INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI)_____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #:_____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** _____

***Referred By:** _____

Ethnicity: Hispanic or Latino / Other **Preferred Language:** _____

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White **Smoking Status:** Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):_____

PRIMARY INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

Who is responsible for payment? Self / Other - *(Relationship)* _____

Other than Self:
Full Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

PATIENT INTAKE FORM

Patient's Name: _____ Date: _____

1. Is today's problem caused by _____ Auto Accident _____Workman's Compensation
2. How often do you experience your symptoms?
   ____constantly (76-100% of the time) ____occasionally (26-50% of the time)
   ____frequently (51-75 % of the time) ____intermittently (1-25% of the time)
3. How are your symptoms changing with time?
   ____getting worse ____staying the same ____getting better
4. How much has the problem interfered with your work?
   ____not at all ____a little bit ____moderately ____quite of bit ____extremely
5. How much has the problem interfered with your social activities?
   ____not at all ____a little bit ____moderately ____quite of bit ____extremely
6. Who else have you seen for your problem?
   ____chiropractor ____massage therapist ____orthopedist ____ER Physician ____Neurologist
   ____Physical Therapist ____Primary Care Physician ____Other: _____
7. How long how you had this problem? _____
8. How do you think your problem began? _____
9. Do you consider this problem to be severe? ____Yes ____Yes, at times ____No
10. What aggravates your problems? _____
11. What alleviates your pain? _____
12. What concerns you most about your problem? _____
13. What does it prevent you from doing? _____
14. What is your: Height _____Weight _____ Date of birth _____
15. Occupation: ____Trader ____Laborer ____Professional/Executive ____Homemaker ____student
    ____white collar ____truck driver ____retired ____unemployed ____other _____
16. What type of exercise do you do? ____strenuous ____moderate ____light ____none
17. Indicate if you have any immediate family members w/any of the following. (M)other, (F)ather or (S)ibing
    ____Rheumatoid Arthritis ____Diabetes ____Lupus ____Heart Problems ____Cancer ____ALS
18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present column".

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		**For Females Only**
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

19. How would you rate your overall health?
__Excellent __Very Good __Good __Fair __Poor
20. Are you allergic to any medications? ____Yes ____No
If yes, what is the reaction? _____
21. Please list all prescription medications you are currently taking.
_____
_____
22. Please list all over-the-counter medications or supplements you are currently taking.
_____
_____
23. Please list all surgical procedures you have had.
_____
_____
24. What activities do you do at work?
Sit: ____ most of the day ____half of the day ____a little of the day
Stand: ____ most of the day ____half of the day ____a little of the day
Computer work: ____ most of the day ____half of the day ____a little of the day
On the phone: ____ most of the day ____half of the day ____a little of the day
Drives: ____ most of the day ____half of the day ____a little of the day
____performs manual labor most of the day ____reads about half of the day ____travels frequently a little of the day ____None
25. What activities to you do outside of work?
____Aerobics ____skiing ____basketball ____soccer ____baseball ____softball ____bicycling ____swimming ____football ____tennis ____golf ____triathlons ____hiking ____volleyball ____ice hockey ____walking ____inline skating ____weight lifting ____jogging ____working out ____marital arts ____yoga ____rock climbing ____other_____
26. Have you ever been hospitalized? ____Yes ____No _____ Previously mentioned
If yes, why?
_____
27. Have you ever been to a chiropractor before? ____Yes ____No. If yes, how long ago? _____
Results: ____great ____good ____fair ____poor
28. Have you had any significant trauma? ____Yes ____No. If yes, what kind? _____
29. Anything else pertinent to your visit today? _____

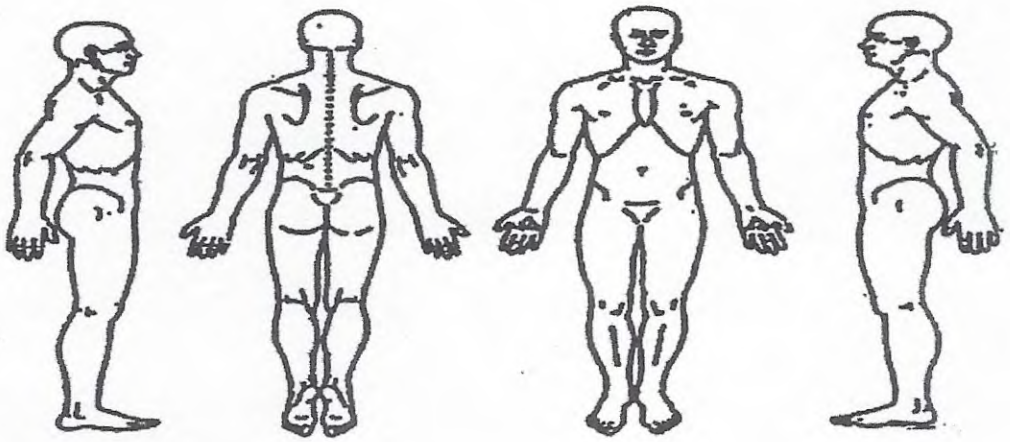
Patient or Patient's guardian signature: _____ Date: _____

Care Chiropractic & Acupuncture
1503 Graham Avenue
Henderson, NC 27536
252.438.2273

A: Identity your areas of discomfort by marking the affected body parts in the illustration in order of complaint with a number. i.e.: 1 lower back; 2 neck; 3 shoulder; etc.

B: Indicate the area name along with your specific symptoms associated with each selected area.

C: Rate your discomfort associated with each selected with 1 (least pain) to 10 (worst pain).



	Sharp	Dull	Diffuse	Achy	Burning	Shooting	Stiff	Numb	Tingly	Sharp w/motion	Shooting w/motion	Stabbing w/ motion	Electric like w/motion	other
Example														
L R Lower back	X			X			X							

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	(X) 7	8	9	10

1.

L R														

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10

2.

L R														

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10

3.

L R														

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10

4.

L R														

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10

Care Chiropractic & Acupuncture Clinic
1503 Graham Avenue
Henderson, NC 27536

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

Section 1 - Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ 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.

Section 2 - 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 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.

Section 3 – Lifting

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Section 5 – Headaches

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

Section 6 – Concentration

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

Section 7 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

Section 8 – Driving

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

Section 9 – 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 can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

Section 10 – Recreation

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

Patient Name _____ Date _____

Score _____ [50] Benchmark -5 = _____

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.

Back Index Score _____