WINFIELD CHIROPRACTIC RELIEF & WELLNESS

Patient Information & Forms

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1. CONCERNS / COMPLAINTS

What is your **PRIMARY** complaint? _____

_____

Does this interfere with: □**Work** □**Sleep** □**Walking** □**Family** □**Hobbies** □**Leisure** □other_____

When did you start experiencing your **PRIMARY** complaint?_____

Did your complaint come on? □suddenly □gradually Is this a: □first occurrence □re-occurrence

Is the source of your complaint due to an Injury? □no □yes [□work comp □auto □other accident]
If yes please describe_____

_____

If no, what do you believe is the **cause** of your **PRIMARY** complaint?_____

_____

What makes your **PRIMARY** complaint feel better? □sit □stand □lie down □rest □exercise □other_____
What makes your **PRIMARY** complaint feel worse? □sit □stand □lie down □rest □exercise □other_____

How does your **PRIMARY** complaint feel?
□no pain □dull/achy □sharp □numb □tingling □throbbing □burning □deep □superficial □stiff

How often do you experience your **PRIMARY** complaint?
□occasionally □constantly □daily □weekly □monthly □yearly
Is there a time of; day, month or year when your complaint is worse? □yes □no
If yes please describe_____

If you have seen any physicians for this condition please list their name and what diagnosis or explanations have been given to you for this condition? _____

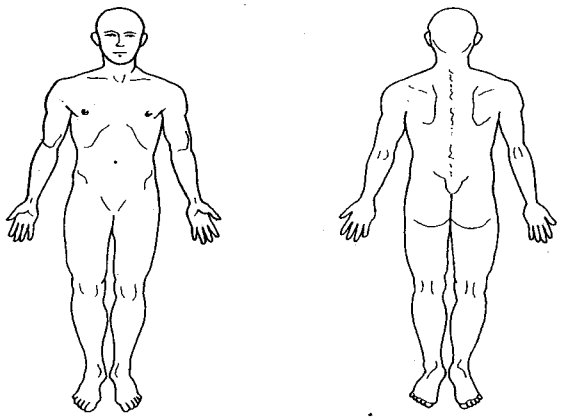
_____

Use the scale below to rate how your **PRIMARY** complaint affects your daily activities (please circle only one)

1 no pain discomfort	**2** slight discomfort	**3** pain that does not affect my activity	**4** pain that affects my daily activities	**5** pain that prevents performing my daily activities	**6** pain that limits my work schedule	**7** pain that prevents working at all	**8** pain that prevents work & all personal activities	**9** pain that keeps me bed ridden	**10** pain that causes thoughts of suicide

Please mark the areas of concern
on the diagram to the right and where it refers

N = numbness
T = tingling
P = pain
W = weakness
B = Burning
A = Ache
TH = Throbbing



Printed Patient Name_____
Patient Signature_____ Date_____ Doctor Signature_____

Patient Name_____ Date_____

2. LIFESTYLE HABITS / MEDICATIONS/ SUPPLEMENTS

Activity		Frequency per week	Duration in Minutes
Stretching	□Yes □No		
Walking/Running	□Yes □No		
Strength Training	□Yes □No		
Other (Pilates, yoga, boxing etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading etc.)			

How many hours of television do you watch a day? □ 0 □ 1-2 □ 3-5 □ > 5

How many hours per day do you ride in a car or other vehicle? □ 0 □ 1-2 □ 3-5 □ > 5

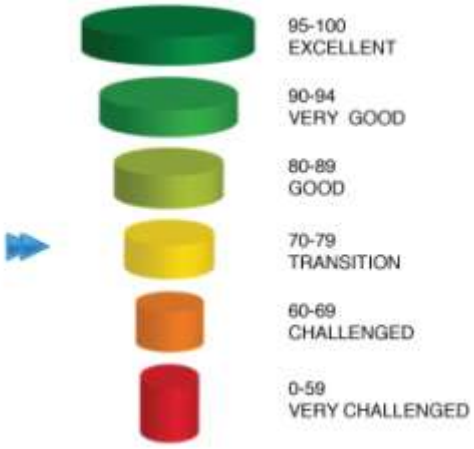
Have you ever used tobacco? □ Never □ Past □ Weekly □ Monthly □ Yearly

How many servings of alcohol do you drink each week? □ 0 □ 1-2 □ 3-5 □ > 5

How many servings of coffee do you drink each week? □ 0 □ 1-2 □ 3-5 □ > 5

How many servings of soda do you drink each week? □ 0 □ 1-2 □ 3-5 □ > 5

Please mark an "X" where you believe your health is and an "O" where you would like to be.



DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? _____

MEDICATION or SUPPLEMENT LOG **List the type of medications or supplements you are taking now.**

Medication or Supplement Name	Date started	Dated Stopped	Reason for use

Patient Name_____ Date_____

3. FAMILY & SELF HISTORY

(Indicate with the bold letter below) **: *F*ather, *M*other, *B*rother, *S*ister, *U*ncle, *A*unt, *GM*-grandmother, *GF*-grandfather, *self***)

Cancer, type:
Heart disease:
Hypertension:
Stroke:
High Cholesterol:
Diabetes:
Weight Problems:
Arthritis:
Low Back pain:
Headaches:
PMS:
Other:
Is there any other family history we should know about? □Yes □No
If yes, please comment

Prior Injuries: □ **No History of previous injury or pain.** (Please indicate when and describe how the injury occurred.)

☐ Fall Injury	_____
☐ Lifting Injury	_____
☐ Work- Job Related Injury	_____
☐ Bicycle Injury	_____
☐ Pedestrian Injury	_____
☐ Military Injury	_____
☐ Car Accident	_____
☐ Motorcycle Injury	_____
☐ Other_____	_____
☐ Other_____	_____
☐ Other_____	_____

Previous Surgeries: □ **No history of surgical procedure.** (If any previous surgery, type and when.)

	Surgery	***Year***
☐ Hernia	_____	
☐ Rib/Collar bone:	_____	
☐ Shoulder/Elbow/Wrist/Hand:	_____	
☐ Gallbladder/Stomach/Kidney:	_____	
☐ Disc surgery (neck or back):	_____	
☐ Spine Surgery (neck or back):	_____	
☐ Thigh/Knee/Ankle/Foot:	_____	
☐ Hip Replacement	_____	
☐ Heart:	_____	
☐ Cancer	_____	
☐ Other	_____	

Fractures/Broken Bones: □ **No History of fracture** For fracture/broken bones indicate LEFT / RIGHT and when the fracture occurred.) _____

Patient Name_____ Date_____

4. REVIEW OF SYSTEMS

Please check (✓) any symptoms you currently have, even if they do not seem relateded to your current problem:

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Irregular Cycles	☐ Ulcers
☐ Sinus Problems	☐ Earaches	☐ Asthma	☐ Sore Throat
☐ Bronchitis	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Chest Pain
☐ Shoulder Pain	☐ Arm Pain	☐ Knee Pain	☐ Foot Pain

5. FAMILY HEALTH PROFILE

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother(s): _____

Sister (s): _____

Others: _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

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

2. Sleeping

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

3. Personal Care (washing, dressing, etc.)

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

4. Travel (driving, etc.)

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

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

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

7. Frequency of pain

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

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

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