

BROWN CHIROPRACTIC

PATIENT ADMITTANCE FORM / SPINAL HEALTH SURVEY

Purpose: To determine if any problems you are experiencing may be improved through chiropractic.

Name: _____
Last First MI

Address: _____
Apt #

City: _____ State: _____

Zip Code: _____ Birthdate: _____

Male: _____ Female: _____ Marital Status: _____

Social Security: _____

Name of Personal Physician: _____

Nearest Relative Not Living With You (Emergency Contact): _____

Relationship: _____ Phone: () _____

Home Phone: () _____

Work Phone: () _____

Cellular Phone: () _____

Email Address: _____

Best Time to Call: _____

Employer: _____

Occupation: _____

Driver's License: _____

Spouses's Name: _____

Birthdate: _____

I certify my sole purpose of entering this office is for healthcare. Signature **X** _____

FAMILY HISTORY

Name of Physician: _____

Are you satisfied with the care you have received there? yes no

Number of doses of Antibiotics you have taken:
 During the past six months _____ Total during lifetime _____

Number of doses of other Prescription Medications you have taken:
 During the past six months _____ Total during your lifetime _____

PRENATAL HISTORY

Name of Obstetrician: _____

Complications During Pregnancy: yes no

Explain: _____

Medications During Pregnancy: yes no

Which Medications: _____

Cigarettes/Alcohol/Drug Use During Pregnancy: yes no

Location of Birth _____ Hospital _____ Birthing Center _____ Home _____

Have you seen a chiropractor before? yes no My last adjustment was _____

1. Check off the following symptoms you have experienced and CIRCLE the ones that affect you the most.

___ Headaches / Migraines	___ Low Energy / Tired	___ Sciatica	___ Injured on the Job _____ Date	___ Attention Disorders
___ Sinus / Allergies	___ Shoulder / Arm Pain	___ Disc Problems	___ Slip and Fall _____ Date	___ Ear aches / Infections
___ Neck Pain	___ Numbness / Tingling	___ Leg / Hip Pain	___ Car Accident _____ Date	___ Digestive problems
___ Dizziness	___ Mid-back Pain	___ Muscle Stress	___ Pregnancy	___ Bed wetting
___ Asthma	___ Scoliosis	___ Constipation	___ Chemical Stress	___ ADHD
___ Frequent colds / flu	___ Low Back pain	___ Hyperactivity	___ Physical Stress	___ Recurring fevers
___ Stomach Problems	___ Wrist / Joint Pain	___ Emotional Stress	___ Depression	___ Growing / Back Pains

Other Health Problems: _____

2. Do these conditions disrupt? Career Family Life Ability to Exercise Sleeping Pattern Social Life

3. What methods have you tested? Exercise Physical Therapy Prescription Drugs Massage Nothing

4. Check all TRUE statements: Previous methods ineffective My problems could get worse I want to be energetic again I want answers and/or results I want to be healthy

5. How long have you been living this way? Weeks (#) _____ Months (#) _____ Years (#) _____

6. Rate the importance of finding the cause of your problem. (Yes) 10 9 8 7 6 5 4 3 2 1 (No)

7. Rate how important quality of life is to you. (High) 10 9 8 7 6 5 4 3 2 1 (Low)

8. What results do you want for yourself? Reduce Pain Restore Health Maintain Health

9. What excuse has stopped you from being well? Money Time Other _____

10. What activities can you not do now that you would like to be able to do again? _____

DATE:

NAME:

Back Index

FUNCTIONAL RATING

How long have you had back pain? _____ Year _____ Month _____ Weeks _____ Days

How long have you had leg pain? _____ Year _____ Month _____ Weeks _____ Days

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

- ① The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%
- ③ Because of pain my normal sleep is reduced by less than 50%
- ④ Because of pain my normal sleep is reduced by less than 75%
- ⑤ The Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ① I have some pain while standing but it does increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid sitting because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ① I have some pain while walking but it does increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights

Traveling

- ① I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.)
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

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

Back
Index
Score

Neck Index

FUNCTIONAL RATING

How long have you had neck pain? _____ Year _____ Month _____ Weeks _____ Days

How long have you had arm pain? _____ Year _____ Month _____ Weeks _____ Days

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

- ① I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment

Sleeping

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

Reading

- ① I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

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

Work

- ① I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ① I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed. I wash with difficulty and stay in bed.

Lifting

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

Driving

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

Recreation

- ① I am able to engage in all my recreational activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain
- ⑤ I cannot do any recreation activities at all.

Headaches

- ① I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches all the time.

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Back
Index
Score