Personal Information

Date: ________________

Name ________________________ Address ____

City ______________________________ Zip ________ Social Security # ____________________

Cell Phone (   )_____ - ________ Work/Home Phone(   ) _____- ________

E-mail Address _________________________________

What is the best way to contact you? □ Phone □ E-mail or □ Text (cell phone carrier)_____________

Who May We Thank For Referring You? ____

Birth Date ____________ Age _____ Sex ____ Emergency Contact, Name & # _________________

Employer ____ Occupation ___________________

Employer's Address ____

Circle One: Married / Single / Widowed / Divorced / Separated Spouse's Name _________________

Health Insurance ________________________________ Phone # ___________________________

Health Insurance ID# _________________________________ Group # _____________________

Research is showing that many of our health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood Years	Yes	No	Unsure	Comments (if any)
Did you have any childhood illnesses?	□	□	□	____________________
Were you vaccinated?	□	□	□	____________________
Did you have any falls from a height over 3 feet? (i.e. crib, bunk bed, trees)	□	□	□	____________________
Did you play youth sports?	□	□	□	____________________
Did you take/use any drugs?	□	□	□	____________________
Was there any prolonged use of medicine such as antibiotics or an inhaler?	□	□	□	____________________
Were you involved in any physical accidents? ex. Car, Bicycle, Work	□	□	□	____________________
Did you suffer any form of abuse?	□	□	□	____________________
Were you under regular Chiropractic care?	□	□	□	____________________
Adulthood - (18 to present)				
Do / did you smoke? How much?	□	□	□	____________________
Do / did you drink alcohol? How much?	□	□	□	____________________
List any accidents and when.	□	□	□	____________________
Do / did you play adult / extreme sports?	□	□	□	____________________

What kinds? ____

On a scale of 1-10 describe your level of stress (1 = none / 10 = extreme)

Occupational ______ Personal ___---____ Non-Occupational ______

Name: ________________________Date: ____________

FEMALE ONLY: Is there any chance that you may be pregnant? □ Yes □ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. The doctor's office may bill my insurance as a courtesy to me and will prepare any necessary reports and forms (fees may apply) to assist in making collection from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of all fees for service including legal fees, collection agency fees, and any other expenses incurred in collecting my account. I also understand and agree that if I suspend or terminate care, any fees for services rendered to me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he/she deems appropriate through the use of, but not limited to, spinal adjustments. It is understood and agreed that the x-rays will remain property of this office, being on file where they may be seen at any time. The client also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Client's Signature ____ Date _____________
Legal Guardian / Print______________________________Signature ___________________________

Family Chiropractic
at Northwest Wellness Center

Name:________________________ Date:_____________

WORK RELATED INJURY REPORT

Date of Accident:_____________ Time:___________ AM □ PM□ Location:__________________________
Did you report the accident? Yes□ No□ To Whom?____
Describe the accident:____
____
____
If lifting, how much weight was involved:________ What position were you in?_________________________
Was the accident caused by someone besides you? Yes □ No □ If yes, who? ________________________
What, if any, kind of equipment was involved? ____
What is the function of this equipment?____
Was the accident caused by failure of equipment or a product? Yes □ No □ If yes, what was it?______________
If struck by an object, what was it? _______________ If you fell, how far did you fall?________________
Inside □ Outdoors □ What body parts were impacted? Head □ Chest □ Knee □ Shoulder □ Hand □ Hip □
Foot □ Back □ Other ____________________________ What physical conditions may have contributed to the present injury? (Example: Icy, slippery floor, object in the way etc.?)________________________________
Did you continue working that day? Yes □ No □ If yes, how long?________________ What shift hours were you working?_______________ Describe your job duties:________________________________
____

Office use only:____
____
____

How did you feel immediately following the accident?_______________________________________
Were you unconscious after the accident? Yes □ No □ If yes, how long?_________________________
What hurt the next day?____
What hurt a week later (if applicable), explain?____
____
Which hospital or emergency center did you go to after the accident?__________________ When?_________
How were you transported?__________________ What was the name of the attending Doctor?____________
Were x-rays taken? Yes □ No □ What was the diagnosis as you understood it?______________________
What treatment was given, if any?____________________________________ Are you on any medications?
List:_______________________________ Dosage: ______________ Were you released the same day?
Yes □ No □ If not, when were you released? ___________________________ What, if any, were the recommendations for home care?____
Were there any other doctors seen for injuries resulting from this accident? Yes □ No □ If yes, please list the names and degrees, (DC, DO, MD), and respective diagnoses and treatments:_______________________
____ Since the accident, have you had any additional traumas, falls, injuries, aggravations, etc. Yes □ No □ If yes, explain:_____________________________________
Have you ever injured this body part(s) previously? Yes □ No □ Please explain:_______________________
____

Office use only:____
____
____

Family Chiropractic
at Northwest Wellness Center

Name:_________________________ Date:_____________

Put a check by the symptoms you have noticed since the accident:

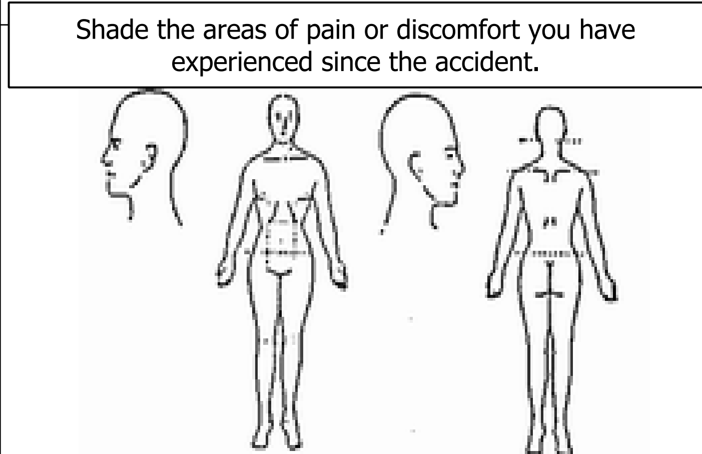
□ Headaches	□ Chest pain	□ Dizziness	□ Fainting	□ Abdominal cramp
□ Head seems too heavy	□ Leg pain/tingling/numb	□ Blurred vision	□ Palpitations	□ Heartburn
□ Neck pain	□ Numbness in toes	□ Vision problems	□ Indigestion	□ Loss of smell/taste
□ Neck stiffness	□ Cold feet	□ Light bothers eyes	□ Gas/bloating after meals	□ Difficult urination
□ Pain between shoulder Blades	□ Walking problems	□ Loss of concentration forgetfulness	□ Poor/excessive appetite	□ Painful/excessive urine
□ Cold hands	□ Hip pain	□ Depression/ confusion	□ Excessive thirst	□ Discolored urine
□ Numbness in fingers	□ Leg pain	□ Anxiety/nervousness	□ Frequent nausea	□ Poor circulation
□ Arm pain/tingling/numb	□ Knee pain	□ Irritability	□ Vomiting	□ Blood pressure problems
□ Elbow pain	□ Ankle pain	□ Sleep disturbance	□ Diarrhea	□ Irregular heartbeat
□ Wrist pain	□ Foot pain	□ Energy loss/fatigue	□ Constipation	□ Heart problems
□ Hand pain	□ Cold sweats	□ Tired AM/PM	□ Hemorrhoids	□ Bladder trouble
□ Mid back pain	□ Difficult chewing/ clicking jaw	□ Weakness	□ Black/bloody stool	□ Liver trouble
□ Low back pain	□ Dental problems	□ Buzzing/ringing ears	□ Weight trouble	□ Gall bladder trouble
□ Short breath	□ Sore throat	□ Earaches	□ Menstrual Irregularity	□ Varicose veins
□ Fever	□ stuffed nose/sinus	□ Hearing difficulty	□ Menstrual Cramping	□ Ankle swelling
□ Other	□ Allergies			□ Prostate/sexual dysfunction

Office use only:____
____

How are you able to perform the following activities after the accident? Indicate by using N=Normal, L=Limited, D=Difficult, P=Painful, U=Unable to perform:

___ Coughing/sneezing	___ Pushing
___ Getting in/out of car	___ Lying on back
___ Turning over in bed	___ Kneeling
___ Walking short distance	___ Balancing
___ Standing more than 1 hour	___ Dressing self
___ Sexual activity	___ Sleeping
___ Lying on side w/knees bent	___ Stooping
___ Lying flat on stomach	___ Gripping
___ Bending over forward	___ Pulling
___ Sitting at table	___ Reaching
___ Bending forward/brushing teeth	
___ Other	___ Climbing

Shade the areas of pain or discomfort you have experienced since the accident.



Office use only:____
____

Have you lost any time from work as a result of injuries from the accident? Yes □ No □ If yes, please list the dates: From________________________ to ________________________ If no, are your work duties restricted because of the accident? Yes □ No □ If yes, how?____ Are you being compensated? Yes □ No □

Do you have an attorney representing you? Yes □ No □ Name of law firm:_______________________________

Attorney's name:________________________ Address:_____________________________ Phone:_______________

The information I have provided is correct and accurate to the best of my knowledge.

Patient's signature:____ Date:_______________

Family Chiropractic
at Northwest Wellness Center

Neck Index

Patient Name: **Date:**

This questionnaire will give your provider and insurance company information about how your neck condition affects your everyday life. Please answer every section by marking the ONE statement that best applies to you. If two or more statements in one section apply, please mark ONE that most closely describes your problem.

Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain comes and goes and is moderate.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is worst imaginable at the moment.

Sleeping

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

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 hardly read at all because of sever neck pain.
- I cannot read at all because of neck pain.

Concentration

- I can concentrate fully when I want with no difficulty.
- I can concentrate fully when I want with slight difficulty.
- I have a fair degree of difficulty concentrating when I want.
- I have a great deal of difficulty concentrating when I want.
- I cannot concentrate at all.

Headaches

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

Work

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

Personal Care

- I can look after myself normally without causing extra pain.
- I can look after myself normally but is causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but I 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.

Lifting

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

Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight neck pain.
- I can drive my car as long as I want with moderate neck pain.
- I cannot drive my car as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I cannot drive my car at all because of neck pain.

Recreation

- I am able to engage in all my recreation activities without neck pain.
- I am able to engage in my usual recreation activities with some neck pain.
- I am able to engage in most, but not all my usual recreation activities because of neck pain.
- I can hardly do any recreation activities because of neck pain.
- I cannot do any recreation activities at all.

On a scale from 0-10 with 0= no pain and 10= worst pain you have ever experienced, where are you currently?

Best **Average** **Worst**

Neck Pain Score

Family Chiropractic
at Northwest Wellness Center

Back Index

Patient Name: **Date:**

This questionnaire will give your provider and insurance company information about how your back condition affects your everyday life. Please answer every section by marking the ONE statement that best applies to you. If two or more statements in one section apply, please mark ONE that most closely describes your problem.

Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is very severe and does not vary much.

Sleeping

- I get no pain while in bed.
- I get pain while in bed but it doesn't prevent me from sleeping well.
- My pain reduces my normal sleep is by less than 25%
- My pain reduces my normal sleep is by less than 50%
- My pain reduces my normal sleep is by less than 75%
- Pain prevents me from sleeping at all.

Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

Standing

- I can stand as long as I want without pain.
- I have some pain while standing but it does not increase with time.
- I can't stand for longer than 1 hour without increasing pain.
- I can't stand for longer than ½ hour without increasing pain.
- I can't stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases pain immediately.

Walking

- I have no pain while walking.
- I have some pain while walking but it doesn't increase with time.
- I can't walk for more than 1 mile without increasing pain.
- I can't walk for more than ½ mile without increasing pain.
- I can't walk for more than ¼ mile without increasing pain.
- I can't walk at all without increasing pain.

Personal Care

- I don't have to change my way of washing or dressing in order to avoid pain.
- I don't normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I'm unable to do some washing and dressing without help.
- Because of the pain I'm unable to wash and dress without help.

Lifting

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

Traveling

- I get no pain while traveling.
- I get some pain while traveling but none of my usual forms of travel make it worse.
- I get extra pain while traveling but it doesn't cause me to seek alternate forms of travel.
- I get extra pain while traveling which causes me to seek alternate forms of travel.
- Pain restricts all forms of travel except that done while lying down.
- Pain restricts all forms of travel.

Social Life

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

Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better
- My pain seems to be getting better but improvement is slow.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

On a scale from 0-10 with 0= no pain and 10= worst pain you have ever experienced, where are you currently?

Best **Average** **Worst**

Back Pain Score