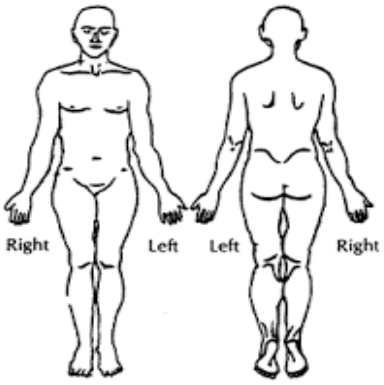
PATIENT INTAKE FORM

Patient Name: _____ **Date:** _____

1. Is today's problem caused by: ____Auto Accident ____Workman's Compensation
2. Indicate on the drawings below where you have pain/symptoms



Problem #1
Location _____

Problem #2
Location_____

Problem #3
Location_____

3. How often do you experience your symptoms? (Please indicate which problem)
   ____Constantly (76-100% of the time) #_____ ____Occasionally (26-50% of the time) #_____
   ____Frequently (51-75% of the time) #_____ ____Intermittently (1%-25% of the time) #_____
4. How would you describe the type of pain? (please indicate which problem)

_____Sharp	#_____	_____Numb	#_____
_____Dull	#_____	_____Tingly	#_____
_____Diffuse	#_____	_____Sharp with motion	#_____
_____Achy	#_____	_____Shooting with motion	#_____
_____Burning	#_____	_____Stabbing with motion	#_____
_____Shooting	#_____	_____Electric with motion	#_____
_____Stiff	#_____	_____Other:	#_____

5. How are your symptoms changing with time?
   ____Getting Worse ____Staying the Same ____Getting Better
6. Using a scale from 0-10 (10 being the worst) how would you rate:
   Problem #1_____ Problem #2_____ Problem #3_____
7. How much have the problems interfered with your work?
   ____Not at all ____A little bit ____Moderately ____Quite a bit ____Extremely
8. How much have the problems interfered with your social activities?
   ____Not at all ____A little bit ____Moderately ____Quite a bit ____Extremely
9. Who else have you seen for your problems?
   ____Chiropractor ____Neurologist ____Primary Care Physician
   ____ER Physician ____Orthopedist ____Other:_____
   ____Massage Therapist ____Physical Therapist ____No one
10. How long have you have this problem? #1_____ #2_____#3_____
11. How do you think your problem began? _____
    _____
12. Do you consider this problem to be severe? ____Yes ____Yes, at times ____No
13. What aggravates your problem? _____
14. What improves your problem? _____
15. What concerns you the most about your problem; what does it prevent you from doing? _____
    _____
16. What is your: Height _____ Weight _____ Date of Birth _____

CONFIDENTIAL PATIENT INFORMATION Date_____

Name_____

Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

E-Mail Address_____ Birth Date_____ Age_____

Marital Status (M) (S) (W) (D) How Many Children?_____ Soc. Sec #_____

Occupation_____ Employer_____

Address_____ Work Phone_____

Name of Spouse/Nearest Relative_____ Phone #_____

Referred By_____ Date of Last Physical_____

Name of Primary Doctor_____ Address_____

Purpose of this Appointment_____

Other Doctors Seen for this Condition_____

Have you been treated for any health condition by a physician in the last year? YES _____ NO _____

Describe_____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of Person Responsible for Payment_____

Are you Insured? YES _____ NO _____

Name of Primary Insurance Company_____

Name of Secondary Insurance Company_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Grant Chiropractic Health Center, LLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Grant Chiropractic Health Center, LLC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I authorize the release of all medical records/information to my insurance company referring and/or primary care physician. Furthermore, I authorize and request that all insurance payments be made directly to **Dr. Carol Grant**.

Patient's signature_____ Date_____

Guardian's signature_____ Date_____

Information taken by_____ Date_____

All attempts will be made to keep your health care information confidential. If you have any questions or concerns in this matter, please speak directly to Dr. Grant. With your signature you grant permission for this office use your personal information in the normal course of your treatment in this office including phone calls to remind you or reschedule your appointments.

*Signature*_____ *Date*_____

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: _____ Scores Total: _____; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than one per week
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	☐	☐	☐
F2. Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
E3. No one understands the effect my headaches have on my life.	☐	☐	☐
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	☐	☐	☐
E5. My headaches make me angry.	☐	☐	☐
E6. Sometimes I feel that I am going to lose control because of my headaches.	☐	☐	☐
F7. Because of my headaches I am less likely to socialize.	☐	☐	☐
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel I am going to go insane.	☐	☐	☐
E10. My outlook on the world is affected by my headaches.	☐	☐	☐
E11. I am afraid to go outside when I feel that a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14. My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15. I avoid being around people when I have a headache.	☐	☐	☐
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
F17. I am unable to think clearly because of my headaches.	☐	☐	☐
F18. I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
F19. I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20. I feel irritable because of my headaches.	☐	☐	☐
F21. I avoid traveling because of my headaches.	☐	☐	☐
E22. My headaches make me feel confused.	☐	☐	☐
E23. My headaches make me feel frustrated.	☐	☐	☐
F24. I find it difficult to read because of my headaches.	☐	☐	☐
F25. I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital headache disability inventory (HDI). Neurology 1994;44:837-842.

17. **How would you rate your overall Health?** ___Excellent ___Very Good ___Good ___Fair ___Poor

18. What type of exercise do you do? ___Strenuous ___Moderate ___Light ___None

19. Indicate if you have any immediate family members with any of the following:

___Rheumatoid Arthritis ___Diabetes ___Lupus ___Heart Problems ___Cancer ___ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past/Present	Past/Present	Past/Present
____/____ Headaches	____/____ High Blood Pressure	____/____ Diabetes
____/____ Neck Pain	____/____ Heart Attack	____/____ Excessive Thirst
____/____ Upper Back Pain	____/____ Chest Pains	____/____ Frequent Urination
____/____ Mid Back Pain	____/____ Stroke	____/____ Smoking/Tobacco Use
____/____ Low Back Pain	____/____ Angina	____/____ Drug/Alcohol Dependence
____/____ Shoulder Pain	____/____ Kidney Stones	____/____ Allergies
____/____ Elbow/Upper Arm Pain	____/____ Kidney Disorders	____/____ Depression
____/____ Wrist Pain	____/____ Bladder Infection	____/____ Systemic Lupus
____/____ Hand Pain	____/____ Painful Urination	____/____ Epilepsy
____/____ Hip Pain	____/____ Loss of Bladder Control	____/____ Dermatitis/Eczema/Rash
____/____ Upper Leg Pain	____/____ Prostate Problems	____/____ HIV/AIDS
____/____ Knee Pain	____/____ Abnormal Weight Gain/Loss	
____/____ Ankle/Foot Pain	____/____ Loss of Appetite	**For Females Only**
____/____ Jaw Pain	____/____ Abdominal Pain	____/____ Birth Control Pills
____/____ Joint Pain/Stiffness	____/____ Ulcer	____/____ Hormonal Replacement
____/____ Arthritis	____/____ Hepatitis	____/____ Pregnancy
____/____ Rheumatoid Arthritis	____/____ Liver/Gall Bladder Disorder	
____/____ Cancer	____/____ General Fatigue	
____/____ Tumor	____/____ Muscular Incoordination	
____/____ Asthma	____/____ Visual Disturbances	
____/____ Chronic Sinusitis	____/____ Dizziness	
____/____ Other: _____		

21. List all Prescription AND Over-the-Counter Medications you are currently taking:

Medication	Dosage	Medication	Dosage

22. Are you allergic to any medications? ___Yes ___No (if yes please list medication and reaction below)

_____

_____

23. List all surgical procedures you have had: _____

_____

24. What activities do you do at work? (M) Most of Day (H) Half of Day (L) A Little of the Day

Sit: M H L Stand: M H L Computer Work: M H L On the Phone: M H L

25. What activities do you do outside of work?

26. Have you ever been hospitalized? ___Yes ___No

If yes, why? _____

27. Have you had a significant past trauma? ___Yes ___No

28. Anything else pertinent to your visit today?_____

Gender (circle one) MALE FEMALE Preferred Language:

Race (circle One) American Indian or Alaska Native
Asian/Black or African American Caucasian
Caucasian
Native Hawaiian or Pacific Islander
Other _____
Decline to Answer

Ethnicity (circle one): Hispanic or Latino
Not Hispanic or Latino
Decline to Answer

Do you smoke? ___Never ___Past ___Present (Occasionally Daily)

Patient Signature_____**Date**_____

REVISED LOW BACK OSWESTRY INDEX

Name:_____ **Date:**_____ **File #:**_____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – 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 moderately increasing
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I would 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 increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase 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.

SECTION 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives 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, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 – Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only 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 ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain 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 ½ hour without increasing
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 – 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 night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- ☐ Pain has restricted my social life and I do not go much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9 – 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 compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 – Changing Degrees 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 slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

NECK DISABILITY INDEX

Name:_____ **Date:**_____ **File #:**_____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ 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.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ 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 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.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 - Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can not do any work at all.

SECTION 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415