# INITIAL CHIROPRACTIC ASSESSMENT

Bay Shore Chiropractic, S.C. (920) 834-7034

NAME: ______________________ BIRTH DATE______________________
ADDRESS: ______________________ HOME PHONE______________________
CITY/STATE/ZIP______________________ WORK PHONE______________________
EMERGENCY CONTACT ______________________ CONTACT PHONE______________________
MARITAL STATUS: SINGLE MARRIED WIDOWED RACE: White Black Asian Other
LANGUAGE: English Other______________ ETHNICITY: Hispanic Non-Hispanic

(Please contact your insurance company to verify your chiropractic coverage.)

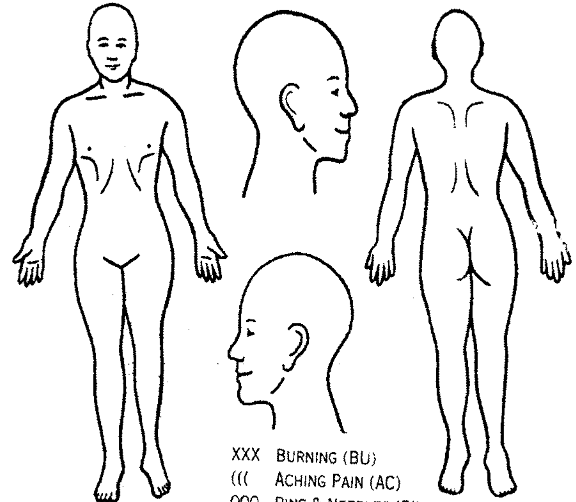
**NAME OF INSURANCE CARRIER**:______________________________ $________ Co-Pay

* Please note: Medicare and Medicare replacements and supplements may not cover evaluations or x-rays.

**SYMPTOMS DEVELOPED FROM: WORK-RELATED Y N AUTO ACCIDENT Y N OTHER________**

**CURRENTS SYMPTOMS:**

PAIN: YES NO LOCATION OF PAIN ________________
STIFFNESS: YES NO
NUMBNESS: YES NO LOCATION________________
WEAKNESS: YES NO
LOCATED IN NECK: YES NO
LOCATED IN BACK: YES NO
LOCATED IN LEG: YES NO / RIGHT LEFT BOTH
LOCATED IN ARM: YES NO / RIGHT LEFT BOTH
RADIATION of pain: YES NO location ________________
FREQUENCY: NEVER SOMETIMES ALWAYS
CAUSE OF SYMPTOM: ________________________
SEVERITY: NONE 1 2 3 4 5 6 7 8 9 10 UNBEARABLE
HOW LONG DOES IT LAST: ______________________
AFFECTS SLEEP: YES NO
ARE YOU CURRENTLY PREGNANT? YES NO




**ALLEVIATING FACTORS: makes the pain feel better**

REST: YES NO
ACTIVITY: YES NO
ANALGESIC MEDICATIONS: YES NO
ADDITIONAL SELF-CARE: ______________________

**EXACERBATING FACTORS: makes pain feel worse**

BENDING OR LIFTING: YES NO
STANDING: YES NO
ACTIVITY: YES NO
DRIVING OR SITTING: YES NO
WALKING: YES NO
RESTING: YES NO
OTHER: ______________________________

**VITALS**

Ht ________
Wt ________
BP ____/____
P ________

TIME ABLE TO WALK: MINUTES_______ HOURS________ UNRESTRICTED____
TIME ABLE TO SIT: MINUTES_______ HOURS________ UNRESTRICTED_____
PHYSICAL LIMITATION IN AMOUNT ABLE TO LIFT: YES NO
DAILY ACTIVITY RESTRICTIONS: YES NO
WORKING WITH RESTRICTIONS: YES NO

DATE ________

**PAST MEDICAL HISTORY:**

PREVIOUS NECK PAIN: YES NO

NECK INJURY: YES NO DESCRIBE INJURY____________________________________________

PREVIOUS BACK PAIN: YES NO

BACK INJURY: YES NO DESCRIBE INJURY____________________________________________

PRIOR TESTING FOR PAST PROBLEM: YES NO IF YES WHAT: ____________________________

PRIOR TREATMENT FOR PAST PROBLEM: YES NO IF YES WHAT: __________________________

SURGERIES: ______________________________________________________________

MAJOR ILLNESSES:__________________________________________________________

DO YOU HAVE A PACEMAKER? YES NO

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? YES NO

**SOCIAL HISTORY:**

PHYSICAL ACTIVITY: YES NO HOW OFTEN AND TYPE: _______________________________

OCCUPATION: ________________________PT FT RETIRED STUDENT DISABLED

NUTRITION: POOR AVERAGE EXCELLENT

SMOKING: CURRENT FORMER NEVER ANY DESIRE TO QUIT? YES NO

ALCOHOL: NONE RARE OCCASIONAL SOCIAL DAILY

SEIZURES: YES NO IF YES PLEASE DESCRIBE _____________________________________

DEPRESSION: YES NO

HIGH BLOOD PRESSURE YES NO

CORONARY HEART DISEASE: YES NO

DIABETES: YES NO TYPE I TYPE II

CANCER: YES NO IF YES, WHAT KIND____________________YEAR__________

ALCOHOLISM: YES NO

ANXIETY: YES NO

ASTHMA: YES NO

STROKE: YES NO

OTHER: ______________________________________

DO YOU WEAR A SEATBELT: YES NO

| **FAMILY HISTORY**: | | FATHER | MOTHER | SIBLINGS |
|---|---|---|---|---|
| HIGH BLOOD PRESSURE: | | [ ] | [ ] | [ ] |
| HIGH CHOLESTEROL: | | [ ] | [ ] | [ ] |
| CORONARY HEART DISEASE: | | [ ] | [ ] | [ ] |
| DIABETES: | | [ ] | [ ] | [ ] |
| CANCER: | WHAT KIND | [ ]__________ | [ ]__________ | [ ]__________ |
| ALCOHOLISM: | | [ ] | [ ] | [ ] |
| STROKE: | | [ ] | [ ] | [ ] |
| DEPRESSION: | | [ ] | [ ] | [ ] |
| ANXIETY: | | [ ] | [ ] | [ ] |
| OTHER:__________________________ | | [ ] | [ ] | [ ] |
| DECEASED: | | [ ] | [ ] | [ ] |

**MEDICATIONS**:

______ mg./dosage MED NAME:______________________________ used for ______________

______ mg./dosage MED NAME:______________________________ used for ______________

______ mg./dosage MED NAME:______________________________ used for ______________

______ mg./dosage MED NAME:______________________________ used for ______________

______ mg./dosage MED NAME:______________________________ used for ______________

______ mg./dosage MED NAME:______________________________ used for ______________

**MEDICATION ALLERGIES**:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**ALLERGIES**:

______________________________________________

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______________________________________________

# INFORMED CONSENT

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform you, the patient, of such risks prior to initiating care. While Chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment. Our office uses trained staff personnel to assist with portions of your consultation, examination, x-rays, physical therapy applications, exercise instruction, etc. Occasionally, when your Chiropractor is unavailable, another qualified Doctor of Chiropractic may treat you.

**Specific Risk Possibilities Associated with Chiropractic Care:**

**Stroke**- Stroke is the most serious complication of Chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 treatments to 1 per 10 million treatments. The most recent studies (Journal of the CCA. Vol. 37, No. 2 June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

**Soreness**- Chiropractic adjustments and Physical Therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to Chiropractic Care. While it is not generally dangerous, please advise your Chiropractor if you experience soreness or discomfort.

**Soft Tissue Injury**- Occasionally Chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

**Rib Injury**- Manual adjustments to the thoracic spine, in rare cases. May cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

**Physical Therapy Burns**- Heat generated by Physical Therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your Chiropractor or staff if they occur.

**Other Problems**- There is occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your Chiropractor promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation. If you have any questions concerning the above, please ask your Chiropractor.

Having carefully read the above, I hereby give my informed consent to have Chiropractic Treatment administered.

Patient Signature________________________________ Date ____________________________

Parent/Guardian Signature for Minor _________________________________________________

~ Please call if you are not able to keep your new patient appointment time. ~
A 24 hour notice would be appreciated.

# LOW BACK PAIN DISABILITY QUESTIONNAIRE (REVISED OSWESTERY)

Name: ______________________________ Date: ____________________

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 moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very 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 causes 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 for example 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 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 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.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting for more than a 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

Section 6 - **Standing**

- ☐ I can stand as long as I want without extra pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand longer than 1/2 an hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

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 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ 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, i.e. dancing etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Section 9 - **Traveling**

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel except that done lying down.
- ☐ Pain restricts me from all forms of travel.

Section 10 - **Changing Degree 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 improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

# **NECK PAIN** DISABILITY QUESTIONNAIRE (VERNON-MIOR)

Name: ______________________________ Date: ______________________

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 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 my 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 causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - **Reading**

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot 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.

Section 5 - **Headaches**

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which 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 concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty 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 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 cannot 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 cannot 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 cannot 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 (1-2hrs. 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 pain in my neck.
- ☐ 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 the pain in my neck.
- ☐ I cannot do any recreation activities at all.

# HEADACHE DISABILITY INDEX

NAME: ____________________ DATE: __________ AGE: ______ SCORES TOTAL: ____(100); E____(52); F____(48)

**INSTRUCTIONS:** PLEASE CIRCLE THE CORRECT RESPONSE:

1. I HAVE A HEADACHE: (1) 1 PER MONTH (2) MORE THAN 1 BUT LESS THAN 4 PER MONTH (3) MORE THAN 1 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 OF "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 AM I GOING INSANE. | ❒ | ❒ | ❒ |
| E10. MY OUTLOOK OF 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 DEPRESSED BECAUSE OF MY HEADACHES. | ❒ | ❒ | ❒ |
| F13. I AM CONCERNED THAT I AM PAYING PENALTIES AT WORK AND AT HOME BECAUSE OF MY HEADACHES. | ❒ | ❒ | ❒ |
| E.14. MY HEADACHES PLACE STRESS ON MY RELATIONSHIPS WITH FAMILY AND 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. | ❒ | ❒ | ❒ |

FOR OFFICE USE ONLY:

JACOBSON GARY P., RAMADAN NM, ET AL., THE HENRY FORD HOSPITAL HEADACHE DISABILITY INVENTORY (HDI). NEUROLOGY 1994; 44:837-842.