# Adult Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

First Name: Last Name: Date:

SS#: DOB: Sex: ○M ○F

Marital Status: # of Children: Occupation:

Street Address: Height:

City, State, Postal Code: Weight:

Email: Cell Phone: Other Phone:

Emergency Contact: Emergency Relation: Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

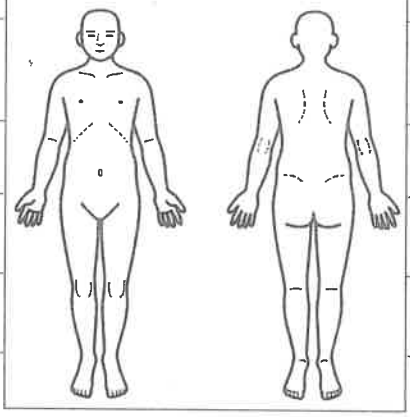
Are you also receiving care from any other health professionals? ○Yes ○No
- If yes, please name them and their specialty:

Please note any significant family medical history:

## CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.
X= Current condition O= Past condition



Have you received care for this problem before? ○Yes ○No
- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ○Suddenly ○Gradually ○Post-Injury

Is this condition: ○Getting worse ○Improving ○Intermittent ○Constant ○Unsure

What makes the problem better?

What makes the problem worse?

## YOUR HEALTH GOALS

Your top three health goals:

1.

2.

3.

## CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ○ Resolve existing condition(s) ○ Overall wellness ○ Both

Have you ever visited a chiropractor? ○ Yes ○ No If yes, what is their name?

What is their specialty? ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutritional ○ Subluxation-based ○ Other: _____

Do you have any health concerns for other family members today?

## TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ○ Yes ○ No
- If yes, please explain:

Notable childhood injuries? ○ Yes ○ No If yes, please explain:

Youth or college sports? ○ Yes ○ No If yes, list major injuries:

Any auto accidents? ○ Yes ○ No If yes, please explain:

Exercise Frequency? ○ None ○ 1-3x per week ○ 4-6x per week ○ Daily
What types of exercise?

How do you normally sleep? ○ Back ○ Side ○ Stomach Do you wake up: ○ Refreshed and ready ○ Stiff and tired

Do you commute to work? ○ Yes ○ No If yes, how many minutes per day?

List any problems with flexibility. *(ex. Putting on shoes/socks, etc.)*

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

## TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

| | *None* | | *Moderate* | | *High* |
|---|---|---|---|---|---|
| Alcohol | ① | ② | ③ | ④ | ⑤ |
| Water | ① | ② | ③ | ④ | ⑤ |
| Sugar | ① | ② | ③ | ④ | ⑤ |
| Dairy | ① | ② | ③ | ④ | ⑤ |
| Gluten | ① | ② | ③ | ④ | ⑤ |

| | *None* | | *Moderate* | | *High* |
|---|---|---|---|---|---|
| Processed Foods | ① | ② | ③ | ④ | ⑤ |
| Artificial Sweeteners | ① | ② | ③ | ④ | ⑤ |
| Sugary Drinks | ① | ② | ③ | ④ | ⑤ |
| Cigarettes | ① | ② | ③ | ④ | ⑤ |
| Recreational Drugs | ① | ② | ③ | ④ | ⑤ |

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

## THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

| | *None* | | *Moderate* | | *High* |
|---|---|---|---|---|---|
| Home | ① | ② | ③ | ④ | ⑤ |
| Work | ① | ② | ③ | ④ | ⑤ |
| Life | ① | ② | ③ | ④ | ⑤ |

| | *None* | | *Moderate* | | *High* |
|---|---|---|---|---|---|
| Money | ① | ② | ③ | ④ | ⑤ |
| Health | ① | ② | ③ | ④ | ⑤ |
| Family | ① | ② | ③ | ④ | ⑤ |

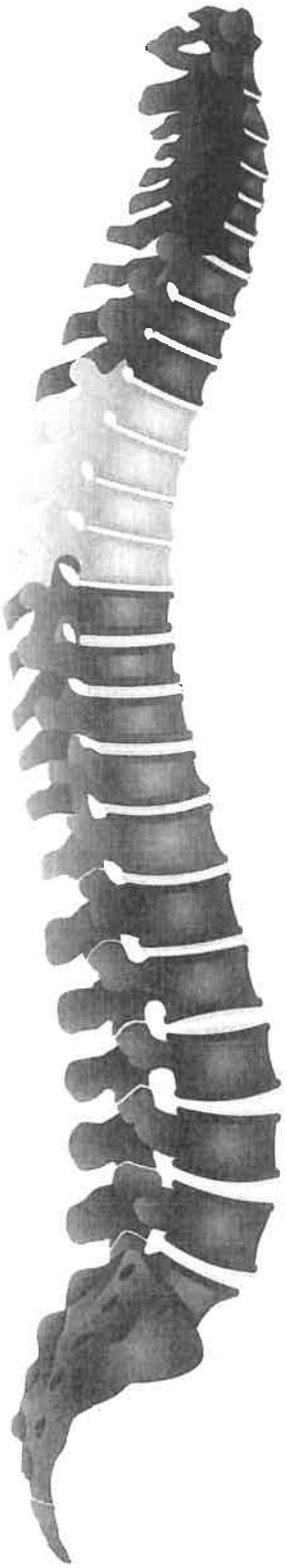
## ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ Date: _____

# Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

*Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.*



| REGIONS | FUNCTIONS | SYMPTOMS (PAST / PRESENT) | | SYMPTOMS (PAST / PRESENT) | |
|---|---|---|---|---|---|
| **Cervical** | • Autonomic Nervous System<br>• ENT System<br>• Vision, Balance & Coordination<br>• Speech<br>• Immune System<br>• Digestive System<br>• Nerve Supply to Shoulders, Arms & Hands<br>• Sympathetic Nucleus<br>• Metabolism | ☐☐ Colic & Excessive Crying<br>☐☐ Ear & Sinus Infections<br>☐☐ Allergies & Congestion<br>☐☐ Immune Deficiency<br>☐☐ Headaches & Migraines<br>☐☐ Vertigo & Dizziness<br>☐☐ Sore Throat & Strep<br>☐☐ Swollen Tonsils & Adenoids<br>☐☐ Vision & Hearing Issues<br>☐☐ Low Energy & Fatigue<br>☐☐ Difficulty Sleeping<br>☐☐ Pain, Numbness & Tingling in Arms to Hands | ☐☐ Epilepsy & Seizures<br>☐☐ Sensory & Spectrum<br>☐☐ ADD / ADHD<br>☐☐ Focus & Memory Issues<br>☐☐ Anxiety & Stress<br>☐☐ Balance & Coordination<br>☐☐ Speech Issues<br>☐☐ TMJ / Jaw Pain<br>☐☐ Stiff Neck & Shoulders<br>☐☐ Depression<br>☐☐ High Blood Pressure<br>☐☐ Poor Metabolism & Weight Control | |
| **Upper Thoracic** | • Upper G.I.<br>• Respiratory System<br>• Cardiac Function | ☐☐ Reflux / GERD<br>☐☐ Chronic Colds & Cough<br>☐☐ Asthma | ☐☐ Bronchitis & Pneumonia<br>☐☐ Functional Heart Conditions | | |
| | • Major Digestive Center<br>• Detox & Immunity | ☐☐ Gallbladder Pain / Issues<br>☐☐ Jaundice<br>☐☐ Fever | ☐☐ Indigestion & Heartburn<br>☐☐ Stomach Pains & Ulcers<br>☐☐ Blood Sugar Problems | | |
| **Lower Thoracic** | • Stress Response<br>• Filtration & Elimination<br>• Gut & Digestion<br>• Hormonal Control | ☐☐ Behavior Issues<br>☐☐ Hyperactivity<br>☐☐ Chronic Fatigue<br>☐☐ Chronic Stress | ☐☐ Allergies & Eczema<br>☐☐ Skin Conditions / Rash<br>☐☐ Kidney Problems<br>☐☐ Gas Pain & Bloating | | |
| **Lumbar, Sacrum & Pelvis** | • Lower G.I. (Absorption & Motility)<br>• Gut-Immune System<br>• Major Hormonal Control | ☐☐ Constipation<br>☐☐ Chrohn's, Colitis & IBS<br>☐☐ Diarrhea<br>☐☐ Bed-wetting<br>☐☐ Bladder & Urination Issues<br>☐☐ Cramps & Menstrual Issues<br>☐☐ Cysts & Endometriosis<br>☐☐ Infertility<br>☐☐ Impotency<br>☐☐ Hemorrhoids | ☐☐ Sciatica & Radiating Pain<br>☐☐ Lumbopelvic / SI Joint Pain<br>☐☐ Hamstring Tightness<br>☐☐ Disc Degeneration<br>☐☐ Leg Weakness & Cramps<br>☐☐ Poor Circulation & Cold Feet<br>☐☐ Knee, Ankle & Foot Pain<br>☐☐ Weak Ankles & Arches<br>☐☐ Lower Back Pain<br>☐☐ Gluten & Casein Intolerance | | |

Patient Name _____ Date _____

FAMILY FIRST HEALTH CENTER
910.755.5483

# Electronic Health Records Intake Form

*This form complies with CMS EHR incentive program requirements*

**First Name:**_____ **Last Name:**_____

**Email address:** _____@_____

**Preferred method of communication for patient reminders** (Circle one): Email / Phone / Mail

**DOB:** __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

**Smoking Status (Circle one):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Smoking Start Date (Optional):** _____

| **Family Medical History** ***(Record one diagnosis in your family history and the affected*** | | | | |
|---|---|---|---|---|
| **Diagnosis (Write in below)** | Father | Mother | Sibling: (_____) | Offspring: (_____) |
| *Example: Heart Disease* | | *X* | | |
| | | | | |

**Race (Circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

**Ethnicity (Circle one):** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

| **Are you currently taking any medications?** *(Include regularly used over the counter medications)* | |
|---|---|
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
| | |
| | |
| | |

| **Do you have any medication allergies?** | | | |
|---|---|---|---|
| Medication Name | Reaction | Onset Date | Additional Comments |
| | | | |
| | | | |
| | | | |

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

***For office use only***

Height: _____ Weight:_____ Blood Pressure:_____/_____ HR_____ TemP._____

Dr. Monique Weddle, DC
Dr. William R McGowan, DC
Dr. Kate Petersen, DC

FAMILY FIRST HEALTH CENTER

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# INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand, but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____
Print Name Signature Date

**Consent to evaluate and adjust a minor/child:**

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature Date

**Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ _____ _____
Signature Date

# Neck Disability Index

**Patient Name:** _____ **Date:** _____ **Score:** _____

**Please Read:** This questionnaire is designed to enable us to understand how much your neck back pain has affected your ability to manage your everyday activities. Please answer every section by checking **ONE CHOICE** that most applies to you. We realize that you may feel that two of the statements in any one section relate to you, but please check the **one choice which most closely describes your problem.**

**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 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 causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can 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 can't 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 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't read as much as I want because of severe pain in my neck.
- ☐ I can't read at all.

**Section 5 – Headache**
- ☐ I have no headaches at all.
- ☐ I have slight headaches which 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 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 can't 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't do any work at all.

**Section 8 – Driving**
- ☐ I can drive my car without 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 my car 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 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

**Section 10- Recreation**
- ☐ I am able to engage in all recreational activities with no pain in my neck at all.
- ☐ I am able to engage in all recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all recreational activities because of pain in my neck.
- ☐ I am able to engage in few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do any recreational activities at all.

## Modified Oswestry Low Back Disability Questionnaire

Patient Name: _____ Date: _____

### Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad, but I can manage without having to take pain medication.
- ☐ Pain medication provides me with complete relief from pain.
- ☐ Pain medication provides me with little relief from pain
- ☐ Pain medication provides me with little relief from my pain
- ☐ Pain medication has no effect on my pain.

### Section 2 – Personal Care (IE: Washing, Dressing)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally, but it increases my pain.
- ☐ It is painful to take care of myself, and I am slow and careful.
- ☐ I need help, but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, I wash with difficulty, and stay in bed.

### Section 3 – Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights, but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (IE 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 only very light weights.
- ☐ I cannot lift of carry anything at all.

### Section 4 – Walking
- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than a mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can walki only with crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

### Section 5 – Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair for as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting form more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

### Section 6 – Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but it increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

### Section 7 – Sleeping
- ☐ My sleep is never disturbed by pain.
- ☐ I can sleep well only using pain medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

### Section 8 – Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (IE sports, dancing)
- ☐ Pain prevents me form going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

### Section 9 – Traveling
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere, but it increases my pain.
- ☐ My pain restricts my travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ My pain prevents all travel except for visits to the physician/therapist or hospital.

### Section 10 – Employment/Homemaking
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (IE lifting, vacuuming)
- ☐ Pain prevents me from doing anything buy light duties
- ☐ Pain prevents me from doing even light duties
- ☐ Pain prevents me from performing any job or homemaking chores

**Score:** _____ out of 50. _____% dysfunction

References: Fritz & Irrgang (2001) A Comparison of a Modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale, Physical Therapy, pg 81: 776-788