Alaska Health Improvement Center

PLEASE PRINT CLEARLY:

Name _____ Date _____

Street _____ Apt # _____

City _____ State_____ZIP_____

Social Security Number _____ - ___ - _____ Date of Birth_____ Age ____ Gender: M / F

Occupation _____ Employer / # hours per week _____/ _____

Home Phone (____) ____-_____ Cell (____) ____-_____Work (____) ____-_____

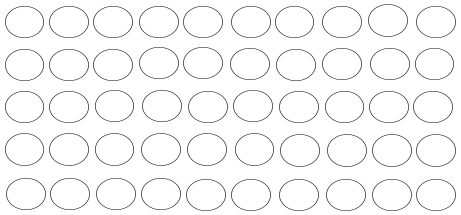
e-mail address: _____

REFERRED BY: _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other:_____

Please list your top symptoms in order of importance: How bad? **Really bad** **Perfect**

1. _____
2. _____
3. _____
4. _____
5. _____



Previous treatment(s) for symptom(s):_____

_____

How would fixing these symptoms help you in life?

1. _____

What long term health problem is effecting your desire to do what?

1. _____

List any Life Threatening Allergies:_____

Are you currently under the care of a physician or other health care professionals? Yes / No

Provider's name:_____ Date of last visit: _____

Provider's name:_____ Date of last visit:_____

Provider's name:_____ Date of last visit:_____

Current medications/drugs and dose: (use separate sheet if needed)

Name / dose:	Name / dose:
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Nutritional supplements you are taking: _____

_____

Name: _____ Date_____

HEALTH HISTORY, FAMILY, LIFESTYLE:

List other major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date:_____

_____

Past accidents or injuries: _____

_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much per day):

Cigarettes _____ Coffee _____ Alcohol _____

What role do sports and exercise play in your life?_____

_____

Marital Status: S M D W Spouse's name: _____

Please describe your spouse's health:_____

Name(s) of Children	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle any that apply or describe):

Cancer / Diabetes / Heart / Other:_____

Do you or family members come in close contact with household pets or other animals? (List)

_____

WHAT ARE YOUR EXPECTATIONS?

How long do you expect it to take to fully resolve your health?_____

The most important things I should do to improve my health are:

1. _____
2. _____

Will your family and/or friends be supportive of your desire to make food and/or lifestyle changes? ___

On a scale of 1-10, how important is it for you to improve this situation?

Unimportant **1 2 3 4 5 6 7 8 9 10** I'd do anything to fix this!

Are there specific services you are seeking from this office? (check all that apply)

r Chiropractic
r Nutrition Response Testing℠
r Designed Clinical Nutrition℠
r Allergy Clearing
r Physical Rehabilitation & Clinical Massage
r Education regarding my health situation
r Comprehensive testing and treatment plan

SIGNED:_____ **DATE** _____

Name: _____ Date_____

DIETARY INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

Please write down what you have eaten over the last two days:

Breakfast	Lunch	Dinner	Snacks	Liquids

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you cook? _____ What percentage of your food is home-cooked?

Where do you get the rest from?_____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

Please explain: _____

_____

BODY CARE INFORMATION

Please list the body care products you typically used as a child/teenager (lotions, deoderant, perfume, makeup)

_____

_____

Please list the body care products you currently use or used recently (lotions, deoderant, perfume, makeup)

_____

_____

_____

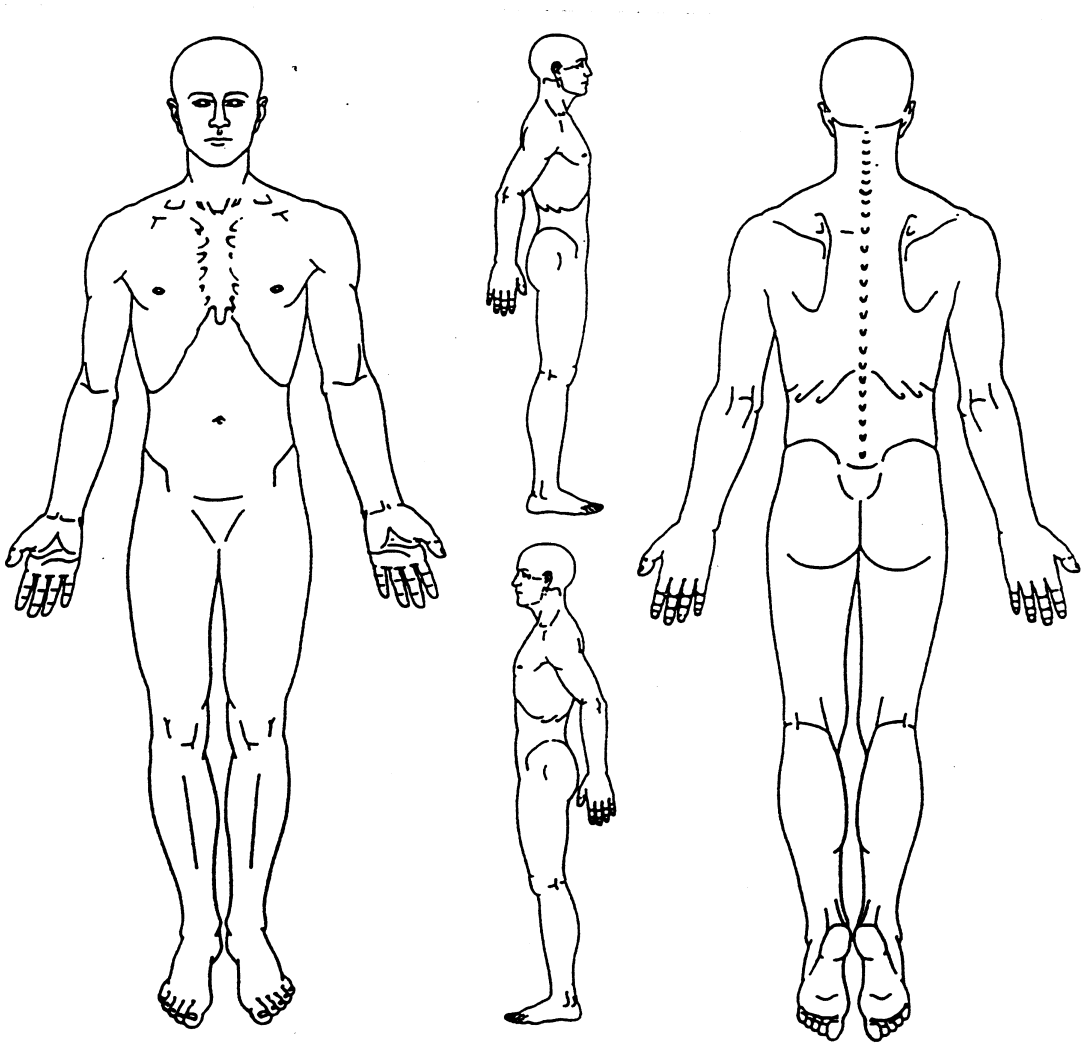
Name: _____ Date_____

SCARS

Your "automatic" body functions (heart rate, blood pressure, digestion, elimination of waste, rebuilding the body and growth) are coordinated by your nervous system.[1]

Scars, just like exposures to toxins, food sensitivities, nutrient deficiencies and spinal misalignments, can disrupt proper nervous system function. Much (80 percent!) of the nerves that coordinate how your body responds to things around it are in your skin, organized into patterns, or "meridians," that form distinct patterns. Scars cut across these ordered patterns and can block or disorder nerve flow.

For proper healing, we need to evaluate any scars. Please draw all "scars" from surgery, injury, stretch marks, burns, scrapes, etc. Please write the cause of the scar and how long it has been there.



[1] The autonomic nervous system is divided into two portions: the sympathetic nervous system activates glands and organs that produce action and defend the body from attack. It is sometimes called the "fight or flight" system. The parasympathetic system is concerned with nourishing, healing, and regeneration of the body. It is more active at rest.

Patient Name: _____Date: _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to the **Alaska Health Improvement Center** for services performed.

Patient or Guardian Signature _____

Date_____

240 E Tudor Rd, Ste 110 Anchorage, AK 99503 **907-743-3040 fax 907 743-6050**

Name:_____ **Date:**_____

Do you currently experience… ?	**Intensity Now?** Mild	Moderate	Severe	**Mark** Office Use	
WEIGHT					
Binge eating / compulsive eating / drinking	O	O	O		
Craving certain foods (what?_____)	O	O	O		
Overweight or underweight (which?)	O	O	O		
Water retention	O	O	O		
Swollen ankles, legs, etc.	O	O	O		
HEAD					
Headaches	O	O	O		
Migraines	O	O	O		
Faintness	O	O	O		
Dizziness	O	O	O		
EYES					
Watery or itchy eyes	O	O	O		
Swollen, red, or sticky eyelids	O	O	O		
Bags or circles under eyes	O	O	O		
Blurred or tunnel vision (*not near or far-sighted*)	O	O	O		
EARS					
Itchy ears	O	O	O		
Earaches / ear infections	O	O	O		
Drainage from ear	O	O	O		
Ringing in ears / hearing loss	O	O	O		
NOSE					
Stuffy nose	O	O	O		
Sinus problems	O	O	O		
Sneezing attacks	O	O	O		
Excessive mucous formation	O	O	O		
ALLERGIES					
Animal (which _____)	O	O	O		
Insects (which _____)	O	O	O		
Trees / pollen (which _____)	O	O	O		
Wheat / grains (which _____)	O	O	O		
Nuts (which _____)	O	O	O		
Dairy	O	O	O		
Seasonal / hay fever	O	O	O		
other (what _____)	O	O	O		
MOUTH / THROAT					
Chronic coughing	O	O	O		
Gagging, need to clear through often	O	O	O		
Sore throat, hoarse, loss of voice	O	O	O		
Swollen or discolored tongue, gums, lips	O	O	O		
Canker sores	O	O	O		
SKIN					
Acne	O	O	O		
Hives, rashes	O	O	O		
Itchy, dry skin	O	O	O		
Hair loss	O	O	O		
Flushing, hot flashes	O	O	O		
Excessive sweating	O	O	O		

HEART	Mild	Moderate	Severe	**Office use**	
Irregular or skipped heartbeat	O	O	O		
Rapid or pounding heartbeat	O	O	O		
Chest pain	O	O	O		
High or Low blood pressure (which?)	O	O	O		
LUNGS					
Chest congestion	O	O	O		
Asthma, bronchitis	O	O	O		
Shortness of breath	O	O	O		
Difficulty breathing	O	O	O		
DIGESTIVE TRACT					
Nausea, vomiting	O	O	O		
Diarrhea	O	O	O		
Constipation (# days between stools? _____)	O	O	O		
Bloating, belching, gas	O	O	O		
Heartburn, acid reflux	O	O	O		
Intestinal / stomach pain	O	O	O		
JOINTS / MUSCLE					
Pain or aches in joints (where?_____)	O	O	O		
Arthritis (where?_____)	O	O	O		
Stiffness, limited movement	O	O	O		
Muscle pain or cramps	O	O	O		
Weak, tired muscles	O	O	O		
Numbness	O	O	O		
Bone pain	O	O	O		
Bone demineralizing, osteoporosis	O	O	O		
ENERGY / ACTIVITY					
Fatigue, sluggishness	O	O	O		
Apathy, lethargy	O	O	O		
Hyperactivity	O	O	O		
Restlessness	O	O	O		
MIND / COGNITIVE					
Poor memory	O	O	O		
Brain fog, confusion, poor comprehension	O	O	O		
Poor concentration	O	O	O		
Learning disabilities	O	O	O		
Poor physical coordination	O	O	O		
Stuttering, stammering	O	O	O		
Slurred speech	O	O	O		
EMOTIONS					
Mood swings	O	O	O		
Anxiety, fear, nervousness	O	O	O		
Anger, irritability, aggressiveness	O	O	O		
Depression	O	O	O		
OTHER					
Get sick easily or often	O	O	O		
Frequent urination	O	O	O		
Insomnia (average # hours sleep _____)	O	O	O		
MALE / FEMALE					
PMS	O	O	O		
Irregular menses	O	O	O		
Lowered libido	O	O	O		
Erectile dysfunction	O	O	O		

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back 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 apply to you, but PLEASE JUST CIRCLE THEONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity

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

Section 2 – Personal Care

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

Section 3 – Lifting

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

Section 4 – Walking

1. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than one mile.
3. Pain prevents me from walking more than ½ mile.
4. Pain prevents me from walking more than ¼ mile.
5. I can only walk while using a cane or on crutches.
6. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

1. I can sit in any chair as long as I like without pain.
2. I can only 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 ½ hour.
5. Pain prevents me from sitting more than ten minutes.
6. Pain prevents me from sitting at all.

Section 6 – Standing

1. I can stand as long as I want without pain.
2. I have some pain while standing, but it does not increase with time.
3. I can not stand for longer than one hour without increasing pain.
4. I can not stand for longer than ½ hour, without increasing pain.
5. I can not stand for longer than ten minutes, without increasing pain.
6. I avoid standing, because it increases the pain straight away.

Section 7 – Sleeping

1. I get no pain in bed.
2. I get pain in bed, but it doesn't prevent me from sleeping well
3. Because of my pain, my normal night's sleep is reduced by less than one-quarter.
4. Because of my pain, my normal night's sleep is reduced by less than one-half.
5. Because of my pain, my normal 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. My social life is normal, but increases the degree of my pain.
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
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

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

Section 10 – Changing Degree of Pain

1. My pain is rapidly getting better.
2. My pain fluctuates, but overall is definitely getting better.
3. My pain seems to be getting better, but improvement is slow at present.
4. My pain is neither getting better or worse.
5. My pain is gradually getting worse.
6. My pain is rapidly worsening

Comments: _____

Patient's Signature: _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: 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 apply to you, but PLEASE JUST CIRCLE THEONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity
1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

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

Section 3 – Lifting
1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
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, but I can manage light to medium weights if they are conveniently positioned.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

Section 4 – Reading
1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want to with moderate pain in my pain in my neck.
4. I cannot read as much as I want because of moderate pain in my neck.
5. I cannot read as much as I want because of severe pain in my neck.
6. I cannot read at all.

Section 5 – Headaches
1. I have no headaches at all.
2. I have slight headaches, which come infrequently.
3. I have moderate headaches, which come infrequently.
4. I have moderate headaches, which come frequently.
5. I have severe headaches, which come frequently.
6. I have headaches almost all of the time.

Section 6 – Concentration
1. I can concentrate fully when I want to with no difficulty.
2. I can concentrate fully when I want to with slight difficulty.
3. I have a fair degree of difficulty in concentrating when I want to.
4. I have a lot of difficulty in concentrating when I want to.
5. I have a great deal of difficulty in concentrating when I want to.
6. I cannot concentrate at all.

Section 7 – Work
1. I can do as much work as I wan to.
2. I can do only my usual work, but no more.
3. I can do most of my usual work, but no more.
4. I cannot do my usual work.
5. I can hardly do any work at all.
6. I cannot do any work at all.

Section 8 – Driving
1. I can drive my car without any neck pain.
2. I can drive my car as long as I want with slight pain in my neck.
3. I can drive my car as long as I want with moderate pain in my neck.
4. I cannot drive my car as long as I want because of moderate pain in my neck.
5. I can hardly drive at all because of severe pain in my neck.
6. I cannot drive my car at all.

Section 9 – Sleeping
1. I have no trouble sleeping.
2. My sleep is slightly disturbed (less than 1 hour sleepless).
3. My sleep is mildly disturbed (1-2 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless).
5. My sleep is greatly disturbed (3-5 hours sleepless).
6. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation
1. I am able to engage in all of my recreational activities, with no neck pain at all.
2. I am able to engage in all of my recreational activities, with some pain in my neck.
3. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
4. I am able to engage in a few of my usual recreational activities because of pain in my neck.
5. I can hardly do any recreational activities because of pain in my neck.
6. I cannot do any recreational activities at all.

Comments: _____

Patient's Signature: _____ Date: _____

RAND 36 ITEM HEALTH SURVEY 1.0

Patient Name: _____

1. In general, would you say your health is:
(**Circle One Number)**

Excellent 1
Very Good 2
Good 3
Fair 4
Poor 5

2. **Compared to one year ago**, how would you rate your: general health right **now** ?
(Circle One Number)

Much better than one year ago 1
Somewhat better than one year ago 2
About the same 3
Somewhat worse now than one year ago 4
Much worse now than one year ago 5

The following items are about activities you might do during a typical day: Does **your health now limit you** in these activities ? If so, how much ? **(Circle One Number on Each Line)**	**Yes, Limited A Lot**	**Yes, Limited A Little**	**No, Not Limited at All**
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table pushing a vacuum cleaner, bowling or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** fights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking **more than a mile**	1	2	3
10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health** ?: **(Circle One Number on Each Line)**	**Yes**	**No**
13. Cut down the amount of time you spend on work or other activities	1	2
14. Accomplish less than you would like	1	2
15. Were limited in the kind of work or other activities	1	2
16. Had difficulty performing the work or other activities (for example, took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** ?: (depressed, anxious) (**Circle One Number on Each Line**)	**Yes**	**No**
17. Cut down the amount of time you spend on work or other activities	1	2
18. Accomplish less than you would like	1	2
19. Didn't do work or other activities as carefully as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional: problems interfered with your normal social activities with family, friends, neighbors or groups?
(Circle One Number)

Not at all 1
Slightly 2
Moderate 3
Quite a bit 4
Good 5

21. How much **bodily** pain have you had during the **past 4 weeks**:
(Circle One Number)

None 1
Very Mild 2
Mild 3
Moderate 4
Severe 5
Very Severe 6

22. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework ?
(Circle One Number)

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

These questions are about how you feel and how things have been with you **during the past 4 weeks**.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . . **(Circle One Number on Each Line)**	**All of the Time**	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
23. Did you feel full of pep ?	1	2	3	4	5	6
24. Have you been a very nervous person ?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up ?	1	2	3	4	5	6
26. Have you felt calm and peaceful ?	1	2	3	4	5	6
27. Do you have a lot of energy ?	1	2	3	4	5	6
28. Have you felt downhearted and blue ?	1	2	3	4	5	6
29. Did you feel worn out ?	1	2	3	4	5	6
30. Have you been a happy person ?	1	2	3	4	5	6
31. Did you feel tired ?	1	2	3	4	5	6

32. During the **past 4 weeks**, to what extent has your **physical health or emotional problems** interfered with your normal social activities like visiting with family, friends, relatives, etc.?
(Circle One Number)

All of the time 1
Most of the time 2
Some of the time 3
A little of the time 4
None of the time 5

How TRUE or FALSE is each of the following statements for you ?

(Circle One Number on Each Line)	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Comments: _____

_____

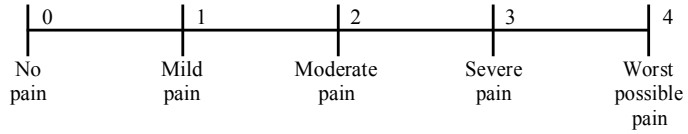
Patient Signature: _____ Date _____

Functional Rating Index

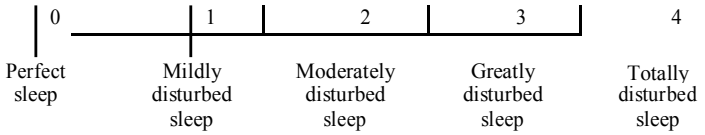
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

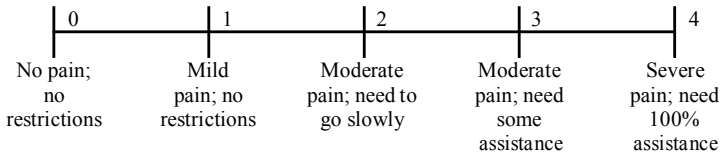
1. Pain Intensity



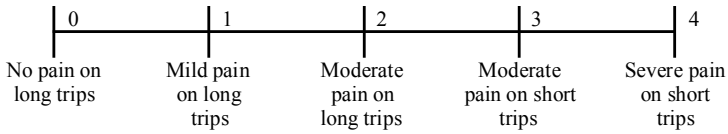
2. Sleeping



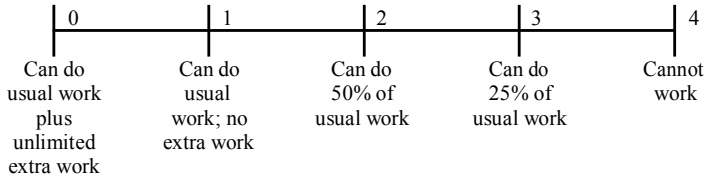
3. Personal Care (washing, dressing, etc.)



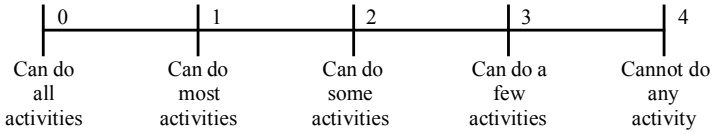
4. Travelling (driving, etc.)



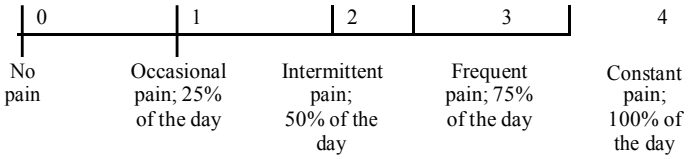
5. Work



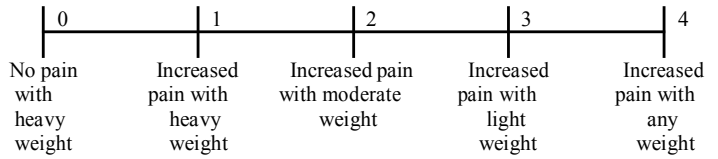
6. Recreation



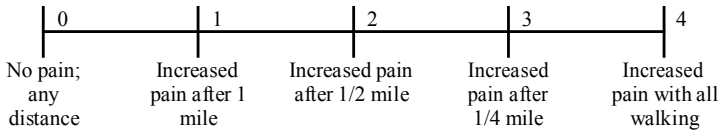
7. Frequency of Pain



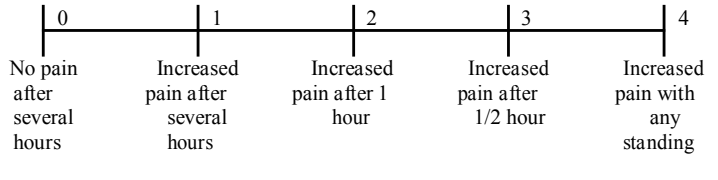
8. Lifting



9. Walking



10. Standing



Patient's Signature _____ **Date** _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#: _____

Patient Name: _____Date: _____

SYMPTOM HISTORY

Symptom (Spine & Joint Pain) _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? _____
    - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____

- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
    - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

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