



Patient # \_\_\_\_\_

Date \_\_\_\_\_

## NEW PATIENT LOG

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX M F

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

MARITAL STATUS S M D W NUMBER OF CHILDREN \_\_\_\_\_

OCCUPATION \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

REFERRED BY \_\_\_\_\_ DRIVERS LICENSE # \_\_\_\_\_

E-MAIL \_\_\_\_\_

IS THIS THE RESULT OF AN AUTO ACCIDENT? Y N

IS THIS THE RESULT OF A WORK RELATED INJURY? Y N

IF YES INDICATE DATE \_\_\_\_\_

# CURRENT COMPLAINT HISTORY

Name \_\_\_\_\_ Patient # \_\_\_\_\_ Date \_\_\_\_\_

**Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.**

Please list your present complaint(s) and mark your level of pain today for each complaint—If you have more than one area of complaint list them in order of most severe to least severe.

1. \_\_\_\_\_ **Duration - (How Long / Date):** \_\_\_\_\_ **# of Previous Episodes:** \_\_\_\_\_  
 (Please circle one) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
2. \_\_\_\_\_ **Duration - (How Long / Date):** \_\_\_\_\_ **# of Previous Episodes:** \_\_\_\_\_  
 (Please circle one) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)
3. \_\_\_\_\_ **Duration - (How Long / Date):** \_\_\_\_\_ **# of Previous Episodes:** \_\_\_\_\_  
 (Please circle one) (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Has anyone treated you for this episode?  Yes  No If yes, by whom? \_\_\_\_\_

How did your symptoms begin?

- Immediately after a specific incident  After multiple incidents  Gradually developed over time  Other \_\_\_\_\_

What makes your symptoms better?

- Nothing  Lying down  Standing  Sitting  Movement/Exercise  Other \_\_\_\_\_

What makes your symptoms worse?

- Nothing  Lying down  Standing  Sitting  Movement/Exercise  Other \_\_\_\_\_

Are your symptoms?

- Decreasing  Increasing  
 Not Changing  Other \_\_\_\_\_

Description of pain or symptoms:

- Sharp  Shooting  
 Dull  Burning  
 Ache  Numb  
 Weakness  Tingling  
 Throbbing  Other \_\_\_\_\_

Does your pain move or radiate?

- No  Yes Where \_\_\_\_\_

Check the best and worse time of the day for your pain:

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| <b>Worse</b>                         | <b>Best</b>                          |
| <input type="checkbox"/> First Awake | <input type="checkbox"/> First Awake |
| <input type="checkbox"/> Morning     | <input type="checkbox"/> Morning     |
| <input type="checkbox"/> Afternoon   | <input type="checkbox"/> Afternoon   |
| <input type="checkbox"/> Evening     | <input type="checkbox"/> Evening     |
| <input type="checkbox"/> Other       | <input type="checkbox"/> Other       |

Frequency of pain or symptoms:

- Constant (76 - 100%)  
 Frequent (51 - 75%)  
 Intermittent (26 - 50%)  
 Occasional (25 - or less)

**SHOW US YOUR PAIN**  
**USE THE LETTERS BELOW TO INDICATE**  
**THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY**

KEY: **A**=ACHE    **B**=BURNING    **N**=NUMBNESS    **P**=PINS & NEEDLES  
**S**=STABBING    **X**=STIFFNESS    **T**=THROBBING    **O**=OTHER

The diagrams show a human figure from the front, back, and two sides. The front view is labeled 'RIGHT' on the left side and 'LEFT' on the right side. The back view is labeled 'LEFT' on the left side and 'RIGHT' on the right side. The two side views are labeled 'RIGHT' and 'LEFT' respectively. The diagrams are intended for marking the location and type of pain using the key provided.

How many days out of an average week are you in pain? (Please circle one) 1 2 3 4 5 6 7

How much time during the day are you in pain?

- less than 1 hour  1 to 6 hours  6 to 12 hours  12 to 18 hours  18 to 24 hours  24 hours

Name \_\_\_\_\_ Patient # \_\_\_\_\_ Date \_\_\_\_\_

**What is your current work status:**

- Full time, no restrictions     Full time, restrictions     Full time Homemaker     Full time Student  
 Part time, no restrictions     Part time, restrictions     Retired     Unemployed  
 Off work due to restrictions     Other \_\_\_\_\_

**Restrictions:**

Off work:     Yes     No     Previously From: \_\_\_\_\_ to \_\_\_\_\_  
Light Duty:     Yes     No     Previously If yes, what are/were your restrictions? \_\_\_\_\_

Do/did you require outside help at home:

Yes     No If yes, what do/did you need? \_\_\_\_\_

Do you wear orthotics or heel lifts?     Yes     No    Fitted by whom? \_\_\_\_\_

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc:

Please list: \_\_\_\_\_

Is your condition interfering with your:     Work     Sleep     Daily Routine     Other: \_\_\_\_\_

Have you ever been to a chiropractor before?     Yes     No Dr.'s Name: \_\_\_\_\_ When: \_\_\_\_\_

Operations/Surgeries? \_\_\_\_\_

Broken Bones? \_\_\_\_\_

Bad falls? \_\_\_\_\_

Auto Accidents? \_\_\_\_\_

Hospitalized? \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING CONDITIONS THAT YOU HAVE NOW OR HAVE HAD IN THE PAST.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Abdominal Pain              |
| <input type="checkbox"/> Blurred Vision             | <input type="checkbox"/> Poor Appetite          | <input type="checkbox"/> Hip Pain (Sacroiliac)       |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Bed Wetting                 |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Constipation                |
| <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Gas/Gas Pains          | <input type="checkbox"/> Cramps                      |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Hemorrhoids                 |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Injury Back Pain            |
| <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Heart Pain             | <input type="checkbox"/> Low Back Pain               |
| <input type="checkbox"/> Headache                   | <input type="checkbox"/> Heart Palpitations     | <input type="checkbox"/> Tailbone/Sacrum Pain        |
| <input type="checkbox"/> Hearing Trouble            | <input type="checkbox"/> Heart Attacks          | <input type="checkbox"/> Pins & Needles in Legs      |
| <input type="checkbox"/> Unable to Sleep            | <input type="checkbox"/> Liver Trouble          | <input type="checkbox"/> Gout                        |
| <input type="checkbox"/> Bursitis                   | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Cold Feet                   |
| <input type="checkbox"/> Run Down Feeling (Malaise) | <input type="checkbox"/> Stomach Trouble        | <input type="checkbox"/> Numbness in Legs            |
| <input type="checkbox"/> Ring or Buzzing in Ears    | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Swollen Ankles              |
| <input type="checkbox"/> Neck Pain                  | <input type="checkbox"/> Painful Joints         | <input type="checkbox"/> Colitis                     |
| <input type="checkbox"/> Pain in Forearm, Elbow     | <input type="checkbox"/> Swollen Joints         | <input type="checkbox"/> Appendicitis                |
| <input type="checkbox"/> Pain in Hand, Wrist        | <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Groin Pain                  |
| <input type="checkbox"/> Pain in Head. Face         | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Menstrual Pain (PMS)        |
| <input type="checkbox"/> Sinus                      | <input type="checkbox"/> Gallbladder Troubles   | <input type="checkbox"/> Pain in Lower Leg, Knees    |
| <input type="checkbox"/> Thyroid Trouble            | <input type="checkbox"/> Kidney Trouble         | <input type="checkbox"/> Pain in Pelvic Region/Thigh |
| <input type="checkbox"/> Pins & Needles in Hand/Arm | <input type="checkbox"/> Indigestion            | <input type="checkbox"/> Muscle Spasm                |
| <input type="checkbox"/> Cold Hands                 | <input type="checkbox"/> Colds                  | <input type="checkbox"/> Varicose Veins              |
| <input type="checkbox"/> Carpal Tunnel Syndrome     | <input type="checkbox"/> Difficulty Breathing   | <input type="checkbox"/> Bladder Problems            |
| <input type="checkbox"/> Cold Sweats                | <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Prostate Problems           |
| <input type="checkbox"/> Laryngitis                 | <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Menstrual Irregularity      |

Would you like nutritional counseling?     Yes     No

# Neck Index

ChiroCare of Wisconsin, Inc.

ChiroCare use Only rev 1/15/99

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

This questionnaire will give your provider 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.

## 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 the 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 sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours 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 cannot read as much as I want because of moderate neck pain.
- I can hardly read at all because of severe 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 lot of difficulty concentrating when I want.
- I have a great deal of difficulty concentrating when I want.
- I cannot concentrate at all.

## 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 work at all.

## 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 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 all 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 am only able to engage in a few of 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.

## 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.

## Calculate Score

Neck  
Index  
Score

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

# Back Index

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/10/99

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

- 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 in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal sleep is reduced by less than 25%.
- Because of pain my normal sleep is reduced by less than 50%.
- Because of pain my normal sleep is reduced 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 1/2 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 cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot 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 distance.
- I cannot walk more than 1 mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

## Personal Care

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not 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 am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing 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 does not 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 more energetic interests (e.g., dancing, etc).
- 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 the 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.

## Calculate Score

Back  
Index  
Score

**STOP**

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100