Orono Chiropractic

~ A Drugless Healthcare Practice ~

DEMOGRAPHICS

Date: ______/______/______ **SS#:** ________/________/__________ **DOB:** ______/______/______

Name: ____ **Marital Status:** ________________ **Gender: Male / Female**

Billing Address: ____ **Home Phone:** ________________________

City: ______________________ **State:** _________ **Zip:** ___________ **Cell Phone:** __________________________

Email Address: ____ **Work Phone:** ________________________

Preferred Language: ____ Ethnicity: **[ ] Hispanic [ ] Non-Hispanic**

Race: **[ ] Caucasian [ ] African American [ ] Asian [ ] Hispanic [ ] American Indian [ ] Other:** _____________

If patient is a minor: Parent/Guardian Name: __________________________________ SS#:______/______/______

Person to notify in case of emergency: ________________________________ Relation: _______________________

Home Phone: __________________ Cell Phone: __________________ Work Phone: ___________________

Primary Physician: ___________________________________ **Referred by:** _______________________________

Problem list: 1.) ____

2.) ____

Does the problem change with the **time of day** or **day of the month**? **[ ] Yes [ ] No**

If yes, please specify: ____

Please list any allergies you may have.

____

____

Please list all prescription medications including dosage and frequency (continue on back if needed).

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____

Please list your medical history (i.e hospitalizations, etc.)

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____

____

What is your condition preventing you from doing?

____

____

Have you received a pneumonia vaccination in the past year? **[ ] Yes [ ] No**

Have you received an influenza vaccination in the past year? **[ ] Yes [ ] No**

(female patients only): Have you had a mammogram to screen for breast cancer in the past year? **[ ] Yes [ ] No**

Patient Signature: ____ Date: ______________________

Parent/Guardian Signature: _____________________________________ Date: ____________________

(if patient is a minor)

Orono Chiropractic

Please **CIRCLE** current conditions and **CHECK** former conditions. (This document and its information are confidential.)

GENERAL
- Allergy
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Headache
- Loss of Sleep
- Loss of Weight
- Nervousness
- Numbness
- Tremors
- Depression

CARDIOVASCULAR
- Hardening of the Arteries
- High Blood Pressure
- Low Blood Pressure
- Pain Over the Heart
- Poor Circulation
- Rapid Heartbeat
- Slow Heartbeat
- Swelling of the Ankles
- Previous Heart Attack
- Paralytic Stroke

RESPIRATORY
- Wheezing
- Asthma
- Chest Pain
- Chronic Cough
- Difficulty Breathing
- Spitting Up Blood

SKIN
- Sensitive Skin
- Varicose Veins
- Boils
- Bruise Easily
- Dryness of Skin
- Hives or Itching
- Skin Rash

EARS, EYES, NOSE, THROAT
- Hearing
- Taste
- Touch
- Sight
- Smell
- Nosebleeds
- Sore Throats
- Tonsillitis
- Dental Decay
- Earaches
- Ear Noises
- Enlarged Glands
- Eye Pain
- Gum Trouble
- Hoarseness

GASTRO-INTESTINAL
- Belching or Gas
- Colitis
- Colon Trouble
- Constipation
- Diarrhea
- Difficult Digestion
- Distention of the Abdomen
- Excessive Hunger
- Gall Bladder Trouble
- Jaundice
- Intestinal Worms
- Liver Trouble
- Vomiting of Blood
- Nausea
- Pain Over Stomach

MUSCULOSKELETAL
- Swollen Joints
- Arthritis
- Bursitis
- Foot Trouble
- Hernia
- Low Back Pain
- Neck Pain
- Neck Stiffness
- Pain Between Shoulders
- Pain or Numbness in:
  - Shoulders
  - Arms
  - Elbows
  - Hands
  - Hips
  - Legs
  - Knees
  - Feet
- Painful Tailbone
- Faulty Posture
- Sciatica
- Scoliosis

GENITO-URINARY
- Blood in Urine
- Frequent Urination
- Incontinence
- Bladder Infection
- Bed Wetting
- Pus in Urine
- Painful Urination

FEMALE
- Pregnancy
- Congested Breasts
- Cramps/Backache
- Excessive Menstrual Flow
- Vaginal Discharge
- Irregular Cycle
- Painful Menstruation
- Menopausal Symptoms

MISCELLANEOUS
- AIDS / HIV
- Alcoholism
- Allergy Shots
- Anemia
- Anorexia
- Appendicitis
- Bleeding Disorder
- Breast Lump
- Bulimia
- Cancer
- Chemical Dependency
- Diabetes
- Emphysema
- Epilepsy
- Fractures
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herniated Disk
- Herpes
- High Cholesterol
- Kidney Disease
- Migraines
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Osteoporosis
- Parkinson's Disease
- Pneumonia
- Prostate Problems
- Rheumatoid Arthritis
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tuberculosis
- Tumors or Growths
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease
- Whooping Cough

OTHER

Please specify:

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____

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____

Please do only <u>one</u> (1) of the next 3 pages-
(Only the one most applicable to your condition).

Thank you!

Neck Index

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 can tolerate the pain I have without having to use pain medication.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
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.

Personal Care (Washing, Dressing, etc.)

0 I can take care of myself normally without causing increased pain.
1. I can take care of myself normally, but it increases my pain.
2. It is painful to take care of myself, and I am slow and careful.
3. I need help, but I am able to manage most of my personal care.
4. I need help every day in most aspects of my care.
5. I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting

0 I can lift heavy objects without increased pain.
1. I can lift heavy objects, but it causes increased pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g. on the table).
3. Pain prevents me from lifting heavy weights, 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.

Reading

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

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 in concentrating when I want.
3. I have a lot of difficulty in concentrating when I want.
4. I have a great deal of difficulty in 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 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.

Driving

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

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).

Recreation

0 I am able to engage in all of my recreation activities with no pain in my neck.
1. I am able to engage in all of my recreation activities with some pain in my neck.
2. I am able to engage in most, but not all, of my recreation activities because of pain in my neck.
3. I am able to engage in only a few of my recreation activities because of pain in my neck.
4. I can hardly do any recreation activities because of pain in my neck.
5. I cannot do any recreation activities at all.

Patient Initials: _______

Back Index

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 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 severe and does not vary much.

Personal Care

0 I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of dressing or washing 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 the 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

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 manage if they are conveniently positioned (e.g. on a table).
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at the most.

Walking

0 I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than one mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Sitting

0 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 one hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain right away.

Standing

0 I can stand as long as I want without pain.
1. I have some pain on standing, but it does not increase with time.
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain right away.

Sleeping

0 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 night's sleep is reduced by less than ¼.
3. Because of pain, my normal night's sleep is reduced by less than ½.
4. Because of pain, my normal night's sleep is reduced by less than ¾.
5. Pain prevents me from sleeping at all.

Social Life

0 My social life is normal and gives me no pain.
1. My social life is normal, but increases the degree of pain.
2. Pain has no significant effect 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.

Travelling

0 I get no pain while travelling.
1. I get some pain while travelling, but none of my usual forms of travel make it any worse.
2. I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while travelling, which compels me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.
6.

Changing Degree of Pain

0 My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Patient Initials: _______

Functional Rating Index

Complete this page if your discomfort is affecting something other than neck or back pain.

Pain Intensity

- **0** No pain
- **1.** Mild pain
- **2.** Moderate pain
- **3.** Severe pain
- **4.** Worst possible pain

Sleeping

- **0** Perfect sleep
- **1.** Mildly disturbed sleep
- **2.** Moderately disturbed sleep
- **3.** Greatly disturbed sleep
- **4.** Totally disturbed sleep

Personal Care (washing, dressing, etc.)

- **0** No pain; no restrictions
- **1.** Mild pain; mild restrictions
- **2.** Moderate pain; need to go slowly
- **3.** Moderate pain; need some assistance
- **4.** Severe pain; need 100% assistance

Traveling (driving, etc.)

- **0** No pain on long trips
- **1.** Mild pain on long trips
- **2.** Moderate pain on long trips
- **3.** Moderate pain on short trips
- **4.** Severe pain on short trips

Work

- **0** Can do usual amounts of work, plus unlimited amounts of extra work
- **1.** Can do usual work; no extra work
- **2.** Can do 50% of usual work
- **3.** Can do 25% of usual work
- **4.** Cannot work

Recreation

- **0** Can do all activities
- **1.** Can do most activities
- **2.** Can do some activities
- **3.** Can do a few activities
- **4.** Cannot do any activities

Frequency of Pain

- **0** No pain
- **1.** Occasional pain; 25% of the day
- **2.** Intermittent pain; 50% of the day
- **3.** Frequent pain; 75% of the day
- **4.** Constant pain; 100% of the day

Lifting

- **0** No pain with heavy weights
- **1.** Increased pain with heavy weight
- **2.** Increased pain with moderate weight
- **3.** Increased pain with light weight
- **4.** Increased pain with any weight

Walking

- **0** No pain; any distance
- **1.** Increased pain after 1 mile
- **2.** Increased pain after ½ mile
- **3.** Increased pain after ¼ mile
- **4.** Increased pain with all walking

Standing

- **0** No pain after several hours
- **1.** Increased pain after several hours
- **2.** Increased pain after 1 hour
- **3.** Increased pain after ½ hour
- **4.** Increased pain with any standing

Patient Initials: _______