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

CONFIDENTIAL PATIENT QUESTIONNAIRE

Dear Patient: *Today's Date:*_____

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

Name_____ Prefer To Be Called_____
Address_____ Home Phone_____
City_____ State_____ Zip_____ Work Phone_____
Sex □ M □ F Marital Status □ Single □ Married □ Widowed □ Divorced Age_____ Date of Birth_____
Occupation _____ Employer_____ Years Employed_____
Employer's Address_____ City_____ State_____ Phone_____
Spouse's Name_____ Occupation_____ Number of Children_____

Have you ever had □ Chiropractic □ Naturopathic care before? □ Yes □ No For what problem?_____
What type of care / treatment are you seeking from this clinic? □ Chiropractic □ Naturopathic □ Physical Therapy □ Whatever Helps
You were referred to this clinic by □ Newspaper Ads □ Web □ Friend □ Clinic Sign □ Other_____

What is your major complaint for which you came to our clinic?_____
_____
_____
_____

Other complaints_____

Please describe in detail how your present illness developed / started from first sign and / or symptom to the present (includes time, place, reasons, courses, mode, results, etc.)
_____
_____
_____
_____
_____

Are your symptoms the result of an auto accident, work- related injury or other personal injury(slip and fall, etc.)? If you answered yes, please fill out accident specific form, available at the front desk. □ Yes □ No

Did symptoms/pain begin □ gradually □ suddenly?

When was the very last episode of symptoms/discomforts experienced?_____

How long have you had these episodes of symptoms?_____

Please describe in detail how your health problem (s) disturbed / bothered you (including how each of the problems you described).
_____
_____
_____
_____
_____

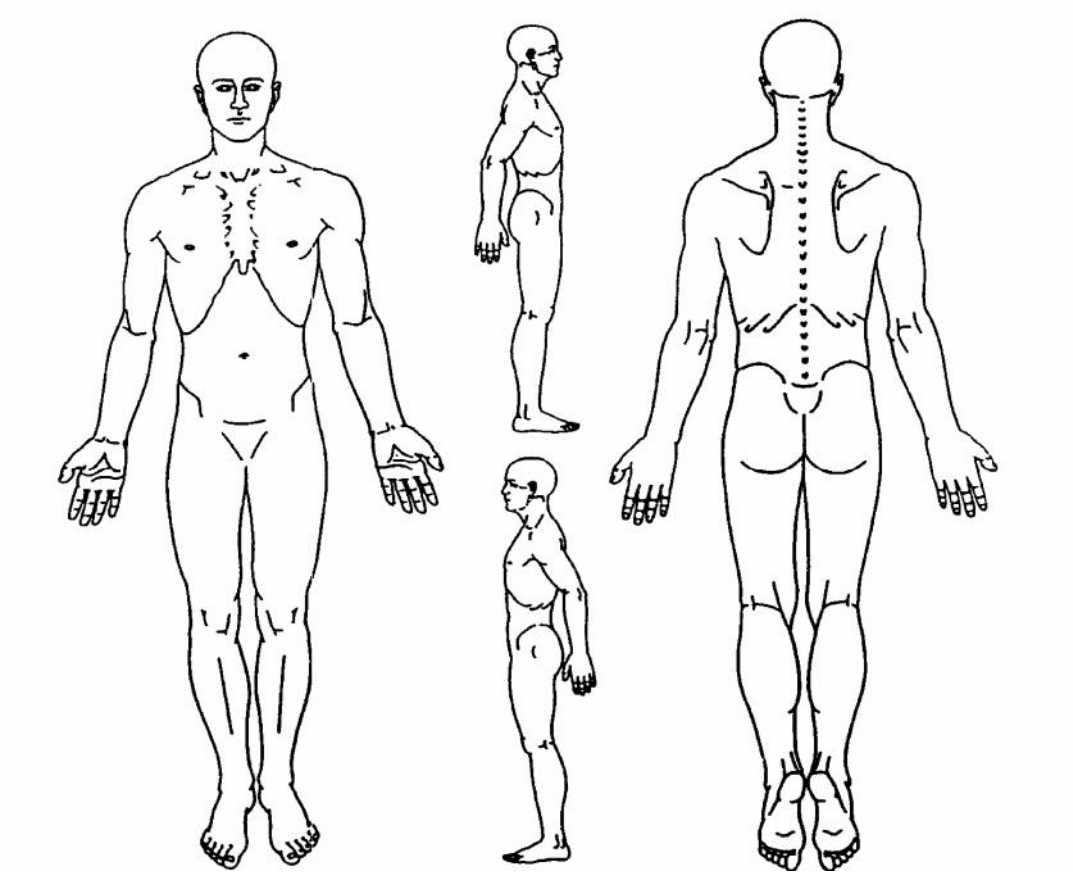
Are your symptom (s) / pain □ localized □ traveling? Please describe where your symptom (s) / pain go to_____
_____

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, please circle.

What is your pain/discomfort like today? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
What is your least pain/discomfort? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
What is your worst pain/discomfort? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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
- □ Between 4 and 8 hours per day
- □ Almost anytime that you are not lying down
- □ Almost 24 hours per day
- □ Other_____

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

What made your current symptoms worse?_____

What made your current symptoms better?_____

Is your sleep disturbed by these symptoms? □ YES □ NO

If you are restricted/limited or have difficulties in any activities or performance of your work because of your discomfort/pain, please describe in detail □ YES □ NO

_____
_____
_____

If you are restricted/limited or have difficulties in any activities or performance at your home/activities of daily living or recreational activities because of your discomfort/pain, please describe in detail(such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.) □ YES □ NO

_____
_____
_____
_____

Have you done anything to try to help or relieve your complaint, such as rest, heat, cold, aspirin, medication, sit, lie down. Or other?
□ YES □ NO Describe in detail_____
_____

Are you doing any corrective exercises for your present symptoms? □ YES □ NO
If yes, who recommended them?_____ Briefly describe the exercises/stretches you are doing
_____

Do you participate in other exercises (aerobics, walking, jogging, etc.)? □ YES □ NO
If yes, what type and how many times per week/month_____

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

A. 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
B. 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)_____
_____
C. How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

A. 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
B. 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)_____
_____
C. How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

A. 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
B. 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)_____
_____

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

Have you seen a physical therapist for this problem? □ YES □ NO
If yes, whom did you see? Name:_____Address:_____
What type of therapies were received? _____
How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

Have you seen a physician, chiropractor or physical therapist for any other problems? □ YES □ NO
If yes, please describe_____
_____

Are you aware of any blood relatives with **similar** discomforts/problems?
□ No □ YES, please describe_____

Any family history of diseases or death of parents, siblings and children (e.g. heart problems, diabetes, asthma, hereditary disease etc.)
□ No □ YES_____
_____

Please list all major past diseases and accidental injuries (include concussions, head injuries, broken bones, high blood pressure, etc.) you may have had which did not require hospitalization (please include dates and any recurring problems)

Illness/injury Date Recurring
_____
_____
_____
_____
_____
_____

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

Please list all surgeries/operations you have ever had. Please also list when these were done, where they were done, who the surgeon was, and if you have had any remaining problems associated with these procedures. (Attach separate sheet if necessary.)
Date Type of surgery Where Surgeon's name Complications Remaining problems
_____
_____
_____
_____

Please list all hospitalizations you have had in the past which did not involve surgery. Also list any remaining problems you attribute to these illnesses.
Date Cause of hospitalizations Remaining problems
_____
_____
_____
_____
_____

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?_____

Do you smoke or use any tobacco products? If yes, how much & often?_____

Do you drink alcoholic beverages? If yes, how Much & often?_____

Do you drink caffeinated beverages? If yes, how much & often?_____

Please circle your level of formal education group:

- □ Less than High School
- □ High School Diploma or GED
- □ Some College
- □ College Degree
- □ Advanced Degree
- □ Vocational Training in_____

Have you missed any work as a result of this illness/pain? □ YES □ NO

If yes, how many days/weeks?_____ Dates of absence_____to_____

What type of physical activities or postures does your job involve (prolonged sitting, standing, bending, etc.)

_____

Please list all and any other health problems you have had in the past or have now (such as headache, dizziness, blurred vision, vertigo, heart attack, high blood pressure, stomach ache, vomiting, bloody stool, kidney infection, pneumonia, asthma, etc.).

Illness/discomforts Date

_____
_____
_____
_____
_____
_____

Women only

*a. Are you pregnant or think you may be pregnant?*_____

*b. Date of last menstrual period*_____

c. Do you or have you suffered from any menstrual disorders? □ *YES* □ *NO*

*If yes, please describe*_____

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 Signature_____ Date_____

Physician's Signature(upon review)_____ Date_____

Jonathan A. Truhlar, D.C.

PHYSICIAN'S NOTES:

HISTORY IS TAKEN FROM □ PATIENT □ SPOUSE □ OTHER_____

INFORMATION IS □ RELIABLE □ NOT RELIABLE □ SATISFACTORY □ NOT SATISFACTORY.

ADDITIONAL COMMENT □ NO □ YES_____

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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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Neck Index Patient Name:_____ Date:_____

This questionnaire has been designed to give the doctor information as to how your neck 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 without causing extra pain. (0)
- ❑ I can look after myself normally but it causes extra pain. (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 self care. (4)
- ❑ I do not get dressed, I 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, for example 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 very light weights. (4)
- ❑ I cannot lift or carry anything at all. (5)

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck. (0)
- ❑ I can read as much as I want to with slight pain in my neck. (1)
- ❑ I can read as much as I want with moderate pain in my neck. (2)
- ❑ I cannot read as much as I want because of moderate pain in my neck. (3)
- ❑ I can hardly read at all because of severe pain in my neck. (4)
- ❑ I cannot read at all. (5)

Section 5 – Headaches

- ❑ I have no headaches at all. (0)
- ❑ I have slight headaches that come infrequently. (1)
- ❑ I have moderate headaches which come infrequently. (2)
- ❑ I have moderate headaches which come frequently. (3)
- ❑ I have severe headaches which come frequently. (4)
- ❑ I have headaches almost all the time. (5)

Patient Signature: _____

Examiner: _____

Rating: _____

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty. (0)
- ❑ I can concentrate fully when I want to with slight difficulty. (1)
- ❑ I have a fair degree of difficulty in concentrating when I want to. (2)
- ❑ I have a lot of difficulty in concentrating when I want to. (3)
- ❑ I have a great deal of difficulty in concentrating when I want to. (4)
- ❑ I cannot concentrate at all. (5)

Section 7 – Work

- ❑ I can do as much work as I want to. (0)
- ❑ I can do my usual work, but no more. (1)
- ❑ I can do most of my usual work, but no more. (2)
- ❑ I cannot do my usual work. (3)
- ❑ I can hardly do any work at all. (4)
- ❑ I cannot do any work at all. (5)

Section 8 – Driving

- ❑ I can drive my car without any neck pain. (0)
- ❑ I can drive my car as long as I want with slight pain in my neck. (1)
- ❑ I can drive my car as long as I want with moderate pain in my neck. (2)
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- ❑ I can hardly drive at all because of severe pain in my neck. (4)
- ❑ I cannot drive my car at all. (5)

Section 9 – Sleeping

- ❑ I have no trouble sleeping. (0)
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- ❑ My sleep is mildly disturbed (1-2 hours sleepless). (2)
- ❑ My sleep is moderately disturbed (2-3 hours sleepless). (3)
- ❑ My sleep is greatly disturbed (3-5 hours sleepless). (4)
- ❑ My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ❑ I am able to engage in all my recreation activities, with some pain in my neck. (1)
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ❑ I can hardly do any recreation activities because of pain in my neck. (4)
- ❑ I cannot do any recreation activities 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)

_____