

**PATIENT INFORMATION**

Patient's last name:		First:	Middle Initial:	Nickname:		Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Social Security #:	Home Phone:	Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Address Line 2:				Cell Phone:		Cell Service Provider:	
City:		State:	Zip Code:	Email:			
Employer:			Type of Work:		Work Phone:		
<b>How did you hear about our office:</b>							
<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other							
<b>Would you like to receive appointment reminders? Choose ONE:</b> <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> None							
<b>Preferred Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Russian <input type="checkbox"/> Portuguese <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other _____							
<b>Please check ALL races that apply:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Decline to Answer							
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic nor Latino <input type="checkbox"/> Declined to Answer							
<b>Preferred Confidential Communication:</b> <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> In Person							
<b>Smoking Status:</b> <input type="checkbox"/> Never <input type="checkbox"/> Current everyday <input type="checkbox"/> Current some days <input type="checkbox"/> Former Start Year _____ Quit Date _____							
<b>Alcohol Use:</b> <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy			<b>Drug Use:</b> <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy			<b>Exercise:</b> <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	
<b>List Current Medications:</b> <input type="checkbox"/> None							
1. Drug Name: _____		Strength: _____		Dose: _____		Frequency: _____	
Date Started: _____							
2. Drug Name: _____		Strength: _____		Dose: _____		Frequency: _____	
Date Started: _____							
3. Drug Name: _____		Strength: _____		Dose: _____		Frequency: _____	
Date Started: _____							
4. Drug Name: _____		Strength: _____		Dose: _____		Frequency: _____	
Date Started: _____							
5. Drug Name: _____		Strength: _____		Dose: _____		Frequency: _____	
Date Started: _____							
<b>List Drug Allergies:</b> <input type="checkbox"/> No Known Drug Allergies							
1. Drug Name _____		Reaction: _____		Date Started: _____			
2. Drug Name _____		Reaction: _____		Date Started: _____			
3. Drug Name _____		Reaction: _____		Date Started: _____			

**INSURANCE INFORMATION**

Primary Insurance:		ID Number:
Insured Name:		Group Number:
Is insurance through work: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes name of company: _____		
Secondary Insurance:		ID #
Patient is the <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> _____ to the insured.		Ins. Date of Birth:
I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. The Doctor's office has agreed to prepare any necessary reports and billing to my insurance company. Any payment received from insurance will be credited to my account. Payment for x-rays is for examination only and the X-Ray negatives will remain the property of the doctor's office. I also understand that I am responsible for all bills incurred at this office.		
Signature of Patient or Patients Representative		Date

**FAMILY HISTORY**

Please indicate which conditions exist or have existed by marking the boxes below.

What type?		Self	Mother	Father	Sister	Brother	Son	Daughter
		<b>-Cancer:</b>	Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Esophageal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Gastric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Muscle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ovarian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pancreatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Blood Disorder's:</b>	Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Deep Vein Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Unknown Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Dementia/Alzheimer's</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Diabetes:</b>	Regular Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Gestational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Impaired Fasting Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Insulin Resistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Maturity onset Diabetes (MODY)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pre-Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Type 1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Gastrointestinal Disorder's:</b>	Colon Polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Familial adenomatous polyposis (FAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lynch Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Heart Disease:</b>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Unknown Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Hypertension ( High Blood Pressure )</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Kidney Disease's:</b>	Cystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chronic Kidney Disease (assoc. Diabetes Type 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Congenital Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Kidney Nephrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nephritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Nephrotic Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Unknown Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please indicate which conditions exist or have existed by marking the boxes below**

		Self	Mother	Father	Sister	Brother	Son	Daughter
<b>-Lung Disease:</b>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chronic Lower Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Influenza (Flu)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Osteoporosis (Weak and Brittle Bones)</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Psychological Disorder's:</b>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OCD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Social Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Septicemia (Life-Threatening Infection)</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Stroke/Brain Attack</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Sudden Infant Death Syndrome</b>		n/a	n/a	n/a	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>-Unknown</b>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PATIENT HISTORY**

Please describe your past accidents:

1. Accident: \_\_\_\_\_ Job Auto Other Date: \_\_\_\_\_  
 2. Accident: \_\_\_\_\_ Job Auto Other Date: \_\_\_\_\_  
 3. Accident: \_\_\_\_\_ Job Auto Other Date: \_\_\_\_\_

Please describe your past surgeries:

1. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
 2. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_  
 3. Surgery: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have any implants? Yes No If yes, please describe \_\_\_\_\_

Are you currently pregnant? Yes No If yes, please list your due date: \_\_\_\_\_

**Please indicate which conditions YOU (the patient) have experienced by marking the boxes below.**

Have you been tested for HIV? Yes No Test Results Positive Negative

Have you been tested for Hepatitis? Yes No Test Results Positive-Type\_\_\_ Negative

AIDS	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Bladder Trouble	<input type="checkbox"/>	Bone Fracture	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Dislocated Joints	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Headache	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Herniated Disk	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	Loss of Bowel Control	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Numbness	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	Pinched Nerve	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	Reproductive disorder	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Serious Injury	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Tumors or Growths	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	_____	<input type="checkbox"/>

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WHAT IS SYMPTOM 1 (EX: LOW BACK)	WHAT IS THE #1 REASON THAT MAKES IT WORSE? (EX: WALKING, SITTING, WORKING)
<b>Pain Rating:</b>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
<b>Pain Quality:</b>	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling
<b>Pain Frequency:</b>	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional
<b>Pain Radiates into:</b>	<input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____
<b>Pain Cause:</b>	<input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
<b>Pain Duration:</b>	<input type="checkbox"/> _____ Day(S) <input type="checkbox"/> _____ Week(S) <input type="checkbox"/> _____ Month(S) <input type="checkbox"/> _____ Year(S)
<b>Pain Pattern:</b>	<input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged
<b>Pain Aggravated by:</b>	<input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting Up/Down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking Down <input type="checkbox"/> Overhead Activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing <input type="checkbox"/> Coughing <input type="checkbox"/> Exercising <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Preparing Food <input type="checkbox"/> Resting <input type="checkbox"/> Sneezing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking
<b>Pain Relieved by:</b>	<input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Lifting <input type="checkbox"/> Medication <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Turning Head
<b>What has been done to treat this symptom?</b>	<input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription Medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> Over the Counter medicines
<b>For Doctor's Use Only:</b> What restrictions relate to the main impaired activity for this symptom?	

WHAT IS SYMPTOM 2 (EX: LOW BACK)	WHAT IS THE #1 REASON THAT MAKES IT WORSE? (EX: WALKING, SITTING, WORKING)
<b>Pain Rating:</b>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
<b>Pain Quality:</b>	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling
<b>Pain Frequency:</b>	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional
<b>Pain Radiates into:</b>	<input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____
<b>Pain Cause:</b>	<input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
<b>Pain Duration:</b>	<input type="checkbox"/> _____ Day(S) <input type="checkbox"/> _____ Week(S) <input type="checkbox"/> _____ Month(S) <input type="checkbox"/> _____ Year(S)
<b>Pain Pattern:</b>	<input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged
<b>Pain Aggravated by:</b>	<input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting Up/Down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking Down <input type="checkbox"/> Overhead Activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing <input type="checkbox"/> Coughing <input type="checkbox"/> Exercising <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Preparing Food <input type="checkbox"/> Resting <input type="checkbox"/> Sneezing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking
<b>Pain Relieved by:</b>	<input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Lifting <input type="checkbox"/> Medication <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Turning Head
<b>What has been done to treat this symptom?</b>	<input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription Medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> Over the Counter medicines
<b>For Doctor's Use Only:</b> What restrictions relate to the main impaired activity for this symptom?	

WHAT IS SYMPTOM 3 (EX: LOW BACK)	WHAT IS THE #1 REASON THAT MAKES IT WORSE? (EX: WALKING, SITTING, WORKING)
<b>Pain Rating:</b>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
<b>Pain Quality:</b>	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling
<b>Pain Frequency:</b>	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional
<b>Pain Radiates into:</b>	<input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____
<b>Pain Cause:</b>	<input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
<b>Pain Duration:</b>	<input type="checkbox"/> _____ Day(S) <input type="checkbox"/> _____ Week(S) <input type="checkbox"/> _____ Month(S) <input type="checkbox"/> _____ Year(S)
<b>Pain Pattern:</b>	<input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged
<b>Pain Aggravated by:</b>	<input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting Up/Down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking Down <input type="checkbox"/> Overhead Activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing <input type="checkbox"/> Coughing <input type="checkbox"/> Exercising <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Preparing Food <input type="checkbox"/> Resting <input type="checkbox"/> Sneezing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking
<b>Pain Relieved by:</b>	<input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Lifting <input type="checkbox"/> Medication <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Turning Head
<b>What has been done to treat this symptom?</b>	<input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription Medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> Over the Counter medicines
<b>For Doctor's Use Only:</b> What restrictions relate to the main impaired activity for this symptom?	

WHAT IS SYMPTOM 4 (EX: LOW BACK)	WHAT IS THE #1 REASON THAT MAKES IT WORSE? (EX: WALKING, SITTING, WORKING)
<b>Pain Rating:</b>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
<b>Pain Quality:</b>	<input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Deep <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull <input type="checkbox"/> Numbness <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Shooting <input type="checkbox"/> Stiffness <input type="checkbox"/> Tight <input type="checkbox"/> Tingling
<b>Pain Frequency:</b>	<input type="checkbox"/> Constant <input type="checkbox"/> Frequent <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional
<b>Pain Radiates into:</b>	<input type="checkbox"/> Left Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Left Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Foot <input type="checkbox"/> Right Hand <input type="checkbox"/> Right Leg <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Other: _____
<b>Pain Cause:</b>	<input type="checkbox"/> A Fall <input type="checkbox"/> Work Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Illness <input type="checkbox"/> Lifting Injury <input type="checkbox"/> Unknown <input type="checkbox"/> Gradual Onset
<b>Pain Duration:</b>	<input type="checkbox"/> _____ Day(S) <input type="checkbox"/> _____ Week(S) <input type="checkbox"/> _____ Month(S) <input type="checkbox"/> _____ Year(S)
<b>Pain Pattern:</b>	<input type="checkbox"/> Better in Morning <input type="checkbox"/> Better in Afternoon <input type="checkbox"/> Better in Evening <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Worse in Afternoon <input type="checkbox"/> Worse in Evening <input type="checkbox"/> Consistent <input type="checkbox"/> Unchanged
<b>Pain Aggravated by:</b>	<input type="checkbox"/> Bending <input type="checkbox"/> Driving <input type="checkbox"/> Getting Up/Down <input type="checkbox"/> Increased Activity <input type="checkbox"/> Looking Down <input type="checkbox"/> Overhead Activities <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Typing <input type="checkbox"/> Coughing <input type="checkbox"/> Exercising <input type="checkbox"/> House Work <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down <input type="checkbox"/> Preparing Food <input type="checkbox"/> Resting <input type="checkbox"/> Sneezing <input type="checkbox"/> Twisting <input type="checkbox"/> Walking
<b>Pain Relieved by:</b>	<input type="checkbox"/> Exercise <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Knees Bent up <input type="checkbox"/> Lying Down <input type="checkbox"/> No Movement <input type="checkbox"/> Resting <input type="checkbox"/> Standing <input type="checkbox"/> Support <input type="checkbox"/> Walking <input type="checkbox"/> Heat <input type="checkbox"/> Ice <input type="checkbox"/> Lifting <input type="checkbox"/> Medication <input type="checkbox"/> Reaching <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Turning Head
<b>What has been done to treat this symptom?</b>	<input type="checkbox"/> Acupuncture <input type="checkbox"/> Prescription Medicine <input type="checkbox"/> Massage <input type="checkbox"/> Surgery <input type="checkbox"/> Over the Counter medicines
<b>For Doctor's Use Only:</b> What restrictions relate to the main impaired activity for this symptom?	

# Revised Oswestry Low Back Pain Disability Questionnaire

From N. Hudson, K. Tome-Nicholson, A. Breen; 1989 rev. 09/11/92

Please mark the ONE choice from EACH group that best describes you.

## 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 comes and goes and is severe.
- F. The pain is severe and does not vary much.

## 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 increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

## 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 a 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.

## 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 ½ mile.
- D. Pain prevents me from walking more than 1/4 mile.
- 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.

## 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 ½ hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

## 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 cannot stand for longer than ten minutes without increasing pain.
- F. I avoid standing, because it increases the pain straight away.

## SLEEPING

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- 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.

## 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. I have hardly any social life because of the pain.

## 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 of travel.
- F. Pain prevents all forms of travel except that done lying down.

## 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.

Name \_\_\_\_\_ Date \_\_\_\_\_ PT# \_\_\_\_\_

Low Back Pain Questionnaire (2015-05)

# Neck Pain Disability Questionnaire

After Vernon & Mior, 1991, rev. 1/1/95

Please mark the ONE choice from EACH group that best describes you.

## PAIN INTENSITY

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is worst imaginable at the moment.

## PERSONAL CARE

- A. I can look after myself normally without causing extra pain.
- B. I can look after myself normally, but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

## 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, but I can manage if they are conveniently positioned, for example, on a table..
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can only lift very light weights.
- F. I cannot lift or carry anything at all.

## READING

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want to with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

## HEADACHES

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

## CONCENTRATION

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty concentrating when I want to.
- F. I cannot concentrate at all.

## WORK

- A. I can do as much work as I want to
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

## DRIVING

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot drive my car at all.

## SLEEPING

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is midly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

## RECREATION

- A. I am able to engage in all of my recreational activities, with no neck pain at all.
- B. I am able to engage in all of my recreational activities, with some neck pain at all.
- C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

Name \_\_\_\_\_ Date \_\_\_\_\_ PT# \_\_\_\_\_

Neck Pain Questionnaire (2015-05)



**Privacy Patient Consent Form  
and  
Acknowledgement of Receipt of Notice of Privacy Practices**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I also acknowledge that I was provided a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA and that I have read them or declined the opportunity to read them. I have also been informed that your *Notice of Privacy Practices* will be posted & I may request a copy at any time. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

Parties other than me that may have access to my protected health information are as follows: (please print)

\_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_ relationship \_\_\_\_\_

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected and is in effect until the date designated below.

Date: \_\_\_\_\_ effective through December 31, \_\_\_\_\_.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
**SIGNATURE OF PATIENT**

\_\_\_\_\_  
Parent or Patient's Representative's Printed Name

\_\_\_\_\_  
**SIGNATURE OF PARENT OR PATIENT'S REPRESENTATIVE**

ALVAREZ FAMILY CHIROPRACTIC-141 E. INDIANA AV-STE B-DELAND, FL 32724

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