NP Intake - Neck & Back

New Patient Information

1. First Name: ____ Middle Initials: ____ Last Name: ____ Date of Birth: ____

   Gender: ○ Female ○ Male
   Height: ____
   Weight: ____
   Marital Status: ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

   Street Address: ____ Apt./Unit #: ____ City: ____ State: ____ Zip Code: ____

   Mobile/Home Phone: ____ Work Phone: ____ Email: ____

   Occupation: ____ Employer: ____

   Work Address: ____ Apt./Unit #: ____ City: ____ State: ____ Zip Code: ____

   Primary Care Physician: ____ Spouse's Name: ____ Number of Children: ____

   Emergency Contact Name: ____ Emergency Contact Phone: ____

   Emergency Contact Relationship: ____

2. Who may we thank for referring you to the office?

   ____

3. **Have you had chiropractic care before?**

   ○ Yes
   ○ No

   If yes, date:

   ____

4. **Is this injury/illness related to an automobile accident?**

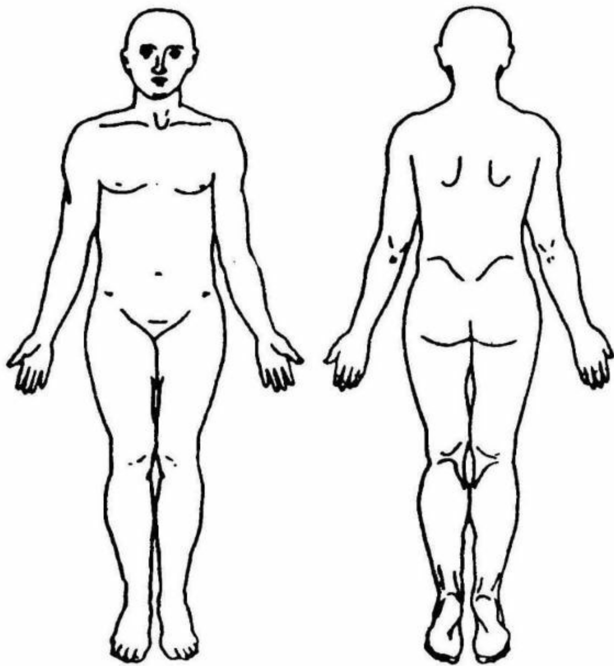
   ○ Yes
   ○ No

   If yes, date:

   ____

Symptoms & Health History

5. Please mark an X on the diagram below to indicate your symptoms.



6. Please describe how the pain/injury/discomfort originated:

____

____

____

____

7. Please describe your pain/discomfort:

____

____

____

____

8. Is the pain/discomfort worse at certain times of the day?

- ○ Yes
- ○ No

If yes, explain:

____

9. Does the weather affect your pain/discomfort?

- ○ Yes
- ○ No

If yes, explain:

____

10. List anything that aggravates your condition:

____
____
____
____

11. List anything that relieves your condition:

____
____
____
____

12. List other practitioners seen for this condition:

____
____
____
____

13. Have you had x-rays taken for this condition?

- ○ Yes
- ○ No

If yes, where?

____

14. Pain level rating – Scale of 1 to 10 (where 1 is least pain and 10 is maximum pain)

At its best:
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

At its worst:
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Current level:
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

15. Have you ever had any broken bones? Did you get professional treatment?

____
____
____
____

16. Have you ever been in an auto accident?

- ○ Yes
- ○ No

If yes, please explain:

____

17. Have you ever had any concussions or been struck unconscious?

- ○ Yes
- ○ No

If yes, please explain:

____

18. Have you had any of these cardiovascular diseases? Select all that apply.

- ☐ Myocardial infarction
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Bypass surgery
- ☐ Coronary artery disease

19. Do you have Diabetes? If so, what type?

- ○ Type I
- ○ Type II
- ○ Juvenile

20. Do you have any stomach/digestive issues? Please select all that apply.

- ☐ Ulcers
- ☐ Reflux
- ☐ IBS

21. Please select all that you have had or currently have:

- ☐ Allergies
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Pain
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cataracts
- ☐ Chest Pain
- ☐ CHF
- ☐ Cold Extremities
- ☐ Constipation
- ☐ COPD/emphysema
- ☐ Cramps
- ☐ CVA (stroke/TIA)
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Diagnosed emotional or mental disorders
- ☐ Dementia/Alzheimer's
- ☐ Dizziness
- ☐ Earaches
- ☐ Epilepsy
- ☐ Excessive Menstruation
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Gallbladder disease/stones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Menstrual Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Liver disease/cirrhosis
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Lung disease
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Nausea/Vomiting
- ☐ Nosebleeds
- ☐ Numbness
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Poor/Excessive Appetite
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Retinal Disease
- ☐ Sciatica
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Congestion or Infection
- ☐ Sleep Problems/Insomnia
- ☐ Skin Sensitivity
- ☐ Smoked
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Vision Problems/Eye Pain
- ☐ Other

If other, please specify:

____

22. Please list current medications (name, amounts, frequency, length of use, reason for use)

	Medication	Dosage	Frequency	Length of use	Reason for taking
1					
2					
3					

23. Please check the frequency of the following lifestyle choices:

	Daily	Weekly	Occasionally	Never
Alcohol				
Diet Food Products				
Energy Products or Over-the-Counter Stimulants				
Fresh & Homemade foods				
Soft Drinks				
Water				
Caffeine Drinks				
Drugs				
Exercise				
Preprocessed, Packaged, & Restaurant Food				
Tobacco				

Family Health History

Many health problems are hereditary in nature and may be handed down generation after generation.

24. Please review the conditions and diseases listed below and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply.

	Age
Mother	
Father	
Spouse	

25.

Brother(s)	Age
1	
2	
3	

26.

Sister(s)	Age
1	
2	
3	

27.

Children	Age
1	
2	
3	

28.

Condition	Father	Mother	Spouse	Brother(s)	Sister(s)	Children(s)
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						

If other, please specify:

___

29. If any of the above family members are deceased, please list their age at death and cause:

____

____

____

____

Functional Rating Index - Neck

For use with NECK COMPLAINTS only.

In order to properly assess your condition, we must understand how much your **neck problems** have affected your ability to manage everyday activities. For each item below, **please select the number which most closely describes your condition right now.**

30.

	0	1	2	3	4
1. Pain Intensity	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
2. Sleeping	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
3. Personal Care (washing, dressing, etc.)	No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; needs some assistance	Severe pain; needs 100% assistance
4. Travel (driving, etc.)	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
5. Work	Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
6. Recreation	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
7. Frequency of pain	No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the pain
8. Lifting	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9. Walking	No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
10. Standing	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Functional Rating Index - Back

For use with BACK COMPLAINTS only.

In order to properly assess your condition, we must understand how much your **back problems** have affected your ability to manage everyday activities. For each item below, **please select the number which most closely describes your condition right now.**

31.

	0	1	2	3	4
1. Pain Intensity	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
2. Sleeping	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
3. Personal Care (washing, dressing, etc.)	No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; needs some assistance	Severe pain; needs 100% assistance
4. Travel (driving, etc.)	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
5. Work	Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
6. Recreation	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
7. Frequency of pain	No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the pain
8. Lifting	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9. Walking	No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
10. Standing	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Oswestry Low Back Pain Disability Questionnaire

The Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) is an extremely important tool that researchers and disability evaluators use to measure a patient's permanent functional disability. The test is considered the 'gold standard' of low back functional outcome tools.

32. This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by choosing ONE circle in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just mark the answer that indicates the statement which most clearly describes your problem.

	0	1	2	3	4	5
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 the worst 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 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 placed eg. 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
Section 4 — Walking*	Pain does not prevent me 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 than 100 yards	I can only walk using a stick or crutches	I am in bed most of the time

Section 5—Sitting	I can sit in any chair as long as I like	I can only sit in my favourite chair as long as I like	Pain prevents me sitting more than one hour	Pain prevents me from sitting more than 30 minutes	Pain prevents me from sitting more than 10 minutes	Pain prevents me from sitting at all
Section 6—Standing	I can stand as long as I want without extra pain	I can stand as long as I want but it gives me extra pain	Pain prevents me from standing for more than 1 hour	Pain prevents me from standing for more than 30 minutes	Pain prevents me from standing for more than 10 minutes	Pain prevents me from standing at all
Section 7—Sleeping	My sleep is never disturbed by pain	My sleep is occasionally disturbed by pain	Because of pain I have less than 6 hours sleep	Because of pain I have less than 4 hours sleep	Because of pain I have less than 2 hours sleep	Pain prevents me from sleeping at all
Section 8—Sex life (if applicable)	My sex life is normal and causes no extra pain	My sex life is normal but causes some extra pain	My sex life is nearly normal but is very painful	My sex life is severely restricted by pain	My sex life is nearly absent because of pain	Pain prevents any sex life at all
Section 9—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 has no significant effect on my social life apart from limiting my more energetic interests eg, sport	Pain has restricted my social life and I do not go out as often	Pain has restricted my social life to my home	I have no social life because of pain
Section 10—Travelling	I can travel anywhere without pain	I can travel anywhere but it gives me extra pain	Pain is bad but I manage journeys over two hours	Pain restricts me to journeys of less than one hour	Pain restricts me to short necessary journeys under 30 minutes	Pain prevents me from travelling except to receive treatment

Scoring Instructions:

For each section the total possible score is 5: If the first statement is marked, the section score is 0; if the last statement is marked, it is 5.

If all 10 sections are completed the score is calculated as follows:

Example:

- 16 (total scored)
- 50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

- 16 (total scored)
- 45 (total possible score) x 100 = 35.5%

Minimum detectable change (90% confidence): 10% points (change of less than this may be attributable to error in the measurement)

Interpretation of Scores:

- **0% to 20%—minimal disability**: The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting sitting and exercise.
- **21%-40%—moderate disability**: The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means.
- **41%-60%—severe disability**: Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.
- **61%-80%—crippled**: Back pain impinges on all aspects of the patient's life. Positive intervention is required.
- **81%-100%**: These patients are either bed-bound or exaggerating their symptoms.

SF-36 Questionnaire

Please answer the 36 questions of the Health Survey completely, honestly, and without interruptions

33. General Health:

In general, would you say your health is:
○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

Compared to one year ago, how would you rate your health in general now?
○ Much better now than one year ago ○ Somewhat better now than one year ago ○ About the same
○ Somewhat worse now than one year ago ○ Much worse than one year ago

34. **Limitations of Activities—The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.			
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
Lifting or carrying groceries			
Climbing several flights of stairs			
Climbing one flight of stairs			
Bending, kneeling, or stooping			
Walking more than a mile			
Walking several blocks			
Walking one block			
Bathing or dressing yourself			

35. **Physical Health Problems—During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

	Yes	No
Cut down the amount of time you spent on work or other activities		
Accomplished less than you would like		
Were limited in the kind of work or other activities		
Had difficulty performing the work or other activities (for example, it took extra effort)		

36. **Emotional Health Problems—During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

	Yes	No
Cut down the amount of time you spent on work or other activities		
Accomplished less than you would like		
Didn't do work or other activities as carefully as usual		

37. **Social Activities:**

Emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
○ Not at all ○ Slightly ○ Moderately ○ Severe ○ Very severe

38. **Pain:**

How much bodily pain have you had during the past 4 weeks?
○ None ○ Very mild ○ Mild ○ Moderate ○ Severe ○ Very severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

39. **Energy and Emotions—These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling.**

	All of the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	None of the time
Did you feel full of pep?						
Have you been a very nervous person?						
Have you felt so down in the dumps that nothing could cheer you up?						
Have you felt calm and peaceful?						
Did you have a lot of energy?						
Have you felt downhearted and blue?						
Did you feel worn out?						
Have you been a happy person?						
Did you feel tired?						

40. **Social Activities:**

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
○ All of the time ○ Most of the time ○ Some of the time ○ A little bit of the time ○ None of the time

41. **General Health—How true or false is each of the following statements for you?**

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
I seem to get sick a little easier than other people					
I am as healthy as anybody I know					
I expect my health to get worse					
My health is excellent					

Medical Symptoms Questionnaire (MSQ)

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

42. Head:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Headaches					
Faintness					
Dizziness					
Insomnia					

43. Eyes:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Watery or itchy eyes					
Swollen, reddened or sticky eyelids					
Bags or dark circles under eyes					
Blurred or tunnel vision (does not include near or far-sighted)					

44. Ears:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Itchy ears					
Earaches, ear infections					
Drainage from ear					
Ringing in ears, hearing Loss					

45. Nose:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Stuffy nose					
Sinus problems					
Hay fever					
Sneezing attacks					
Excessive mucus formation					

46. Mouth/Throat:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Chronic coughing throat					
Gagging, frequent need to clear throat					
Sore throat, hoarseness, loss of voice					
Swollen or discolored tongue, gums, or lips					
Canker sores					

47. Skin:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Acne					
Hives, rashes, dry skin					
Hair loss					
Flushing, hot flashes					
Excessive sweating					

48. Heart:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Irregular or skipped heartbeat					
Rapid or pounding heartbeat					
Chest pain					

49. Lungs:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Chest congestion					
Asthma, bronchitis					
Shortness of breath					
Difficulty breathing					

50. Digestion:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Nausea, vomiting					
Diarrhea					
Constipation					
Bloated feeling					
Belching, passing gas					
Heartburn					
Intestinal/stomach pain					

51. Joints/Muscles:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Pain or aches in joints muscles					
Arthritis					
Stiffness or limitation of movement					
Pain or aches in muscles					
Feeling of weakness or tiredness					

52. Weight:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Binge eating/drinking					
Craving certain foods					
Excessive weight					
Compulsive eating					
Water retention					
Underweight					

53. Energy/Activity:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Fatigue, sluggishness activity					
Apathy, lethargy					
Hyperactivity					
Restlessness					

54. Mind:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Poor memory					
Confusion, poor comprehension					
Poor concentration					
Poor physical condition					
Difficulty in making decisions					
Stuttering or stammering					
Slurred speech					
Learning disabilities					

55. Emotions:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Mood swings					
Anxiety, fear, nervousness					
Anger, irritability, aggressiveness					
Depression					

56. Other:

	Never or almost never have the symptom	Occasionally have it, effect is not severe	Occasionally have it, effect is severe	Frequently have it, effect is not severe	Frequently have it, effect is severe
Frequent illness					
Frequent or urgent urination					
Genital itch or discharge					

Health Satisfaction Score (HSS)

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

57. Section 1—Physical Health:

	1 Absolutely disagree	2	3	4	5	6	7	8	9	10 Absolutely agree
I am a physically fit person and formally exercise on a regular basis.										
I have a physically attractive body that I am proud to look at in the mirror.										
I have not had many traumas in my life (auto accident, broken bones, bad falls).										
I get at least 7 hours of sleep, 7 days at week.										
I have gotten regular Chiropractic care within the past 5 years.										

58. Section 2—Emotional/Mental Health:

	1 Absolutely disagree	2	3	4	5	6	7	8	9	10 Absolutely agree
I am a calm, peaceful person. I can shut my mind off and focus my mind at will.										
I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis.										
Most of the time, I am truly happy and feel a sense of purpose in my life.										
I have healthy relationships and a rich social network of friends and activities.										
I am organized, have time for myself, and can prioritize the important tasks in my life.										

59. Section 3—Chemical/Nutritional Health:

	1 Absolutely disagree	2	3	4	5	6	7	8	9	10 Absolutely agree
I eat 4-6 small meals daily and properly combine my protein, carbs. and fats.										
I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).										
I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.										
I do not smoke cigarettes.										
I drink water as my primary beverage and consume at least 30 ounces per day.										

60. By signing below, I hereby certify that the above information is true and correct to the best of my knowledge, and that I am the above-named patient or the duly authorized general agent of the above-named patient.

Patient or Legal Representative

____
Signature

SUPPLEMENTAL HEALTH QUESTIONNAIRE

Chiropractic Treatment in the Era of COVID-19

If you have been exposed to a communicable disease, you may spread the disease to the chiropractor, chiropractic staff or other patients/parents in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission:

61.

	0	1	2	3	4
1. Pain Intensity	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
2. Sleeping	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
3. Personal Care (washing, dressing, etc.)	No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; needs some assistance	Severe pain; needs 100% assistance
4. Travel (driving, etc.)	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
5. Work	Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
6. Recreation	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
7. Frequency of pain	No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the pain
8. Lifting	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9. Walking	No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
10. Standing	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

62. **Do you, your child, others accompanying you today or anyone else you have recently been in contact with have any of the following symptoms?**

	Yes	No
Fever (defined as above 100.4º)		
Chills		
Cough		
Sore throat		
Shortness of breath and/or trouble breathing		
Persistent muscle pain, pressure, or tightness in the chest		
New loss of taste or smell		

63. **Have you or others accompanying you to today's appointment traveled outside of our local area or outside of the US within the past 14 days?**

- ○ Yes
- ○ No

64. **Have you, your child, or others accompanying you today or anyone you have recently been in contact with tested positive for or been diagnosed as having COVID-19 or any other communicable disease?**

- ○ Yes
- ○ No

65. If yes, provide approximate date of illness: ____________________ through: ____________________

66. ☐ I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's chiropractic appointment to a later date.

Patient or Legal Representative

______________________________ ____________________
Signature Date