



Patient Information Update



Welcome. We are delighted to see you again. Thank you for taking a few minutes to help us update your record.

Name: _____ Today's date: _____
First Middle Last

1. Has your name changed since your last visit here? ____ Yes ____ No
If yes, what was the old name? _____

What name do you use for health insurance? _____

2. If you have a new or different address since your initial visit here, please write it below:

3. Has your marital status changed? ____ Yes ____ No

4. Has your telephone number changed? ____ Yes ____ No

Please write your correct telephone number: _____

5. Has your employment changed? ____ Yes ____ No

Please tell us your new employer name and address:

6. New employer telephone number: _____

7. Have you changed health insurance companies? ____ Yes ____ No

If yes, please write your new health insurance carrier and address. Provide us with the new card to copy.

Primary _____

Secondary _____

Subscriber #: _____

Subscriber #: _____

Group #: _____

Group #: _____

8. Who is responsible for this bill? _____

9. Please note any changes in your health since your last visit:

Illness: _____

Accident: _____

Allergies: _____

Medications being taken: _____

Other: _____

Patient Signature: _____

Name: _____

Date: _____

✓ Check each of your health problems.

✓ Check which side of your body it is located.

At its worst, how severe is your health problem? (10 is the most severe) Circle the number.

What percentage of your waking day do you feel your health problems? (100% is constant)

HEAD PROBLEMS

- 1. Headaches or Migraines
- 2. TMJ (jaw) Pain/Clicking

- WHICH SIDE?
- Left Both Right
 - Left Both Right

MILD	MODERATE	SEVERE
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

OCCASIONAL	CONSTANT
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%

SPINAL PROBLEMS

- 3. Neck Pain Stiffness
- 4. Upper Shoulder (trapezius) Pain
- 5. Upper Back (Shoulder blades) Pain
- 6. Middle Back Pain Stiffness
- 7. Low Back Pain Stiffness
- 8. Pelvis/Buttock Pain

- WHICH SIDE?
- Left Both Right
 - Left Both Right
 - Left Both Right
 - Left Both Right
 - Left Both Right
 - Left Both Right

MILD	MODERATE	SEVERE
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

OCCASIONAL	CONSTANT
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%

UPPER EXTREMITY (ARM) PROBLEMS

- 9. Shoulder Joint Pain
- 10. Elbow Joint Pain
- 11. Wrist Pain
- 12. Hand Pain Numbness Tingling
- 13. Arm Pain Numbness Tingling

- WHICH SIDE?
- Left Both Right
 - Left Both Right
 - Left Both Right
 - Left Both Right
 - Left Both Right

MILD	MODERATE	SEVERE
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

OCCASIONAL	CONSTANT
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%

LOWER EXTREMITY (LEG) PROBLEMS

- 14. Hip Joint Pain
- 15. Knee Joint Pain
- 16. Ankle Joint Pain
- 17. Foot Pain Numbness Tingling
- 18. Leg Pain Numbness Tingling

- WHICH SIDE?
- Left Both Right
 - Left Both Right
 - Left Both Right
 - Left Both Right
 - Left Both Right

MILD	MODERATE	SEVERE
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

OCCASIONAL	CONSTANT
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%

CHEST, ABDOMINAL OR PELVIC PROBLEMS

- 19. Chest Pain/ Symptoms
- 20. Abdominal Pain/ Symptoms
- 21. Pelvic Pain/ Symptoms

- WHICH SIDE?
- Left Both Right
 - Left Both Right
 - Left Both Right

MILD	MODERATE	SEVERE
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0	1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

OCCASIONAL	CONSTANT
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%
0% 25% 50% 75% 100%	0% 25% 50% 75% 100%

Answer the following questions regarding your health problems:

Which health problem concerns you the most? _____

Describe your health problem: sharp dull ache burning radiating/spreading throbbing pinching twinge

Explain: _____

How many days out of the week do you experience you health problem? daily 6 5 4 3 2 1 day (s)

What time of the day is your health problem the worst? morning afternoon evening sleeping all day varies

How long have you been experiencing your health problem? ___ day(s) ___ week(s) ___ month(s) ___ year(s)

Have you experienced your current health problem in the past? No Yes, the last time was _____ ago.

What do you feel caused your health problem? I don't know injury auto accident stress developed over time

Explain: _____

What aggravates or makes you health problem worse? _____

What relieves or makes your health problems better? _____

Who have you seen previously for this health problem? No one Chiropractor Medical Physical Therapist

What treatment did you receive? _____

Which of the following activities of daily life are being adversely affected by your current health problem?

- Bending over
- Caring for family
- Climbing stairs
- Concentrating
- Dressing self
- Driving Car
- Exercising
- Getting in/out of car
- Getting to sleep
- Grocery shopping
- Household chores
- Lifting objects
- Looking over shoulder
- Making love
- Lying down
- Reaching overhead
- Rising out of chair / bed
- Showering or bathing
- Sitting
- Standing
- Staying asleep
- Using a computer
- Walking
- Participating in yardwork

Patient Signature: _____ Date: _____

Name: _____

Date: _____

This questionnaire will give Family Chiropractic 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. Circle the number that corresponds to your answer.

PLEASE ANSWER THESE QUESTIONS SPECIFIC TO YOUR BACK.

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.

PERSONAL CARE

- 0 I would 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, but I can if they are in convenient places (e.g. on a table).
- 3 Pain prevents me from lifting heavy weights off the floor.
- 4 Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
- 5 I can only lift very light weights at the most.

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 ½ mile without increasing pain.
- 4 I cannot walk more than ¼ mile without increasing pain.
- 5 I cannot walk at all without increasing pain.

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 ½ hour.
- 4 Pain prevents me from sitting more than 10 minutes.
- 5 I avoid sitting because it increases my pain right away.

STANDING

- 0 I can stand as long as I want without extra 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 ½ hour without increasing pain.
- 4 I cannot stand for longer than 10 minutes without increasing pain.
- 5 I avoid standing because it increases the pain right away.

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.

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 as often.
- 4 Pain has restricted my social life to my home.
- 5 I have hardly any social life because of pain.

TRAVELING

- 0 I get no pain while traveling.
- 1 I get some pain while traveling, but none of my usual forms of travel makes 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 alternate forms of travel.
- 4 Pain restricts all forms of travel.
- 5 Pain restricts all forms of travel except that done while lying down.

CHANGING DEGREE OF PAIN

- 0 My pain is rapidly getting better.
- 1 My pain fluctuates, but 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.

Name: _____

Date: _____

This questionnaire will give Family Chiropractic 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. Circle the number that corresponds to your answer.

PLEASE ANSWER THESE QUESTIONS SPECIFIC TO YOUR NECK.

PAIN INTENSITY

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain is moderate at the moment.
- 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.

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, but I can manage medium weights if they are conveniently positioned.
- 4 I can lift very light weights.
- 5 I cannot lift or carry anything at all.

READING

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

HEADACHES

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

CONCENTRATION

- 0 I can concentrate fully when I want with no difficulty.
- 1 I can concentrate fully when I want to 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 to.
- 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 can't do any work 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 pain in my neck.
- 2 I can drive my car as long as I want with moderate pain in my neck.
- 3 I can't drive my car as long as I want because of moderate pain in my neck.
- 4 I can hardly drive at all because of severe pain in my neck.
- 5 I can't drive my car at all.

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 (3-4 hours sleepless).
- 5 My sleep is completely disturbed (5-7 hours sleepless).

RECREATION

- 0 I am able to engage in all my recreation activities with no neck pain at all.
- 1 I am able to engage in all my usual recreation activities with some pain in my neck.
- 2 I am able to engage in most, but not all my usual recreation activities because pain in my neck.
- 3 I am only able to engage in a few of my usual recreation activities because of pain in my neck.
- 4 I can hardly do any recreation activities because of pain in my neck.
- 5 I can't do any recreation activities at all.