angry.
_____	_____	_____	Sometimes I feel that I am going to lose control because of my headaches.
_____	_____	_____	Because of my headaches I am less likely to socialize.
_____	_____	_____	My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
_____	_____	_____	My headaches are so bad that I feel that I am going to go insane.
_____	_____	_____	My outlook on the world is affected by my headaches.
_____	_____	_____	I am afraid to go outside when I feel that a headaches is starting.
_____	_____	_____	I feel desperate because of my headaches.
_____	_____	_____	I am concerned that I am paying penalties at work or at home because of my headaches.
_____	_____	_____	My headaches place stress on my relationships with family or friends.
_____	_____	_____	I avoid being around people when I have a headache.
_____	_____	_____	I believe my headaches are making it difficult for me to achieve my goals in life.
_____	_____	_____	I am unable to think clearly because of my headaches.
_____	_____	_____	I get tense (eg, muscle tension) because of my headaches.
_____	_____	_____	I do not enjoy social gatherings because of my headaches.
_____	_____	_____	I feel irritable because of my headaches.
_____	_____	_____	I avoid traveling because of my headaches.
_____	_____	_____	My headaches make me feel confused.
_____	_____	_____	My headaches make me feel frustrated.
_____	_____	_____	I find it difficult to read because of my headaches.
_____	_____	_____	I find it difficult to focus my attention away from my headaches and on other things.

TOTAL _____ _____ **%** _____ **DISABILITY**

Patient's Signature: _____ Date: _____