PATIENT HEALTH HISTORY

DATE:_____ NAME:_____ SEX:_____ DOB:_____

ADDRESS:_____ CITY:_____ STATE:___ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____ EMAIL:_____

SOCIAL SECUIRTY #:_____ MARITAL STATUS:_____ SPOUSE NAME:_____ # OF CHILDREN:____

EMERGENCY CONTANCT:_____ PHONE #:_____

OCCUPATION:_____ EMPLOYER:_____ LOCATION:_____

HOW DID YOU HEAR ABOUT US? _____ IS THERE ANY CHANCE OF PREGNANCY? ☐ YES ☐ NO

INSURANCE INFORMATION: ☐ AUTO ACCIDENT ☐ WORKERS COMP. ☐ GROUP INSURANCE ☐ MEDICARE ☐ PERSONAL PAYMENT

INSURANCE CO.:_____ INSURED'S NAME:_____

PATIENT HEALTH HISTORY: PLEASE CHECK THE BOX IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

☐ LOW BACK PAIN	☐ NUMBNESS/TINGLING IN ARMS/HANDS	☐ FIBROMYALGIA	☐ TIRED/FATIGUED
☐ PAIN BETWEEN SHOULDER BLADES	☐ NUMBNESS/TINGLING IN LEGS/FEET	☐ TENSION ACROSS TOP OF SHOULDERS	☐ DIFFICULTY SLEEPING
☐ NECK PAIN	☐ PAIN IN THE LEGS	☐ CARPAL TUNNEL	☐ ALLERGIES
☐ TENSION/HEADACHES	☐ PAIN IN THE FEET		

DR. USE ONLY [NOTES]

_____

_____

_____

_____

_____

_____

_____

OTHER (EXPLAIN): _____

_____

WHICH OF THE ABOVE IS THE WORST? _____

WHEN DID YOUR COMPLAINT(S) START? [DATE] _____

HOW LONG HAVE YOU HAD IT? _____

HOW OFTEN DO THE COMPLAINT(S) OCCUR? _____

WHEN WAS THE LAST EPISODE? [DATE] _____

WHAT DOES IT FEEL LIKE? [DESCRIBE] _____

DOES THE PAIN TRAVEL ANYWHERE? [RADIATE] _____

WHAT HAVE YOU DONE THAT HAS HELPED THIS PROBLEM? _____

WHAT ACTIVITIES WOULD YOU LIKE TO DO IF THIS WAS NOT A PROBLEM? _____

WAS THERE AN ACCIDENT OR INJURY THAT IS DIRECTLY RELATED TO THIS PROBLEM? _____

[IF YES ABOVE, EXPLAIN] _____

PREVIOUS TREATMENT FOR THIS CONDITION:

☐ CHIROPRACTOR ☐ MD ☐ OTHER NAME OF DOCTOR: _____ RESULTS: ☐ SAME ☐ BETTER ☐ WORSE

HAVE YOU BEEN PLACED ON DISABILITY? ☐ YES ☐ NO BY WHOM?_____ FROM:_____ TO:_____

FAMILY PHYSICIAN:_____ PHONE #:_____

ADDRESS:_____ CITY:_____ STATE:___ ZIP:_____

DOES THIS CAUSE YOU TO BE:	DOES THIS AFFECT YOUR WORK:	DOES THIS AFFECT YOUR LIFE:
☐ MOODY	☐ DECISION MAKING	☐ LOSE PATIENCE WITH SPOUSE/CHILDREN
☐ IRRITABLE	☐ POOR ATTITUDE	☐ RESTRICTED HOUSEHOLD DUTIES
☐ INTERRUPT SLEEP	☐ DECREASED PRODUCTIVITY	☐ HINDER ABILITY TO EXERCISE OR SPORTS
☐ RESTRICTED IN YOUR DAILY ACTIVITIES	☐ EXHAUSTED AT THE END OF THE DAY	☐ INTERFERES WITH ABILITY TO DO HOBBIES OR OTHER ACTIVITIES

WHAT HAVE YOU TRIED TO HELP RELIEVE/GET RID OF THIS PROBLEM AND HOW MUCH DID IT HELP?

• **MEDICATIONS**	**HELPED:**	☐ LITTLE	☐ SOME	☐ MUCH	• **EXERCISE**	**HELPED:**	☐ LITTLE	☐ SOME	☐ MUCH
• **PHYSICAL THERAPY**	**HELPED:**	☐ LITTLE	☐ SOME	☐ MUCH	• **NUTRITION**	**HELPED:**	☐ LITTLE	☐ SOME	☐ MUCH
• **CHIROPRACTIC**	**HELPED:**	☐ LITTLE	☐ SOME	☐ MUCH	• **STRETCHING**	**HELPED:**	☐ LITTLE	☐ SOME	☐ MUCH

SURGERY HISTORY [CHECK BOXES THAT APPLY]

☐ APPENDIX ☐ TONSILS ☐ HERNIA ☐ HEMORRHOID ☐ SPINAL ☐ HYSTERECTOMY ☐ PROSTATE ☐ CYST ☐ CANCER

LIST OTHERS: [INCLUDE APPROXIMATE DATE OF SURGERY] _____

LIST ANY AND ALL MEDICATIONS TAKEN: [INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER, VITAMINS, SUPPLEMENTS]
(CONTINUE ON BACK IF NEEDED)

NAME OF MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING

PLEASE CHECK THE BOX BELOW IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

GASTROINTESTINAL
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Painful bowel movement/constipation
- ☐ Loss of appetite
- ☐ Stomach pain
- ☐ Blood in stool

EARS, NOSE, & THROAT
- ☐ Ringing in the ears
- ☐ Ear aches or drainage
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Hearing loss
- ☐ Bleeding gums
- ☐ Bad breath/taste
- ☐ Sore throat or voice changes
- ☐ Swollen neck glands
- ☐ Mouth sores

GENITOURINARY
- ☐ Sexual difficulty
- ☐ Kidney stones
- ☐ Burning/Painful urination
- ☐ Blood in urine
- ☐ Incontinence or dribbling
- ☐ Frequent Urination
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge

ENDOCRINE
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Heat/Cold intolerance
- ☐ Glandular hormone problem
- ☐ Rash/Itching
- ☐ Change in skin color
- ☐ Change in nails or hair

HEMATOLOGIC/ LYMPHATIC
- ☐ Anemia
- ☐ Slow healing
- ☐ Easy bruising
- ☐ Transfusion
- ☐ Phlebitis

EYE & VISION
- ☐ Wear glasses or contact lenses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury

NEUROLOGY
- ☐ Stroke
- ☐ Head Injury
- ☐ Tremors

PSYCHIATRIC
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep problems
- ☐ Memory loss

RESPIRATORY
- ☐ Spit up blood
- ☐ Shortness of breath
- ☐ Asthma or wheezing
- ☐ Frequent cough

SKIN & BREASTS
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge

HEART & CARDIOVASCULAR
- ☐ Chest pains
- ☐ Rapid heart beat
- ☐ Slowed heart rate
- ☐ Swelling of feet, ankles, hands
- ☐ History of heart disease
- ☐ Shortness of breath

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account, however, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if GRAHAM CHIROPRACTIC extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered tome will be immediately due and payable unless prior arrangements are made. I hereby authorize GRAHAM CHIROPRACTIC and whomever he may designate as his assistants to administer treatment as he deems necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above is true and correct.

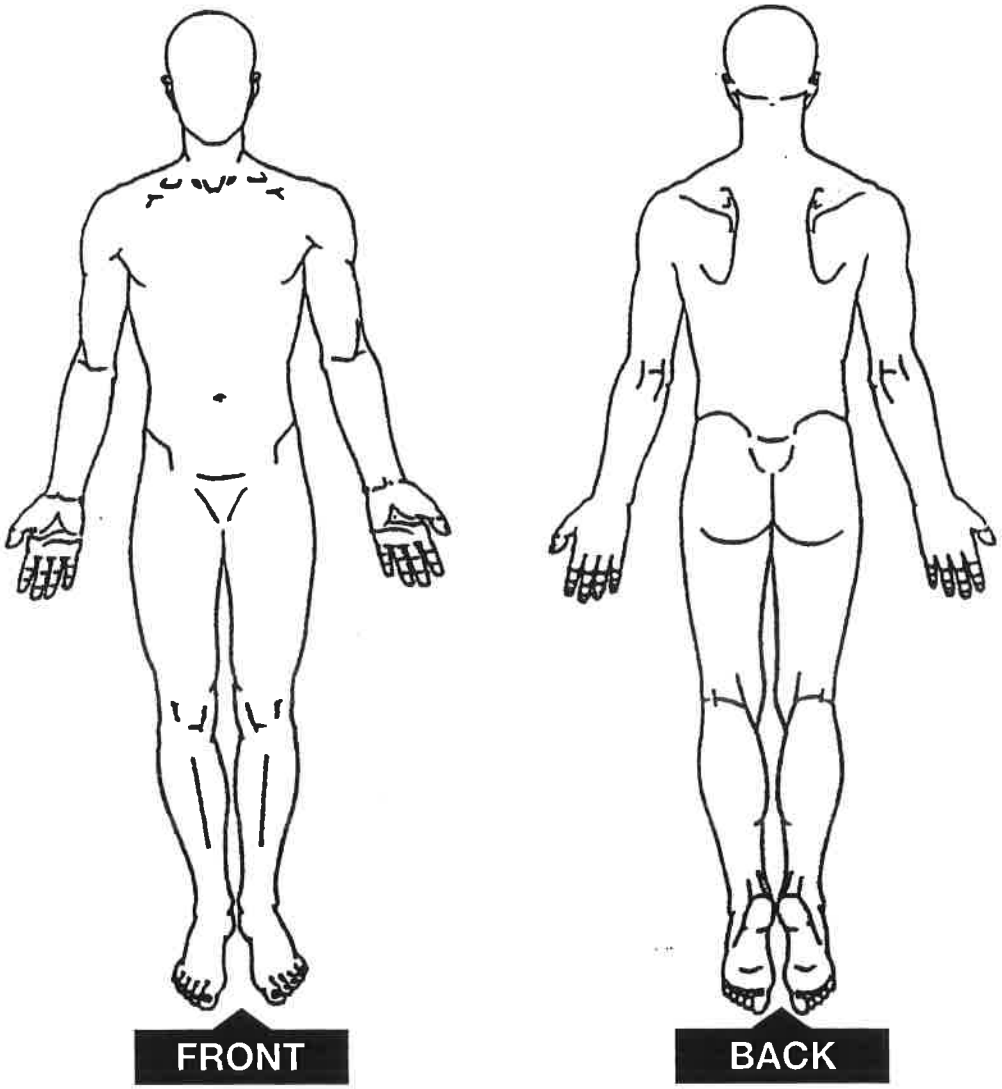
PATIENT'S SIGNATURE: _____ **DATE:** _____

PAIN DRAWING

Patient Name _____ Date _____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face. ☺

A = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing



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

Are You Pregnant? Y N

Personal Medical History (Please Circle The Following Relevant To Your Medical History)

Cancer	**Muscular Dystrophy**	**Rheumatic Fever**	**Digestive Disorders**	**Tuberculosis**	**Convulsions**
Polio	**Multiple Sclerosis**	**Scarlet Fever**	**Sinus Trouble**	**Concussion**	**Backaches**
Diabetes	**Nervousness**	**Numbness**	**Heart Trouble**	**Hepatitis**	**Dizziness**
Asthma	**Venereal Disease**	**High Cholesterol**	**High Blood Pressure**	**HIV**	**Hepatitis C**

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

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 very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

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

Sitting

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

Standing

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

Walking

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

Personal Care

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.

Lifting

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

Traveling

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

Social Life

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

Changing degree 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.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

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

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

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

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

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

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

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

Lifting

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

Driving

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

Recreation

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

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

Neck Index Score _____