INITIAL PROGRESS REPORT

Name: ______________________ Date: __________

1. What symptoms did you come to this office for?______________________

____

2. Have you experienced some relief since your treatment started?__________

3. Have you noticed any new symptoms?________ If Yes, List __________

____

4. Do you feel your Doctor needs additional data?______ If Yes, List__________

____

5. Do you understand what needs to be done in your case to regain optimum health?________

6. What is a Subluxation and how is that being addressed in this office?__________

____

7. Do you have any questions regarding the correction of your health concerns?________

____

8. Please explain the importance of maintaining your spinal health. __________

9. Do you understand your financial arrangements in this office?__________

10. Do you feel others would benefit from Chiropractic care?__________

11. Please list the friends and relatives that live locally and any health concerns they might have:

A.______________________

B.______________________

C.______________________

D.______________________

E.______________________

THANK YOU FOR FILLING THIS OUT. THE DOCTOR WILL GO OVER IT WITH YOU!

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Dr. Signature______________________ Date__________

Update Health Information

General Information

First Name ______________________
Middle Initial ______________________
Last Name ______________________
Suffix ______________________
Called Name ______________________
Race (circle only 1) American Indian Alaska Native
Asian White
Black or African American
Native Hawaiian Other Pacific Islander
Declined to State

Ethnicity (circle only 1) Declined to State Hispanic or Latino
Not Hispanic or Latino

Preferred Language ______________________
Email Address ______________________

Smoking Status (circle only 1) Current Every Day Smoker Current Some Day Smoker
Former Smoke Start Date: __________ End Date: __________
Never Smoker

In an effort to quit smoking, I am currently taking: ______________________

Do you have any allergies to medication? Yes No
If Yes, please indicate the following:

Allergy: ______________________
Reaction: ______________________
Start Date: ______________________
End Date: ______________________

Allergy: ______________________
Reaction: ______________________
Start Date: ______________________
End Date: ______________________

Allergy: ______________________
Reaction: ______________________
Start Date: ______________________
End Date: ______________________

Allergy: ______________________
Reaction: ______________________
Start Date: ______________________
End Date: ______________________

Are you currently taking any new medication since your last visit? Yes No
If Yes, please indicate the following:

Medication: ______________________
Route: Oral
Intravenous
Other: ______________________
Frequency: ______________________
Began Use: ______________________
Discontinued Use: ______________________

Medication: ______________________
Route: Oral
Intravenous
Other: ______________________
Frequency: ______________________
Began Use: ______________________
Discontinued Use: ______________________

Medication: ______________________
Route: Oral
Intravenous
Other: ______________________
Frequency: ______________________
Began Use: ______________________
Discontinued Use: ______________________

Medication: ______________________
Route: Oral
Intravenous
Other: ______________________
Frequency: ______________________
Began Use: ______________________
Discontinued Use: ______________________

For Office Use Only

Account Number ______________________
Patient Height ______________________
Patient Weight ______________________
Patient BMI ______________________
Patient Blood Pressure ______________________

Name: ______________________ Date: ____________________ Account # ____________

It is important for us to know how you are responding to chiropractic care in our office. We ask your cooperation in completing the following information.

1. GRADE YOUR TREATMENT RESPONSES: (Place and "X" in the appropriate box.)

Symptom/Area	Excellent	Good	Intermittent	Poor	Worse
Head					
Neck					
Shoulders, Arms, Hands					
Mid-Back					
Low-Back, Pelvis					
Hips, Legs, Knees, Feet					
Exhaustion					
Other					

2. ENERGY / EXHAUSTION STATUS:

Exhaustion: ___All the time ___In the Morning ___Afternoons ___Evenings
___During Work ___After work ___With physical activity/work

Energized: ___No apparent energy problem ___Energy increased after treatment
___Energy seems to be gradually improving ___Plenty of energy

3. Describe any problem that is new: ____
4. Describe any problem that has worsened: ______________________________________
5. Describe your most impressive benefits: ______________________________________
6. Grade the quality of our services, staff, doctors and procedures: ______________

	Excellent	Good	Poor	Honest/Objective	Reflects Caring
SERVICE					
STAFF					
DOCTOR					

7. Is there anything you do not understand about your condition or treatment?

8. How do you feel we can help you more?

Suggestions/Complaints:

Patient's Signature: ______________________________ Date: ________________

Dr. Signature ______________ Date

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswerstry)

Patient Name:________________________________ Date:________________ Acct#:__________

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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 .

Personal Care:

[ ] 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.

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 manage if they are conveniently positioned.
[ ] Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
[ ] I can only lift light weights at the most.

Walking:

[ ] Pain does not prevent me from walking any distance
[ ] Pain prevents me from walking more than 1 mile
[ ] Pain prevents me from walking more than 1/2 mile
[ ] Pain prevents me from walking more that 1/4 mile
[ ] I cannot walk without a cane or crutches.
[ ] I am in bed most of the time and have to crawl to the toilet.

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 form sitting more than 1/2 hour.
[ ] Pain prevents me from sitting more than 10 minutes.
[ ] Pain prevents me from sitting at all

Standing:

[ ] I can stand as long as I want without pain.
[ ] I have some pain on standing but it does not increase with time.
[ ] I cannot stand for longer than one hour without increasing pain.
[ ] I cannot stand for longer than 1/2 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.

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 my pain my normal night's sleep is reduced by less than 3/4.
[ ] Pain prevents me from sleeping at all.

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 lift apart from limiting my more energetic interests, e.g., dancing, Etc.
[ ] Pain has restricted my social life and I do not go out very often.
[ ] Pain has restricted my social life to my home.
[ ] I have hardly any social life because of the pain.

Travelling:

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

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.

Date

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

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.

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 do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives 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.

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 can't 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.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches with come in-frequently.
- ☐ I have moderate headaches which come in-frequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at
- ☐ 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 pain in my neck.
- ☐ I can't do any recreation activities at all.

Concentration

- ☐ I can concentrate fully when I want to with no 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 cannot concentrate at all.

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.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want the 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 at all because of severe pain In my neck.
- ☐ I can't drive my car at all.

Sleeping (Sleepless)

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (Less than 1hr.)
- ☐ My sleep is mildly disturbed. (1-2 hr)
- ☐ My sleep is moderately disturbed. (2-3 hr)
- ☐ My sleep is greatly disturbed (3-5 hr)
- ☐ My sleep is completely disturbed. (5-7 hr)

Pain Severity Scale: Rate the Severity of your pain by checking one box on the following scale.

No Pain

0	1	2	3	4	5	6	7	8	9	10

Excruciating Pain

Dr. Signature ____________________ Date

Patient Name:_________________________ Date:____________________

Pain and Disability Questionnaire

Please check all that apply:

[ ] I stay home most of the time because of my back.
[ ] I change position frequently to try and get my back comfortable.
[ ] I walk more slowly than usual because of my back.
[ ] Because of my back I am not doing any jobs that I usually do around the house.
[ ] Because of my back, I use a handrail to get upstairs.
[ ] Because of my back, I lie down to rest more.
[ ] Because of my back, I have to hold on to something to get out of an easy chair.
[ ] Because of my back, I try to get other people to do things for me.
[ ] I get dressed more slowly because of my back.
[ ] I only stand up for short periods of time because of my back.
[ ] Because of my back, I try not to bend or kneel.
[ ] I find it difficult to get out of a chair because of my back.
[ ] My back is painful almost all of the time.
[ ] I find it difficult to turn over in bed because of my back.
[ ] My appetite is not very good because of my back.
[ ] I have trouble putting on my socks [stockings] because of my back.
[ ] I only walk short distances because of my back pain.
[ ] I sleep less well because of my back pain.
[ ] Because of my back pain, I get dressed with help from someone else.
[ ] I sit down for most of the day because of my back.
[ ] I avoid heavy jobs around the house because of my back.
[ ] Because of my back pain, I am more irritable and bad tempered with people than usual.
[ ] Because of my back, I go upstairs more slowly than usual.
[ ] I stay in bed most of the time because of my back.

Any other problems not mentioned above, please write below.

Dr. Signature_________________________
Date:__________

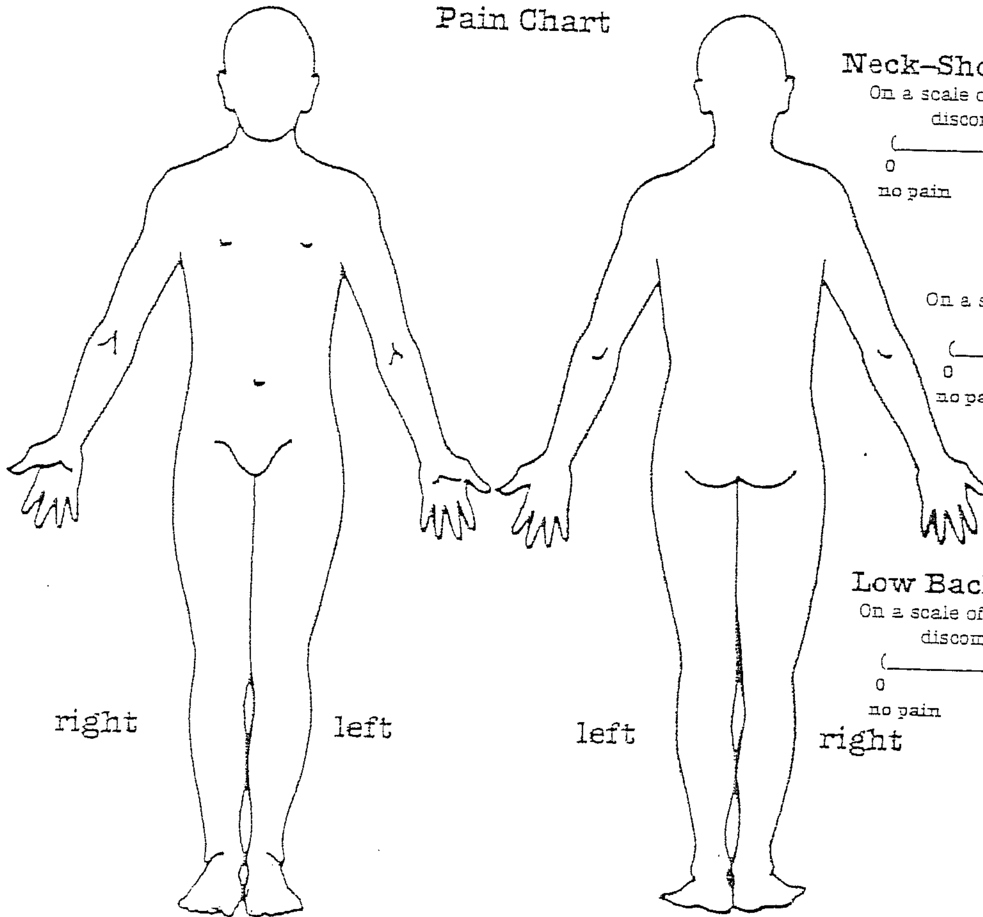
Patient name: Date:

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

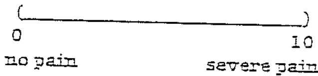
Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	XXXXX	*****	/////
- - - - -	OOOOO	XXXXX	*****	/////
- - - - -	OOOOO	XXXXX	*****	/////

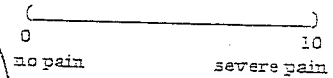
Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.



Neck–Shoulder–Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:



Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:



Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:

Date:____________________

____
Signature

Dr. Signature Date

Appointment Survey

1.) Do you know when your next scheduled appointment is?

2.) Do you have a calendar for your scheduled appointments?

3.) Are there any scheduling conflicts with your appointments, if so explain.

4.) Did you know you can come in at an early or later time then you have scheduled?

5.) Do you have a business card with our telephone number in case of emergency?

6.) Do you have any suggestions in regards to appointments in our office?

7.) Are you aware of the $25 fee for not calling to reschedule an appointment within 15 minutes of your scheduled appointment?

Note: Please let us know if you are going out of town for a vacation so that we can get you in for an appointment before you leave!

Thank you,
Heather