Hammond-Henry Hospital
Medical Group

# Chiropractic New Patient

Patient Name: _____ Date of Birth: _____ Age: _____

Allergies: _____

Referred by: _____ Primary Physician: _____

Previous Chiropractic Care? ☐ No ☐ Yes If yes, Name/Location: _____

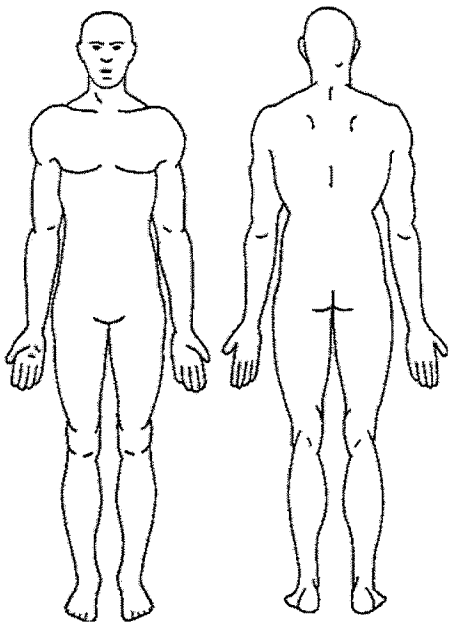
Reason for Today's Visit: _____

Please rate your current pain level

0 1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE

| Symptom #1 | Description | | | |
|---|---|---|---|---|
| Mark location of this symptom on diagram using circles (ooooo) | ☐ Sharp | ☐ Stabbing | ☐ Shooting | ☐ Burning |
| | ☐ Aching | ☐ Sore | ☐ Throbbing | ☐ Tingling |
| | ☐ Dull | ☐ Constricting | ☐ Numbness | ☐ Weakness |
| | Other: _____ | | | |
| | Frequency: | ☐ Constant | ☐ Frequent | ☐ Occasional |
| **Symptom #2** | **Description** | | | |
| Mark location of this symptom on diagram with slashes (//////) | ☐ Sharp | ☐ Stabbing | ☐ Shooting | ☐ Burning |
| | ☐ Aching | ☐ Sore | ☐ Throbbing | ☐ Tingling |
| | ☐ Dull | ☐ Constricting | ☐ Numbness | ☐ Weakness |
| | Other: _____ | | | |
| | Frequency: | ☐ Constant | ☐ Frequent | ☐ Occasional |
| **Symptom #2** | **Description** | | | |
| Mark location of this symptom on diagram using X's (xxxxxx) | ☐ Sharp | ☐ Stabbing | ☐ Shooting | ☐ Burning |
| | ☐ Aching | ☐ Sore | ☐ Throbbing | ☐ Tingling |
| | ☐ Dull | ☐ Constricting | ☐ Numbness | ☐ Weakness |
| | Other: _____ | | | |
| | Frequency: | ☐ Constant | ☐ Frequent | ☐ Occasional |



1. When did your symptoms begin? _____
2. How did the symptoms begin? (auto accident, fall, lifting, etc.) _____
3. Are your symptoms getting better, worse, or staying the same? _____
4. What makes your symptoms better? _____
5. What makes your symptoms worse? _____
6. What daily activities are affected by your symptoms? (dressing, bathing, work, travel, etc.) _____

_____

7. Have you ever had symptoms like this in the past? ☐ No ☐ Yes
   If yes, describe: _____
8. Any changes in bowel or bladder function since symptoms began? ☐ No ☐ Yes
   If yes, describe: _____
9. Have you experienced any recent fever or chills? ☐ No ☐ Yes
   If yes, describe: _____
10. Have you experienced dizziness associated with your symptoms? ☐ No ☐ Yes
    If yes, describe: _____
11. Any unexplained weight loss, fatigue, or bleeding? ☐ No ☐ Yes
    If yes, describe: _____
12. Have you had any recent broken bones, sprains, or dislocations? ☐ No ☐ Yes
    If yes, describe: _____
13. Are your symptoms affecting your sleep? ☐ No ☐ Yes
    If yes, describe: _____

14. Have you had any diagnostic tests for this issue? (Xray, MRI, etc.) ☐ No ☐ Yes

If yes, describe: _____

15. Have you had any treatment for this issue? (therapy, chiropractic, etc.) ☐ No ☐ Yes

If yes, describe: _____

16. Have you had any surgeries or hospitalizations in the last year? ☐ No ☐ Yes

If yes, describe: _____

17. Do you smoke/vape? ☐ Never smoked/vaped ☐ Yes – How much? _____

If you quit, : _____

18. Do you consume alcohol more than socially? ☐ No ☐ Yes

If yes, how much and how often? _____

19. Do you exercise? ☐ No ☐ Yes

If yes, describe: _____

## Past Medical History

1. Have you been treated for any health conditions in the last year? ☐ No ☐ Yes

If yes, describe: _____

2. Date of last physical exam (approximate is fine): _____ Doctor: _____

Women: Are you currently pregnant? ☐ No ☐ Yes Date of last menstrual cycle: _____

3. List any recent x-rays, MRI, or CT scans

| Test | Approximate Date | Performed Where? |
|---|---|---|
| | | |
| | | |
| | | |

4. Describe history of major surgeries: _____

_____

5. Please indicate any condition(s) that you, or someone in your immediate family (parent, sibling, or children) have been diagnosed with.

| Condition | Relation (self, mom, dad, sibling, children) | Condition | Relation (self, mom, dad, sibling, children) |
|---|---|---|---|
| Musculoskeletal Disorder | | Cancer | |
| Connective Tissue Disorder | | Respiratory Issues | |
| Blood Clots | | Osteoporosis/Osteopenia | |
| High Blood Pressure | | Skin Conditions | |
| Low Blood Pressure | | GI/GU | |
| High Cholesterol | | Other: _____ | |

6. Please list all prescribed and over the counter medications and supplements you are currently taking.

| Medication/Supplement Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please check the appropriate column to indicate if you currently have, or have previously had any of the following symptoms and/or conditions:

**GENERAL**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Fatigue |
| | | Fever or Chills |
| | | Loss of Appetite |
| | | Trouble Sleeping |
| | | Weakness |
| | | Unexplained Weight Change |

**MUSKULOSKELETAL**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Joint Pain |
| | | Low Back Pain |
| | | Mid Back Pain |
| | | Muscle Pain |
| | | Neck Pain |
| | | Radiating Pain |
| | | Leg Cramps |
| | | TMJ Issues |
| | | Joint Swelling |
| | | Osteoporosis |

**NEUROLOGICAL**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Confusion |
| | | Headaches |
| | | Tremors |
| | | Dizziness/Fainting |
| | | Head Injury |
| | | Paralysis |
| | | Seizures |
| | | Memory Loss |
| | | Loss of Strength/Coordination |
| | | Anxiety |
| | | Depression |
| | | Stroke |

**EYES**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Eye Discomfort |
| | | Blurred Vision |
| | | Glaucoma |
| | | Eye Pain |
| | | Redness |
| | | Specks/Floaters |
| | | Itchy Eyes |
| | | Glasses/Contacts |

**EARS, NOSE, MOUTH, THROAT**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Difficulty Hearing |
| | | Ringing in the Ears |
| | | Vertigo |
| | | Ear Pain |
| | | Loss of Smell |
| | | Sinus Problems |
| | | Difficulty Swallowing |
| | | Sore Throat |

**CARDIOVASCULAR/RESPIRATORY**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | High Blood Pressure |

**CARDIOVASCULAR/RESPIRATORY (CONTINUED)**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Low Blood Pressure |
| | | Chest Pain/Discomfort |
| | | Fainting |
| | | Leg Swelling |
| | | High Cholesterol |
| | | Emphysema |
| | | Pneumonia |
| | | Shortness of Breath/Wheezing |
| | | Asthma |
| | | Easy Bruising/Bleeding |
| | | Coughing up Blood |
| | | Irregular Heartbeat |

**GASTROINTESTINAL**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Changes in Bowel Habits |
| | | Abdominal Pain |
| | | Constipation |
| | | Heartburn |
| | | Diarrhea |
| | | Nausea |
| | | Black/Bloody Stool |
| | | Yellow Skin |
| | | Anorexia/Bulimia |

**GENITOURINARY**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Pain with Urination |
| | | Difficulty Urinating |
| | | Blood in Urine |
| | | Incontinence |
| | | Kidney Stones |
| | | Urgency to Urinate |
| | | Kidney Infections |
| | | Loss of Libido |
| | | Painful Sex/Intercourse |
| | | Irregular Menstrual Cycle |
| | | Prostate Problems |
| | | Hernia |

**INTEGUMENTARY/SKIN**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Skin Cancer |
| | | Psoriasis |
| | | Eczema |
| | | Rashes/Hives |
| | | Breast Pain/Lump |
| | | Dry/Itchy Skin |
| | | Changes in a Mole |

**ENDOCRINE**

| Currently | Previously | Symptom/Condition |
|---|---|---|
| | | Thyroid Issues |
| | | Heat/Cold Intolerance |
| | | Low Energy |
| | | Immune Disorders |
| | | Hot Flashes/Excessive Sweating |
| | | Hair Changes |
| | | Diabetes |

# Neck Index

Form N1-100

rev 3/27/2003

**Patient Name** _____ **Date** _____

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

## Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

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

## Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

## Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

## Personal Care

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

## Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

## Driving

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

## Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

## Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

~~Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100~~

*Neck Index Score*

# Back Index

Form BI100

rev 3/27/2003

**Patient Name** _____ **Date** _____

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

## Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

## Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

## Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

## Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

## Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

## Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

## Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

## Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

*Back Index Score* _____