13 Chester Ave
Medford, N.J. 08055
609-654-0700

ALIGNIS Clinical Records System

Patient Health Assessment

Please PRINT or WRITE Clearly

General Information

Patient Name:_____ Date:_____

Provider Name: Brett A. Wartenberg, D.C.

Primary Care Physician's Name:_____ Marital Status: Single - Married - Divorced - Separated - Widowed

Patient Sex: M_____ F_____ Date of Birth:_____ Social Security #:_____

Patient Address:_____

Home _____ Work _____ Cell _____ E-Mail _____

Patient Employer:_____ Patient Occupation:_____

Subscriber Name:_____ Relation to Patient:_____

Subscriber Employer:_____ Subscriber Social Security #:_____

Referred for Treatment by:_____

Health Insurance Plan:_____ Group #:_____ Member #:_____

Complaint History

1. Describe your current complaint and how the problem began: _____

_____

How long have you had this condition?_____ **Date of onset:**_____

2. How would you describe pain?

❒ Sharp ❒ Soreness ❒ Throbbing ❒ Tingling ❒ Dull ❒ Stiffness
❒ Spasm ❒ Burning ❒ Ache ❒ Weakness ❒ Numbness ❒ Shooting

3. How would you rate the intensity of your pain? *(Circle the appropriate number)*

0 1 2 3 4 5 6 7 8 9 10

(no pain) *(moderate pain)* *(terrible/unbearable pain)*

4. How often is the pain present?

❒ Constant (81-100%) ❒ Frequent (51-80%) ❒ Occasional (26-50%) ❒ Intermittent (25% or less)

5. Since your problem began is the pain:

❒ Getting worse ❒ Getting better ❒ Staying the same

6. How did your problem begin? **Explain:** _____

❒ An auto accident ❒ Work related accident ❒ Other type of accident
❒ Gradual ❒ Sudden ❒ No specific reason

_____

7. What makes your problem better?

❒ Nothing ❒ Walking ❒ Standing ❒ Sitting ❒ Moving around/exercise ❒ Lying down ❒ Inactivity

8. What makes your problem worse?

❒ Nothing ❒ Walking ❒ Standing ❒ Sitting ❒ Moving around/exercise ❒ Lying down ❒ Inactivity

9. Are you currently taking any medications? ❒ Yes ❒ No

If yes, please describe _____

10. Were you previously treated for an earlier occurrence of this *same* condition? ❒ Yes ❒ No

If yes, by whom? ❒ MD ❒ Chiropractor ❒ Physical therapist ❒ Other_____

What were the approximate dates, type of treatment and the results? _____

_____

11. What is your physical activity at work?

❒ Mostly sitting ❒ Light manual labor ❒ Moderate manual labor ❒ Heavy manual labor

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Patient Health Assessment (cont.)

12. Do you exercise?

❒ No regular exercise ❒ 1-2 times a week ❒ 3-4 times a week ❒ 5-7 times a week
❒ Cardiovascular ❒ Stretching ❒ Weight Machine ❒ Free Weights ❒ Sports _____ Type

13. What is your present general stress level:

❒ No stress ❒ Minimal stress ❒ Moderate stress ❒ Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

❒ No effect
❒ Have some limited physical restrictions, but can function
❒ Need some assistance with daily activities
❒ Cannot work
❒ Cannot function without assistance
❒ Totally disabled

Past Or Present Symptoms, Conditions Or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	❒	❒	High blood pressure	❒	❒
Shoulder pain	❒	❒	Heart condition	❒	❒
Arm/elbow pain	❒	❒	Respiratory condition	❒	❒
Hand pain	❒	❒	Digestive problems	❒	❒
Upper back pain	❒	❒	Kidney/bladder problem	❒	❒
Lower back pain	❒	❒	Menstrual problems	❒	❒
Pain in upper leg or hip	❒	❒	Breast soreness/lump	❒	❒
Pain in lower leg or knee	❒	❒	Sinus conditions	❒	❒
Pain in ankle or foot	❒	❒	Allergies/asthma	❒	❒
Jaw pain	❒	❒	Cancer	❒	❒
Swelling/stiffness of joints	❒	❒	Stroke	❒	❒
Headaches	❒	❒	Excessive weight loss/gain	❒	❒
Dizziness	❒	❒	Skin condition	❒	❒
Fainting spells	❒	❒	Arthritis	❒	❒
Convulsions	❒	❒	Diabetes	❒	❒
General prolonged fatigue	❒	❒	Prostate condition	❒	❒
Condition of uterus/ovaries	❒	❒			

Tobacco use:
❒ **Past** ❒ **Present**
❒ Occasional ❒ Moderate ❒ Heavy

Alcohol use:
❒ **Past** ❒ **Present**
❒ Occasional ❒ Moderate ❒ Heavy

Caffeine use: *(Coffee, tea, soft drinks)*
❒ **Past** ❒ **Present**
❒ Occasional ❒ Moderate ❒ Heavy

Pregnancy: ❒ **Past** ❒ **Present**

Surgical Procedure:
❒ **Past** ❒ **Present**

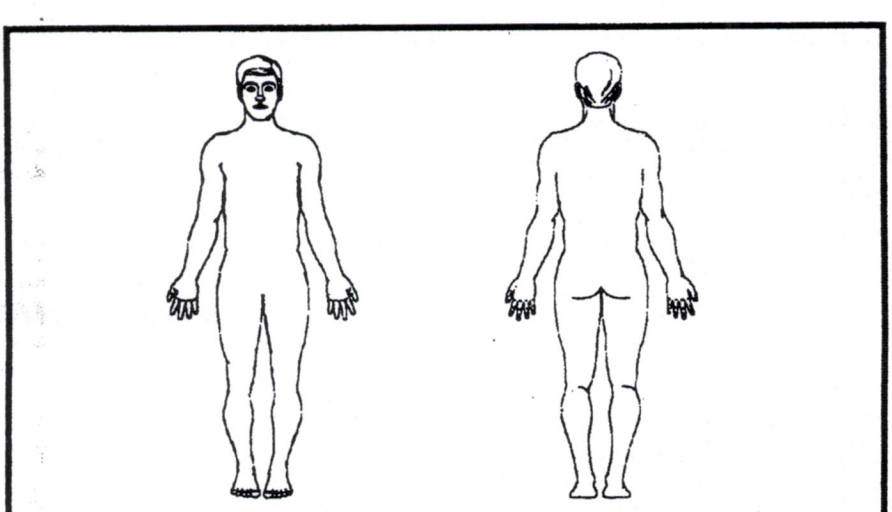
Please list: _____

_____

Comments: _____

_____

Please shade in the figures below where you have pain, or other symptoms:



I have reviewed the information contained on this form with the patient.

_____
Patient Name

_____
Provider Initials

_____
Date

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [72]

Turner JA, Robinson J, McCreary CP. Chronic low back pain: Predicting response to nonsurgical treatment. *Arch Phys Med Rehabilitation* 1983; 64: 560-563

OSWESTRY INDEX QUESTIONNAIRE

This questionnaire is designed to help us better understand how your back 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

- ☐ My pain is mild to moderate. I do not need pain killers.
- ☐ The pain is bad, but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain.

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 – WALKING

- ☐ I can walk as far as I wish.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can walk only if I use a cane or crutches.
- ☐ I am in bed or in a chair for most of every day.

SECTION 5 – SITTING

- ☐ I can sit in any chair for as long as I like.
- ☐ I can sit in my favorite chair only, but for as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all

SECTION 6 – STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 – SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I sleep well but only when taking medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ☐ Social life is normal and causes me no extra pain.
- ☐ Social life is normal, but increases the degree of pain.
- ☐ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ Pain has restricted my social life, and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 9 - SEXUAL ACTIVITY

- ☐ Sexual activity is normal and causes no extra pain.
- ☐ Sexual activity is normal, but causes some extra pain.
- ☐ Sexual activity is nearly normal, but is very painful.
- ☐ Sexual activity is severely restricted by pain.
- ☐ Sexual activity is nearly absent because of pain.
- ☐ Pain prevents any sexual activity at all.

SECTION 10 – TRAVELING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to necessary journeys under ½ hr.
- ☐ Pain prevents traveling except to the doctor/hospital.

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [50]