

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name Middle Initial

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 INSURANCE INFORMATION

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## 3 PHONE NUMBERS

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

### IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## 4 ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## 5 PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

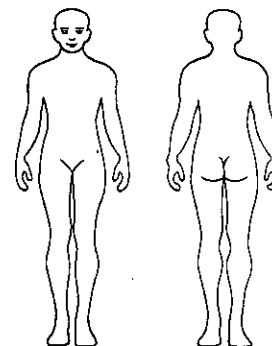
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# 6

## HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- |  |  |   |   |
|--|--|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No            | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No            | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No        | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No          | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No           | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No              | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No       | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No            | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No   | Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No           | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No          | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No            | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No        | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No              | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No   | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No             |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No           | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No                | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No              | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No                | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No         | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No  | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No       | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No            | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No         | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No           | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No  | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No          | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No              | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No        | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No             | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No      | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No            | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No              | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No              | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No                | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No           | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No     | Other _____   |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No    | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No           | _____   |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No         | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No      | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No     | _____   |
|  |  | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |   |

### EXERCISE

- None  
 Moderate  
 Daily  
 Heavy

### WORK ACTIVITY

- Sitting  
 Standing  
 Light Labor  
 Heavy Labor

### HABITS

- Smoking Packs/Day \_\_\_\_\_  
 Alcohol Drinks/Week \_\_\_\_\_  
 Coffee/Caffeine Drinks Cups/Day \_\_\_\_\_  
 High Stress Level Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

# 7

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

Pharmacy Name \_\_\_\_\_

Pharmacy Phone (\_\_\_\_) \_\_\_\_\_

For re-ordering information, contact  
**ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317**  
Phone: (602) 224-0220; Facsimile (602) 224-0230

### NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

HOW LONG HAVE YOU HAD NECK PAIN? \_\_\_ YEARS \_\_\_ MONTHS \_\_\_ WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? \_\_\_ YES \_\_\_ NO

**USE THE LETTERS BELOW TO INDICATE THE TYPE  
AND LOCATION OF YOUR SENSATIONS RIGHT NOW**

(Please remember to complete both sides of this form.)

KEY:

A=ACHE

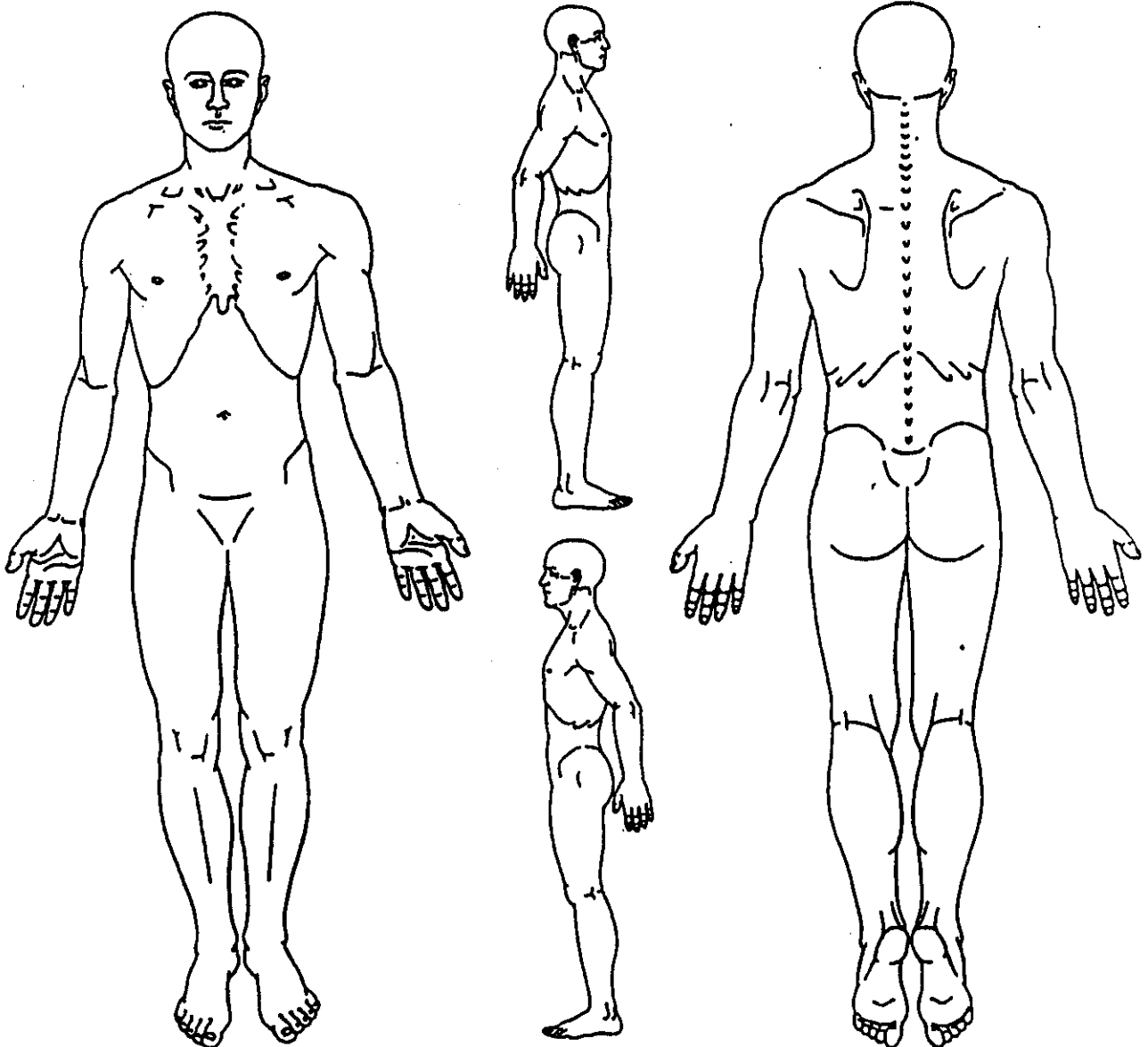
P=PINS & NEEDLES

B=BURNING

S=STABBING

N=NUMBNESS

O=OTHER



OVER PLEASE

For re-ordering information, contact:

ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317

Phone: (602) 224-0220; Facsimile (602) 224-0230

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

**Please Read:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

### Section 1 — Pain Intensity

- A I have no pain at the moment.
- B The pain is very mild at the moment.
- C The pain is moderate at the moment.
- D The pain is fairly severe at the moment.
- E The pain is very severe at the moment.
- F The pain is the worst imaginable at the moment.

### Section 2 — Personal Care (Washing, Dressing, etc.)

- A I can look after myself normally without causing extra pain.
- B I can look after myself normally, but it causes extra pain.
- C It is painful to look after myself and I am slow and careful.
- D I need some help, but manage most of my personal care.
- E I need help every day in most aspects of self care.
- F I do not get dressed, I wash with difficulty and stay in bed.

### Section 3 — Lifting

- A I can lift heavy weights, without extra pain.
- B I can lift heavy weights, but it gives extra pain.
- C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E I can lift very light weights.
- F I cannot lift or carry anything at all.

### Section 4 — Reading

- A I can read as much as I want to with no pain in my neck.
- B I can read as much as I want to with slight pain in my neck.
- C I can read as much as I want with moderate pain in my neck.
- D I cannot read as much as I want because of moderate pain in my neck.
- E I cannot read as much as I want because of severe pain in my neck.
- F I cannot read at all.

### Section 5 — Headaches

- A I have no headaches at all.
- B I have slight headaches which come infrequently.
- C I have moderate headaches which come infrequently.
- D I have moderate headaches which come frequently.
- E I have severe headaches which come frequently.
- F I have headaches almost all the time.

*After Vernon & Mior, 1991*

*Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics*

### Section 6 — Concentration

- A I can concentrate fully when I want to with no difficulty.
- B I can concentrate fully when I want to with slight difficulty.
- C I have a fair degree of difficulty in concentrating when I want to.
- D I have a lot of difficulty in concentrating when I want to.
- E I have a great deal of difficulty in concentrating when I want to.
- F I cannot concentrate at all.

### Section 7 — Work

- A I can do as much as I want to.
- B I can only do my usual work, but no more.
- C I can do most of my usual work, but no more.
- D I cannot do my usual work.
- E I can hardly do any work at all.
- F I cannot do any work at all.

### Section 8 — Driving

- A I can drive my car without any neck pain.
- B I can drive my car as long as I want with slight pain in my neck.
- C I can drive my car as long as I want with moderate pain in my neck.
- D I cannot drive my car as long as I want because of moderate pain in my neck.
- E I can hardly drive at all because of severe pain in my neck.
- F I cannot drive my car at all.

### Section 9 — Sleeping

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

### Section 10 — Recreation

- A I am able to engage in all of my recreational activities, with no neck pain at all.
- B I am able to engage in all of my recreational activities, with some pain in my neck.
- C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E I can hardly do any recreational activities because of pain in my neck.
- F I cannot do any recreational activities at all.

REVISED March 1, 1994

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

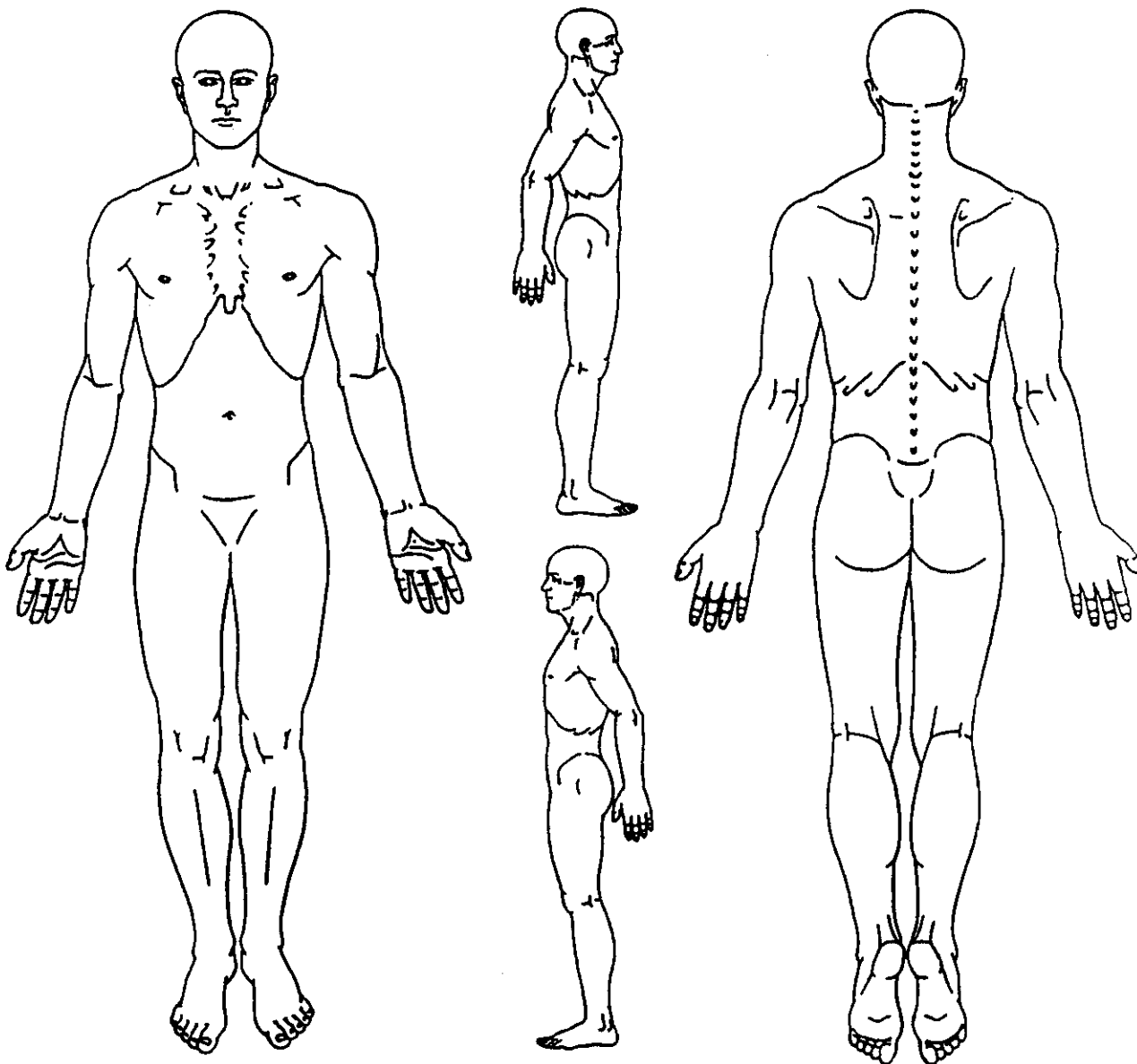
HOW LONG HAVE YOU HAD LOW BACK PAIN? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS \_\_\_\_\_ WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? \_\_\_\_\_ YES \_\_\_\_\_ NO

### USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:            **A**=ACHE                      **B**=BURNING                      **N**=NUMBNESS  
                  **P**=PINS & NEEDLES        **S**=STABBING                      **O**=OTHER



OVER PLEASE

## REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

**Please Read:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

### SECTION 1 -- Pain Intensity

- A The pain comes and goes and is very mild.
- B The pain is mild and does not vary much.
- C The pain comes and goes and is moderate.
- D The pain is moderate and does not vary much.
- E The pain comes and goes and is severe.
- F The pain is severe and does not vary much.

### SECTION 2 -- Personal Care

- A I would not have to change my way of washing or dressing in order to avoid pain.
- B I do not normally change my way of washing or dressing even though it causes some pain.
- C Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E Because of the pain, I am unable to do some washing and dressing without help.
- F Because of the pain, I am unable to do any washing or dressing without help.

### SECTION 3 -- Lifting

- A I can lift heavy weights without extra pain.
- B I can lift heavy weights, but it causes extra pain.
- C Pain prevents me from lifting heavy weights off the floor.
- D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F I can only lift very light weights, at the most.

### SECTION 4 -- Walking

- A Pain does not prevent me from walking any distance.
- B Pain prevents me from walking more than one mile.
- C Pain prevents me from walking more than 1/2 mile.
- D Pain prevents me from walking more than 1/4 mile.
- E I can only walk while using a cane or on crutches.
- F I am in bed most of the time and have to crawl to the toilet.

### SECTION 5 -- Sitting

- A I can sit in any chair as long as I like without pain.
- B I can only sit in my favorite chair as long as I like.
- C Pain prevents me from sitting more than one hour.
- D Pain prevents me from sitting more than 1/2 hour.
- E Pain prevents me from sitting more than ten minutes.
- F Pain prevents me from sitting at all.

*From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989*

REVISED 9/11/92

### SECTION 6 -- Standing

- A I can stand as long as I want without pain.
- B I have some pain while standing, but it does not increase with time.
- C I cannot stand for longer than one hour without increasing pain.
- D I cannot stand for longer than 1/2 hour without increasing pain.
- E I cannot stand for longer than ten minutes without increasing pain.
- F I avoid standing, because it increases the pain straight away.

### SECTION 7 -- Sleeping

- A I get no pain in bed.
- B I get pain in bed, but it does not prevent me from sleeping well.
- C Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D Because of pain, my normal night's sleep is reduced by less than one-half.
- E Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F Pain prevents me from sleeping at all.

### SECTION 8 -- Social Life

- A My social life is normal and gives me no pain.
- B My social life is normal, but increases the degree of my pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D Pain has restricted my social life and I do not go out very often.
- E Pain has restricted my social life to my home.
- F I have hardly any social life because of the pain.

### SECTION 9 -- Traveling

- A I get no pain while traveling.
- B I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D I get extra pain while traveling which compels me to seek alternative forms of travel.
- E Pain restricts all forms of travel.
- F Pain prevents all forms of travel except that done lying down.

### SECTION 10 -- Changing Degree of Pain

- A My pain is rapidly getting better.
- B My pain fluctuates, but overall is definitely getting better.
- C My pain seems to be getting better, but improvement is slow at present.
- D My pain is neither getting better nor worse.
- E My pain is gradually worsening.
- F My pain is rapidly worsening.

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_