

Patient Information Form

Reason for filling out this form: New Patient Consultation Change of Information

Personal Information

First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Email Address: _____ Marital Status: _____

Employment Status: _____ Employer: _____

Emergency Contact: Name _____ Phone Number _____

How did you find out about our office? _____

Spouse Information (or parent/guardian, if patient is a minor)

First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Employment Status: _____ Employer: _____

Insurance Information (skip this section if you do not have insurance)

Type of Insurance: Health Insurance Medicare Medicaid Auto Insurance Worker's Compensation

In whose name is insurance issued? Self Spouse Parent/Guardian Other _____

Do you have secondary insurance coverage? Yes No

Name and date of birth of person in whose name insurance is issued (if not otherwise listed above):

Full name: _____ Date of Birth: _____

Health History: Recent Injuries

Have you suffered any of the following within the past 6 months?

Fall Auto Accident Fracture Sports Injury Work Injury Other Injury _____

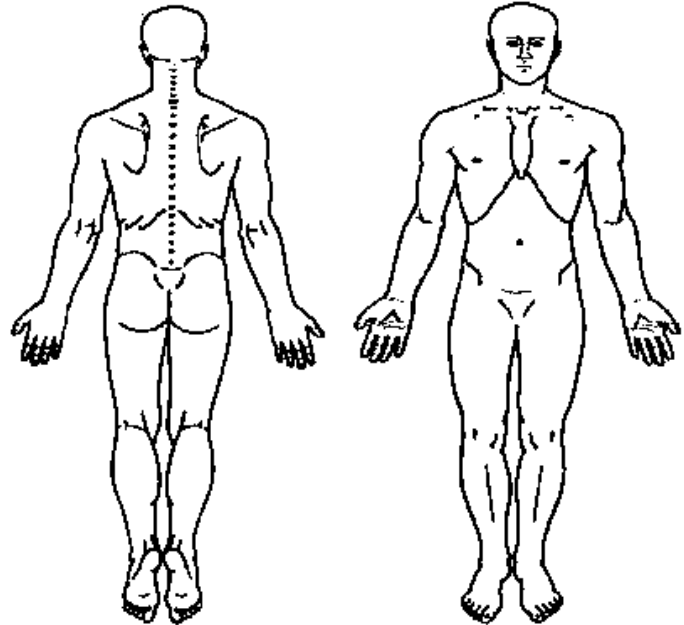
Have you been treated for any of the above? Y N If so, when, where? _____

First Name: _____ MI: _____ Last Name: _____

Health History: Current Complaints

Please indicate below where you are currently experiencing pain:

- Headaches
- Neck Pain
- Mid Back Pain
- Low Back Pain
- Hip Pain
- Shoulder/Arm/Wrist/Hand Pain
- Leg/Knee/Ankle/Foot Pain
- Other Pain _____



Please place an "X" on the diagrams to the right over any areas in which you are currently experiencing pain.

Health History: Medical Intervention

Who is your medical doctor? _____ Date of last visit with MD: _____

Please list any recent surgeries and/or hospitalizations, their dates, and their outcomes below:

Please list any chronic diseases or medical conditions you have been diagnosed with:

Please list any medications you are currently taking: (if you have a list, please provide us with it)

Please list any vitamin and/or herbal supplements you are currently taking:

Please list any known allergies you may have:

First Name: _____ MI: _____ Last Name: _____

Neck Index: Fill out this section only if you currently have **OR** have a history of **NECK PAIN**

Mark only ONE (1) choice per section:

Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain comes and goes and is moderate
- 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

- 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 I 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

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)

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 manage if they are conveniently positioned (e.g. on a table)
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything at all

Reading

- I can read as much as I want with no neck pain
- I can read as much as I want with slight neck pain
- I can read as much as I want with moderate neck pain
- I cannot read as much as I want because of moderate neck pain
- I can hardly read at all because of severe neck pain
- I cannot read at all because of neck pain

Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight neck pain
- I can drive my car as long as I want with moderate neck pain
- I cannot drive my car as long as I want due to moderate neck pain
- I can hardly drive at all because of severe neck pain
- I cannot drive my car at all because of neck pain

Concentration

- I can concentrate fully when I want with no difficulty
- I can concentrate fully when I want with slight difficulty
- I have a fair degree of difficulty concentrating when I want
- I have a lot of difficulty concentrating when I want
- I have a great deal of difficulty concentrating when I want
- I cannot concentrate at all

Recreation

- I am able to engage in all of my recreational activities without neck pain
- I am able to engage in all of my recreational activities with some neck pain
- I am able to engage in most but not all of my recreational activities due to neck pain
- I am only able to engage in a few of my usual recreational activities due to neck pain
- I can hardly do any recreation activities due to neck pain
- I cannot do any recreation activities at all

Work

- I can do as much work as I want
- I can only do my usual work but no more
- I can only do most of my usual work but no more
- I cannot do my usual work
- I can hardly do any work at all
- I cannot do any work at all

Headaches

- 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 of the time

Office Use Only

Neck
Index
Score

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First Name: _____ MI: _____ Last Name: _____

Back Index: Fill out this section only if you currently have **OR** have a history of **BACK PAIN**

Mark only ONE (1) choice per section:

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 very severe and does not vary much

Sleeping

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

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 from sitting more than 1/2 hour
- Pain prevents me from sitting more than 10 minutes
- I avoid sitting because it increases pain immediately

Standing

- I can stand as long as I want without pain
- I have some pain while standing but it does not increase with time
- I cannot stand for longer than 1 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 pain immediately

Walking

- I have no pain while walking
- I have some pain while walking but it doesn't increase with distance
- I cannot walk more that 1 mile without increasing pain
- I cannot walk more that 1/2 mile without increasing pain
- I cannot walk more that 1/4 mile without increasing pain
- I cannot walk at all without increasing pain

Personal Care

- 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 I 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

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 can manage if they are conveniently positioned (e.g. on a table)
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights

Traveling

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

Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain limits only my more energetic interests (e.g. dancing, etc.)
- Pain has restricted my social life and I do not go out often
- Pain has restricted my social life to home
- I have hardly any social life because of the pain

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
- My pain is neither getting better or worse
- My pain is gradually worsening
- My pain is rapidly worsening

Office Use Only

Back
Index
Score

First Name: _____ MI: _____ Last Name: _____

Daily Habits

What is your current occupation? _____

What are the daily duties associated with your occupation? (e.g. lifting, bending, etc.)

What types of things do you like to do for fun? _____

What effects, if any, are your current symptoms having on your work and recreational activities?

What type of exercise do you perform on a daily basis? None Light Moderate Heavy

Are you happy with your current weight? Y N What would you consider to be your ideal weight? _____
If no, what would you like to change about it? _____

Do you smoke or use other tobacco products? Y N If yes, how much per day? _____

Do you consume alcoholic beverages? Y N If yes, how much per week? _____

Do you consume caffeinated beverages? Y N If yes, how much per day? _____

Do you use illicit or "street" drugs? Y N If yes, how much per week? _____

Is there anything else you would like us to know about your health? _____

I certify that the information I have provided above is both truthful and accurate. I understand that providing incorrect information can be dangerous to my health. I agree to hold harmless Dr. Beistline, Beistline Chiropractic, and any employees assisting in my care for any complications which may arise as a result of information I have provided above which is false, incorrect, or incomplete.

Signature _____ Date _____