Elan Wellness Service Corporation
2121 Ridge Avenue, Suite 105, Aurora, IL 60504 Tel: (630) 499-9420 / Fax: (630) 499-9450

PATIENT HISTORY QUESTIONNAIRE

*Name:*_____ *SSN:*_____ *Signature:*_____*Today's Date:*____/____/____

In order for us to better serve you, we need this important confidential questionnaire answered completely by you. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for you own health! Thank you.

Please list and describe your symptom, problem, condition, diagnosis or other factor that is the reason for your visit to this clinic today:_____
_____

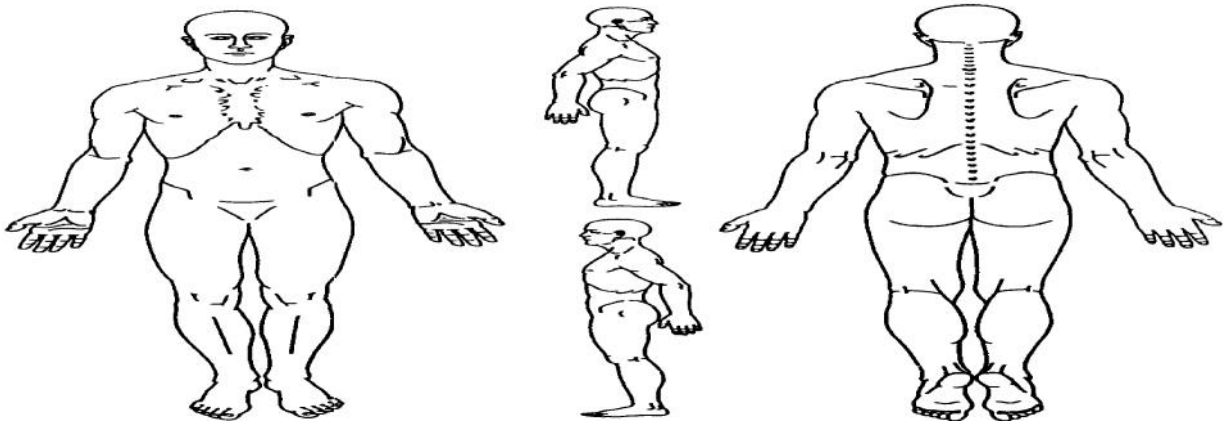
Are your symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? □ Yes □ No If you answered yes, please fill out accident specific form, available at the front desk.

Please describe in detail how your present illness / symptoms developed / started (suddenly or gradually) from first sign and / or symptom to the present (including location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms, etc.)
_____
_____

Describe the quality / character of your symptom(s). Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc._____

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache > > > > > >	Numbness = = = = = =	Pins and Needles ↓↓↓↓↓↓	Burning × × × × × ×
Stabbing ∇ ∇ ∇ ∇ ∇	Throbbing ~ ~ ~ ~ ~ ~	Tingling + + + + +	Sharp ↔ ↔ ↔ ↔
Dull 0 0 0 0 0	Soreness ∩ ∩ ∩ ∩ ∩	Shooting ⊕ ⊕ ⊕ ⊕	Other



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort severity, please circle.

What is your pain/discomfort like today?	No Pain	-0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10	Severe Pain
What is your least pain/discomfort?	No Pain	-0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10	Severe Pain
What is your worst pain/discomfort?	No Pain	-0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10	Severe Pain

How much time during an average day are you in pain/discomfort?
□ Less than 1 hour per day □ Between 1 and 4 hours per day □ Almost anytime when not lying down □ Almost 24 hours per day
□ Between 4 and 8 hours per day □ Other_____

What made your current symptoms better or worse?_____

Is your sleep disturbed by these symptoms? □ YES □ NO □ Slightly □ Moderately □ Severely

(Continued on page 2)

Have you experienced any restrictions or difficulties in any ACTIVITIES OF DAILY LIVING, SOCIAL and RECREATIONAL ACTIVITIES because of your current condition, please describe in detail (such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.) □ YES □ NO □ Slightly □ Moderately □ Severely

_____

_____

Have you experienced any restrictions or difficulties in performance of your JOB DUTIES at work because of your current condition, please describe in detail □ YES □ NO □ Slightly □ Moderately □ Severely

_____

_____

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic?
□ YES □ NO If yes, please list each doctor individually. (for more than one doctor, use additional space to list them)

- If yes, whom did you see? Doctor's Name:_____ Specialty:_____
  Address:_____City_____State_____Phone_____
  When were you seen? From_____to_____ Are you still under this doctor's care? □ Yes □ No
  Were □ X-ray □ MRI □ CAT Scan □ EMG □ Bone scan or others_____ taken?
  What was diagnosis?_____
  What type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others)_____

How much were your symptoms/discomforts improved or helped? Please circle.
No improvement 0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10 Full improvement

Since your symptoms began, were they □ improved □ worsened □ stayed the same?

Please list your past experiences with illnesses, operations, injuries and treatments);
Illness/injury Date Recurring

_____

_____

Are there any medical events in your family, including diseases which may be hereditary or place you at risk □ YES □ NO

_____

Have you ever been involved in injuries from following: □ Yes □ No If yes, please list all of them with date, type, and legal status
□ Automobile accident □ Worker's compensation □ Personal injuries someone else legally liable for (slip and fall, etc.)
Injury Date Settled Not settled Attorney's Name & Address

_____

_____

Please list all medications (including birth control pills, aspirin, cortisone or vitamins), even if only occasionally, include how often you take the medication, how much you take, and how long you have taken it.
Medication How often How much For how long

_____

_____

Are you allergic to anything (medications, lotion, etc.)? □ YES □ N0 If yes, to what?_____

Who is filling out this questionnaire? □ Self □ Spouse □ Other_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Name (print)_____Signature_____Date____/____/_____

Physician's Signature (upon review)_____ Date____/____/____
Jonathan A. Truhlar, D.C.

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ADL Questionnaire Patient Name: _____ Date: _____

Instructions: These questions ask for your views about how much your pain now affects how you function in everyday activities.
Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work Normally — Unable to work at all
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

2. Does your pain interfere with your personal care (such as washing, dressing, etc)?
Take care of myself completely — Need help with all my personal care
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

4. Does your pain affect your ability to sit or stand
No problems — Cannot sit / stand at all
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No Problems — Cannot do at all
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

6. Does your pain affect your ability to lifts objects off the floor, bend, stoop, or squat?
No problems — Cannot do at all
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

7. Does your pain affect your ability to walk or run?
No problems — Cannot walk / run at all
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

8. Has your income declined since your pain began?
No decline — Lost all income
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression / tension — Severe depression / tension
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

15. Are there emotional problems caused by your pain that interfere with your family, social, and / or work activities?
No problems — Severe problems
0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Patient Signature: _____ Examiner: _____

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Low Back Index (Oswestry) Patient Name:_____ Date:_____

This questionnaire has been designed to give the doctor information as to how your lower back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment. (0)
- ❑ The pain is very mild at the moment. (1)
- ❑ The pain is moderate at the moment. (2)
- ❑ The pain is fairly severe at the moment. (3)
- ❑ The pain is very severe at the moment. (4)
- ❑ The pain is the worst imaginable at the moment. (5)

Section 2 – **Personal Care (washing, dressing, etc.)**

- ❑ I can look after myself normally but it is very painful. (0)
- ❑ I can look after myself normally but it is very painful. (1)
- ❑ It is painful to look after myself and I am slow and careful. (2)
- ❑ I need some help but manage most of my personal care. (3)
- ❑ I need help every day in most aspects of my personal care. (4)
- ❑ I do not get dressed, wash with difficulty, and stay in bed. (5)

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain. (0)
- ❑ I can lift heavy weights but it gives extra pain. (1)
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). (2)
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- ❑ I can lift only very light weights. (4)
- ❑ I cannot lift or carry anything at all. (5)

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance. (0)
- ❑ Pain prevents me walking more than 1mile. (1)
- ❑ Pain prevents me walking more than ¼ of a mile. (2)
- ❑ Pain prevents me walking more than 100 yards. (3)
- ❑ I can only walk using a stick or crutches. (4)
- ❑ I am in bed most of the time and have to crawl to the toilet. (5)

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like. (0)
- ❑ I can sit in my favorite chair as long as I like. (1)
- ❑ Pain prevents me from sitting for more than 1 hour. (2)
- ❑ Pain prevents me from sitting for more than ½ hour. (3)
- ❑ Pain prevents me from sitting for more than 10 minutes. (4)
- ❑ Pain prevents me from sitting at all. (5)

Patient Signature: _____

Examiner: _____

Rating: _____

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain. (0)
- ❑ I can stand as long as I want but it gives me extra pain. (1)
- ❑ Pain prevents me from standing more than 1 hour. (2)
- ❑ Pain prevents me from standing for more than ½ an hour. (3)
- ❑ Pain prevents me from standing for more than 10 minutes. (4)
- ❑ Pain prevents me from standing at all. (5)

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain. (0)
- ❑ My sleep is occasionally disturbed by pain. (1)
- ❑ Because of pain, I have less than 6 hours sleep. (2)
- ❑ Because of pain, I have less than 4 hours sleep. (3)
- ❑ Because of pain, I have less than 2 hours sleep. (4)
- ❑ Pain prevents me from sleeping at all. (5)

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain. (0)
- ❑ My sex life is normal but causes some extra pain. (1)
- ❑ My sex life is nearly normal but is very painful. (2)
- ❑ My sex life is severely restricted by pain. (3)
- ❑ My sex life is nearly absent because of pain. (4)
- ❑ Pain prevents any sex life at all. (5)

Section 9 – Social Life

- ❑ My social life is normal and causes me no extra pain. (0)
- ❑ My social life is normal but increases the degree of pain. (1)
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. sports, etc). (2)
- ❑ Pain has restricted my social life and I do not go out as often. (3)
- ❑ Pain has restricted social life to my home. (4)
- ❑ I have no social life because of pain. (5)

Section 10 – Traveling

- ❑ I can travel anywhere without pain. (0)
- ❑ I can travel anywhere but it gives extra pain. (1)
- ❑ Pain is bad but I manage journeys of over two hours. (2)
- ❑ Pain restricts me to short necessary journeys under 30 minutes. (3)
- ❑ Pain prevents me from traveling except to receive treatment. (4)
- ❑ Pain prevents me from traveling at all. (5)

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

_____

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Low Back Index (Oswestry)

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Patient Signature: _____

Examiner: _____

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- ❑ No
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_____