

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient File #: _____

Today's Date: ____ / ____ / ____

WELCOME: The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (First) _____ (Middle) _____ (Last) _____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ____ / ____ / ____ Age: ____ Marital Status (Circle): Divorced Married Single Separated Widowed
Gender (Circle): Male / Female Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
Social Security #: _____ - _____ - _____ Email Address: _____ @ _____
Spouses Name: _____ Names & Ages of Children: _____
Is your spouse a patient in our office? Yes No

Employer /Employment Status Employed Unemployed Full Time / Part Time Student Other

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: (____) _____ - _____ Type of Work: _____

Is it ok to contact you at work? Yes No

Emergency Contact Information

Name: (First) _____ (Middle) _____ (Last) _____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____ Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

Yes No

Who besides yourself is responsible for your bill? Self-Pay Health Insurance

Medicare Medicaid Worker's Comp

Auto Insurance Other (Be Specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: ____ / ____ / ____

Insured Person's Social Security #: _____ - _____ - _____

Auto or Workers' Comp Insurance Carrier & Claim #: _____

PRIMARY COMPLAINT:

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At it's worst ____ At the present time ____ At least severe ____

Does the pain travel? Yes No If yes, from where to where? _____

Is condition getting worse? Yes No

List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped _____

SECOND COMPLAINT:

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At it's worst _____ At the present time _____ At least severe _____

Does the pain travel? Yes No If yes, from where to where? _____

Is condition getting worse? Yes No

List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped _____

THIRD COMPLAINT:

When did it start? _____

Describe the condition: _____

What do you think caused the problem? _____

Rate the pain from 1-10: At it's worst _____ At the present time _____ At least severe _____

Does the pain travel? Yes No If yes, from where to where? _____

Is condition getting worse? Yes No

List the activities that this condition prevents you from doing? _____

List past treatment for this condition and if they helped _____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

Is there any other information that you feel would be relevant to your current condition(s) that was not covered?
Please explain in the following section any information that you feel would be helpful to the doctor.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to _____ for services rendered to me.

REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

PATIENT PRINTED NAME

PATIENT SIGNATURE

DATE

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient signature: _____ Today's Date: __/__/__

Continued on next page

Please mark P for in the Past, C for Currently have, or N for Never

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) |

Neck Index

Form N1-100

rev 3/27/2003

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

- ⓪ 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

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ I am able to engage in all my recreation 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

- ⓪ 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 almost all the time.

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

Neck
Index
Score

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage 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 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 is severe but comes and goes.
 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 increase the pain, but I manage not to change my way of doing it.
 D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
 E. Because of the pain, I am unable to do any 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 the 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 1/4 mile.
 D. Pain prevents me from walking more than 100 yards.
 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.

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 ½ hour without increasing pain.
 E. I can't stand for more than 10 minutes without increasing pain.
 F. I avoid standing because it increases pain right 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.
 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. Pain prevents me from sleeping at all.

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 off 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.

DISABILITY INDEX SCORE: % _____

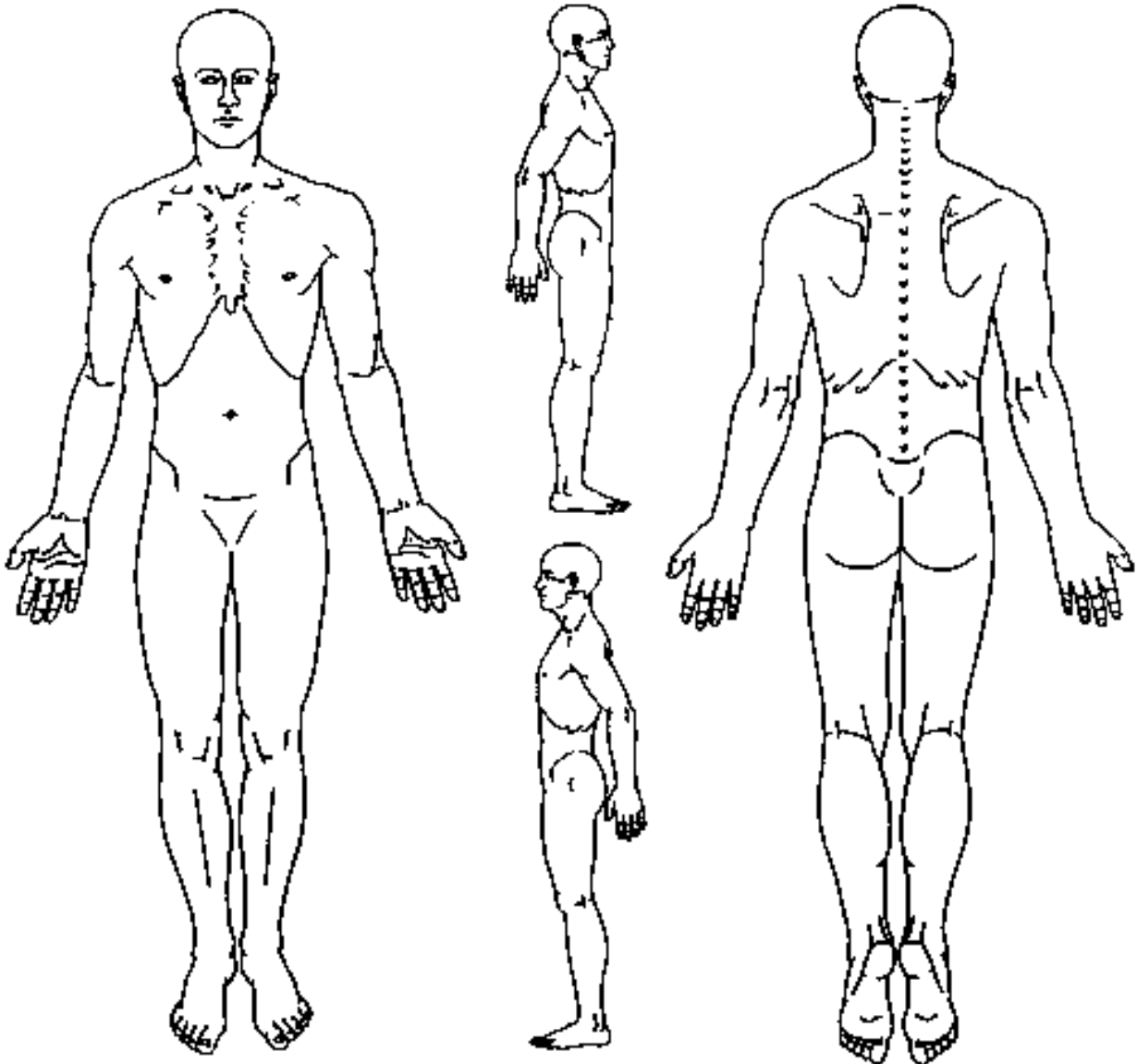
THE LOW BACK PAIN QUESTIONNAIRE

NAME _____

DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE

B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER