Mager Chiropractic Center

Keeping active people active!

305 Mt Lebanon Blvd., Suite 200
Pittsburgh, PA 15234

Tel (412) 341- 3332
Fax (412) 341 -3370
jmagerdc@comcast.net

PERSONAL INFORMATION:

Name: ______________________________________ Age:______ DOB:_________ Sex: M ☐ F ☐
Address: __________________________________City/State/ Zip: ___________________________
Home Phone #: (___)_____-_______ Work Phone #: (___)_____-_________
Cell Phone #: (___)_____-_______ Email Address: _______________________

AUTO INSURANCE INFORMATION:

Your Auto Insurance Name: ____________________________ Phone Number : ______________
Address:________________________________ City/State/ Zip: ___________________________
Policy Number:____________________________ Claim Number: ___________________________
Please indicate your policy coverage: Full Tort ☐ Limited ☐

(**A copy of your Auto Insurance Declarations Page must be provided to our office**)

ACCIDENT DETAILS:

Date of Accident:_________________________ Time of Day:______ AM ☐ PM ☐

Where did the accident occur (name of street): ____

Were you: Driver ☐ Passenger Front Seat ☐ Passenger Back Seat ☐

Were you struck from: Behind ☐ Front ☐ Left side ☐ Right side ☐

Approximate speed of your car: ____mph Approximate speed of other car: ____mph

How many cars were involved in the accident? _____ Were other people injured? Yes ☐ No ☐
Were Police notified? Yes ☐ No ☐ If yes, was a report written? Yes ☐ No ☐
(***If yes, please supply a copy of the report to our office.)***
Were you determined to be at fault? Yes ☐ No ☐ Were you wearing a seatbelt? Yes ☐ No ☐

In your own words, please describe the accident in detail: _______________________________________

____

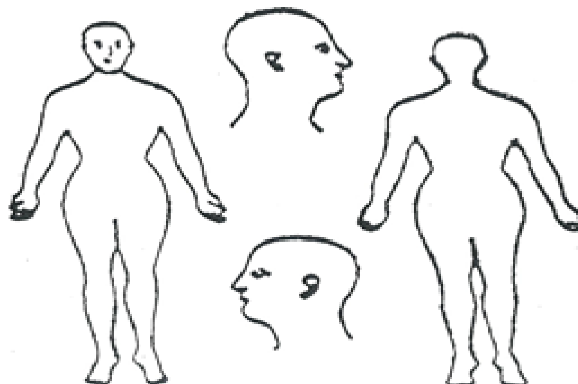
____

How do you describe this accident? Minor ☐ Moderate ☐ Severe ☐
Was anyone else injured in the accident? Yes ☐ No ☐ Were they in your car? Yes ☐ No ☐
Was emergency care provided following the accident? Yes ☐ No ☐ If yes, where? At the scene:____
ER____ MD ____ Other ____ Are there medical records we need to review? Yes ☐ No ☐
Were x-rays taken? Yes ☐ No ☐ ***(If yes, please supply a copy of the x-rays to our office.)***

PHYSICAL ACCIDENT DETAILS:

Please describe your injuries and mark on the diagram any and all areas of discomfort you have experienced since the auto accident: ____

____



When did you notice the signs and symptoms: Gradually ☐ Suddenly ☐

What is the nature of discomfort? Dull ☐ Sharp ☐ Achy ☐ Uncomfortable ☐ Burning ☐ Other ☐
If other, please describe:____

What is frequency of signs/symptoms? Constant ☐ With activity ☐ While sleeping ☐ Occasional ☐ Other ☐
If other, please describe: ____

What helps your signs/symptoms? Ice ☐ Heat ☐ Rest ☐ Meds (otc) ☐ Meds (prescription) ☐ Stretching ☐
Meditation ☐ Yoga ☐ Pilates ☐ Nothing ☐ Other ☐ _______________________________________

Does this interfere with your: Work ☐ Leisure ☐ Sleep ☐ Sports ☐ Other ☐ __________________

Since the accident are your signs/symptoms: Improving ☐ Getting Worse ☐ Staying the same ☐

Have you lost time from work as a result of this accident: Yes ☐ No ☐ If yes, please describe: ___
____

PREVIOUS HISTORY:
Have you ever had similar signs/symptoms? Yes ☐ No ☐ If yes, please describe: ______________
____

Do you have an congenital (from birth) factors which relate to your current signs/symptoms?
Yes ☐ No ☐ If yes, please describe: ____

Have you ever been involved in any other auto accidents? Yes ☐ No ☐
If yes, Number of auto accidents: 1 2 3 4 5 >5
Date (s) of previous accident (s): ____
How do you describe the accident (s): Minor _____ Moderate _____ Severe:______
Describe any injuries: ____
Care received: Yes ☐ No ☐ If yes, MD__ Ortho__ Chiropractor ___ Physical Therapy __
ER ___ Other _______________________________

Because the **Nervous System controls everything in your body**, it is common that current health challenges can be related to the problems you are seeking care for in our office. Please **circle** the following symptoms you have had, whether **CURRENT (C) or Past (P):**

Headaches	**C P**	Fainting / Dizziness	**C P**	Loss of balance	**C P**	Fatigue	**C P**	Depression	**C P**
Ringing / ears	**C P**	Restless legs	**C P**	Tingling / hands	**C P**	Tingling / legs	**C P**	Cold Feet	**C P**
Cold Hands	**C P**	Lights bother eyes	**C P**	Numbness / toes	**C P**	Sleep Problems	**C P**	Numbness / hands	**C P**

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

Signature____ Date: ____________________
(or Parent/Guardian if patient is under 18 years of age)

Thank you for filling out this form. It is your first step to Creating Wellness!
Present this to our staff and in a moment we will be starting our journey together!

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

   No pain ______________________________ Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

   No interference ______________________________ Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

   No interference ______________________________ Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at all anxious ______________________________ Extremely anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed ______________________________ Extremely depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

   Has made it no worse ______________________________ Has made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

   Completely control it ______________________________ No control whatsoever

   0 1 2 3 4 5 6 7 8 9 10

Other Comments:____

Patient Name________________________________ NECK BOURNEMOUTH QUESTIONNAIRE

Signature__________________________________ Date: ________________

(or Parent/Guardian if patient is under 18 years of age)

James J Mager, D.C.
Provider

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

   No pain ______________________________ Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, climbing stairs, getting in/out of bed/chair)?

   No interference ______________________________ Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

   No interference ______________________________ Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at all anxious ______________________________ Extremely anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed ______________________________ Extremely depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

   Has made it no worse ______________________________ Has made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

   Completely control it ______________________________ No control whatsoever

   0 1 2 3 4 5 6 7 8 9 10

Other Comments:____

Patient Name____________________________________ BACK BOURNEMOUTH QUESTIONNAIRE

Signature______________________________________ Date: ____________________

(or Parent/Guardian if patient is under 18 years of age)

James J Mager, D.C.
Provider

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

COMPLICATING FACTORS

NAME________________________________ DATE__________________

In addition to the primary complaint that you have come to our office with, you may have other physical or social factors with will affect your treatment and recovery. Please mark with an "x" any of the following that have taken place *within the last 12 months,* even if they are not related directly to your major complaint.

Life Change Events

HEALTH	
An injury or illness which:	
Kept you in bed for a week or more	
Was less serious than above	
Major dental work	
Major change in eating habits	
Major change in sleeping habits	
Major change in your usual type and/or amount of recreation	

WORK	
Change to a new type of work	
Change in work hours or conditions	
Change in responsibilities at work:	
More responsibilities	
Fewer responsibilities	
Promotion	
Demotion	
Transfer	
Troubles at work:	
With boss	
With coworkers	
With persons under your supervision	
Other work troubles	
Major business adjustment	
Retirement	
Loss of job:	
Laid off	
Fired from work	
Correspondence course for your work	

HOME AND FAMILY	
Major change in living condition	
Change in residence:	
Move within the same town or city	
Move to a different town, city or state	
Change in family get-togethers	
Major change in health or behavior of a family member	
Marriage	
Pregnancy	
Miscarriage or abortion	
Gain of a new family member	
Adoption of a child	
A relative moving in with you	
Spouse beginning or ending work	
Child leaving home:	
To attend college	
Due to marriage	
For other reasons	
Change in arguments with spouse	
In-law problems	
Change in marital status of your parents:	
Divorce	
Remarriage	
Separation from spouse:	
Due to work	
Due to marital problems	
Divorce	
Birth of grandchild	
Death of spouse	
Death of another family member:	
Child	
Brother or sister	
Parent	

COMPLICATING FACTORS

PERSONAL and SOCIAL	
Change in personal habits	
Beginning or ending school or college	
Change in school or college	
Change in political beliefs	
Change in religious beliefs	
Change in social activities	
Vacation	
New, close personal relationship	
Engaged to be marry	
Girfriendl/boyfriend problems	
Sexual difficulties	
"Falling out" of a close personal relationship	
An accident	
Minor violation of the law	
Being held in jail	
Death of a close friend	
Major decision about your immediate future	
Major personal achievement	

FINANCIAL	
Major change in finances:	
Increased income	
Decreased income	
Investment and/or credit difficulties	
Loss or damage of personal property	
Moderate purchase	
Major purchase	
Foreclosure on mortgage or loan	

DATE_____________ PATIENT SIGNATURE_____________________________

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