



Confidential Patient Health Record

Patient Information

Date: (dd/mm/yy) ____/____/____

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone #: (Home) (____) _____ - _____ Work: (____) _____ - _____

(Cell) (____) _____ e-mail _____

Employer: _____ Occupation: _____

Address: _____

Date of birth (dd/mm/yy): ____/____/____ Age: _____ Marital status: S M D W

Spouse's name _____ Number of children _____

Name of emergency contact: _____

Telephone number: (____) _____

Relationship: _____

How did you hear about this clinic? Phone book Advertisement Friend _____

Are you coming here regarding injuries from a:

Recent motor vehicle accident? Yes, Date: _____ No

Work related accident / injury? Yes, Date: _____ No

Have you made a report of your accident to your employer? Y / N

Name of Medical doctor: _____

Address: _____

May we contact your medical doctor? Y / N

Date of last physical or visit to M.D.(dd/mm/yy): ____/____/____

Date of last dental exam: (dd/mm/yy): ____/____/____

Have you ever been to a chiropractor before? Y / N Where? _____

For what condition? _____ Results: _____

Were any X-rays taken? Yes, when? _____

Of which body part? _____

When was your last appointment? _____

Reason for leaving _____

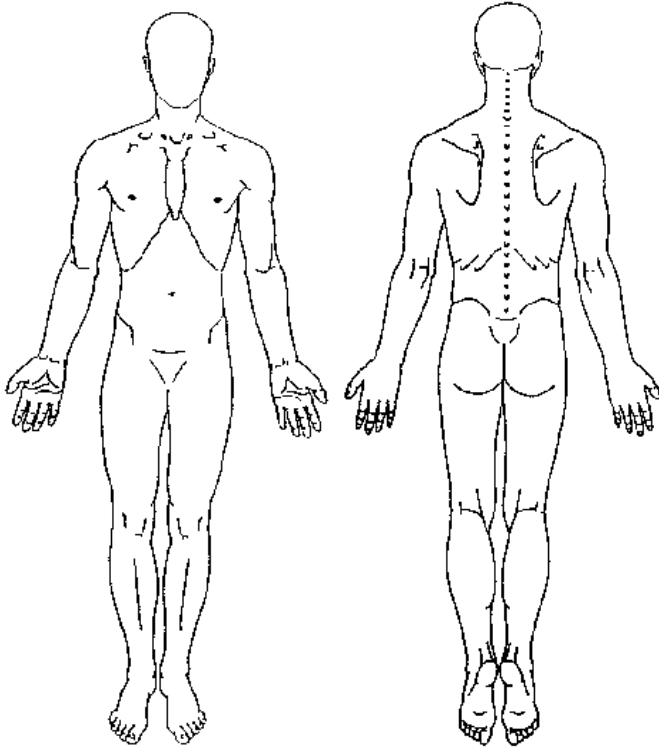
Patient Name: _____

Date: _____

Current health condition

Purpose of this appointment: _____

What is your goal in coming to this clinic? _____



Draw in your face.

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

- Numbness: ● ● ● ● ●
- ● ● ● ●
- Pins and needles: 0 0 0 0
- 0 0 0 0
- Burning: X X X X
- X X X X
- Aching: v v v v v
- v v v v v
- Sharp/Stabbing: / / / / /
- / / / / /
- Stiffness:** # # # #
- # # # #

Doctors only

On a scale of 0 to 10 (10 being the worst pain that you have ever felt), how would You rate your pain: At best: ____At worst: ____Usual: ____

When did this condition begin? _____

Anything associated with the onset? _____

What increases the pain? _____

What decreases the pain? _____

Previous treatment for these complaints? _____

Since it started, is your condition the **Same / Better / Worse**? Please circle.

Do you have any other problems with bones / joints / muscles?

Please describe _____

Init: _____

Patient Name: _____

Date: _____

Past Health history

Medical problems / hospitalizations / treatment: _____

Previous surgeries: _____

Current medications / vitamins: _____

Allergies to drugs / medications: _____

Falls and accidents: _____

Ever unconscious? _____
For how long? _____

Any previous fractures? _____

Surgeries recommended but not performed: _____

Have you ever been treated for depression? Y / N
When? _____

Health and wellness screening questionnaire

Do you have any skin problems? Describe. _____

Do you have any nerve/psychiatric/psychological problems? Describe. _____

Do you have any problems with your eyes/ears/nose/throat? Describe. _____

Do you have any respiratory problems (asthma, bronchitis)? Describe. _____

Do you have any digestive problems (ulcer, irritable bowel, indigestion, Constipation,hiatus hernia)? Describe. _____

Do you have any urinary system problems (recurrent infection, prostate, kidney problems)? Describe. _____

Do you suffer from frequent or intense headaches? Y / N

Cardiovascular system

Do you have a history of (please circle):

- | | | |
|------------------|---------------------|--------------|
| High cholesterol | High blood pressure | Heart attack |
| Angina | Heart surgery | diabetes |

Has your mother, father, a brother or sister developed heart problems before the age of 60? Y / N

Doctors only

Init: _____

Patient Name: _____

Date: _____

Arthritis

Have you ever been diagnosed with arthritis? Y / N

Do you frequently suffer from joint pain, inflammation, or joint stiffness?

Y / N

Questions for women only

Has your doctor ever indicated that you have osteoporosis? Y / N

Does osteoporosis run in your family? Y / N

Have you had a bone density test in the past two years? Y / N

Are you pregnant or planning pregnancy? Y / N

Do you have any problems with your breasts, menstrual cycle, Menopause?

Yes (Please describe) _____ No

Doctors only

Init: _____

Lifestyle Habits

Do you smoke? Y / N

How many packs per day? _____ # of years _____

Do you consume alcohol? Y / N

How many drinks per week? _____

Do you drink coffee? Y / N

How many cups per day? _____

Rate your diet: Poor Fair Medium Good Excellent

Rate your appetite: Poor Fair Medium Good Excellent

How many glasses of water do you drink per day? _____

How many meals do you eat per day? _____

Do you have a history of repeated weight loss followed by weight gain? Y / N

Do you wear orthotics or foot supports? Y / N How old are they? _____

Sleep

How many hours a night do you usually sleep? _____

Do you wake rested? _____

Do you wake in the middle of the night? Y / N

At what time? _____

How do you sleep? On your: Side / front / back

Do you grind your teeth at night? Y / N

Do you have sleep apnea? Y / N

How old is your mattress? _____

Activities

How many days a week do you exercise? _____ Inside _____ Outside

What type of activities do you do? Weights Aerobics Other _____

How often do you stretch? _____

Goals

What are your key wellness goals?

Weight management

Improved fitness

Osteoporosis prevention / management

Arthritis management

Reduce heart disease risk factors (cholesterol, blood pressure)

Back strengthening and rehabilitation

Other _____

What are you prepared to do to achieve these goals? _____

Signature: _____

Date: (dd/mm/yy) ____/____/____

NECK PAIN AND DISABILITY INDEX (VERNON-MIOR)

Patient Name: _____

Date: ____/____/____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely describes your problem.

SECTION 1 - 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 worse than imaginable at the moment.

SECTION 2 - 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 need help every day in most aspects of self-care.
- I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can lift very light objects.
- I cannot lift or carry anything at all.

SECTION 4 - 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 light pain in my neck.
- I can read as much as I want to with moderate pain in my neck.
- I can't read as much as I want to 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.

SECTION 5 - HEADACHES

- I have no headache 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 the time.

SECTION 6 - CONCENTRATION

- I can concentrate fully when I want to with 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.

SECTION 7 - WORK

- I can do as much work as I want.
- I can do only 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 work at all.
- I can't do any work at all.

SECTION 8 - DRIVING

- I can drive without any neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive at all.

SECTION 9 - SLEEPING

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

SECTION 10 - RECREATION

- I am able to engage in all my recreational activities with no neck pain.
- I am able to engage in all my recreational activities with some neck pain.
- I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- I am able to engage in a few of my usual recreational activities because of neck pain.
- I can hardly do any recreational activities because of neck pain.
- I can't do any recreational activities at all.

NECK PAIN SCALE

Rate the severity of your Neck Pain by indicating on the following scale.

Absence | ----- | Extreme

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____

Date: ____/____/____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life.

SECTION 1 - 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.

SECTION 2 - PERSONAL CARE

- I do not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases 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
- Because of the pain, I am unable to do any washing or dressing without

SECTION 3 - LIFTING

- I can lift heavy objects without any extra pain.
- I can lift heavy objects, but it gives extra pain.
- Pain prevents me from lifting heavy objects off the floor.
- Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- I can only lift very light objects at the most.

SECTION 4 - WALKING

- I have no pain on walking.
- I have some pain but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 - 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 one hour.
- Pain prevents me from sitting more than half an hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain.

SECTION 6 - 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 longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Pain reduces my normal sleep by 1/4 each night.
- Pain reduces my normal sleep by 1/2 each night.
- Pain reduces my normal sleep by 3/4 each night.
- Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- My social life is unaffected by pain apart from limiting more energetic interests.
- 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.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

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

SECTION 10 - 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 or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your Low Back Pain by indicating on the following scale.

Absence | ----- | Extreme