MISSION CHIROPRACTIC FAMILY CENTER NEW PATIENT INTAKE FORM

11245 N. Mission Rd; Clare, MI 48617; (989) 386-5437

PERSONAL HISTORY

NAME: _____ BIRTHDATE: _____ AGE: _____ SEX: *M F*

ADDRESS:_____ APT #_____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

MARITAL STATUS: *SINGLE MARRIED DIVORCED WIDOWED* CHILDREN #:____ OCCUPATION: _____

BUSINESS/EMPLOYER: _____ BUS. PHONE: _____

STUDENT STATUS: *FULL-TIME PART-TIME NON-STUDENT* COLLEGE NAME: _____

INSURANCE? YES NO 1º COMPANY:_____ 2º COMPANY: _____

POLICYHOLDER NAME:_____ POLICYHOLDER BIRTHDATE: _____

PRIMARY CARE PROVIDER (full name & phone#):_____

HOW/WHO REFERRED YOU TO THIS OFFICE: _____ RELATIONSHIP:_____

PAST HEALTH HISTORY

MAJOR SURGERIES & PROCEDURES: Include date/year to all that apply

Tonsillectomy _____ Gall Bladder_____ Neck_____ Back_____ Ear Tubes_____ Appendix_____

Female organs_____ Sinus_____ Rectal surgery_____ Hernia_____ Thyroid_____ Stomach_____

Spinal Injections/Taps:Region:_____ Date:_____ Other: Type:_____ Date:_____

MAJOR ACCIDENTS/INJURIES: Include date/year & treatment provided to all that apply

Car: _____

Motorcycle: _____

Buggy: _____

Sports: _____

Slip/Fall: _____

Fractures: _____

Dislocation: _____

Other: _____

CURRENT HEALTH CONDITION(S)

List all your CURRENT COMPLAINTS in order of severity:

_____

_____

_____

Date of Injury/Exacerbation: _____

What happened:_____

_____

Where did it happen?_____

Other doctor(s) seen for these complaints:

_____

Last chiropractic treatment (who &when):

_____

Type of treatment rendered and results:

_____

What makes your complaints better:_____

_____

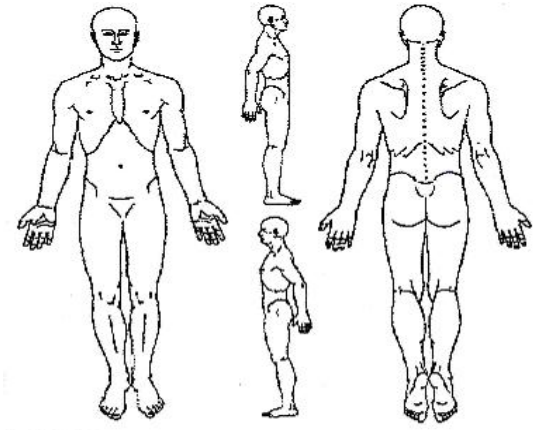
What makes your complaints worse:_____

_____

How often do your complaints occur:

CONSTANT FREQUENT OCCASIONAL COMES & GOES

MARK AREAS OF PAIN ON PICTURES BELOW
CIRCLE TYPES OF PAIN & DURATION FROM THE KEY



Types of Pain

A=Achy pain
B=Burning pain
D=Dull pain
F=Stiffness/Pulling
H=Sharp pain
N=Numbness
P=pins & needles
R=Radiates/Travels
S=Stabbing pain
T=Tingling
Δ=Bruising

CURRENT MEDICATIONS (List all meds & dosages OR provide a copy of all your current prescriptions):

_____

CIRCLE ANY COMPLAINTS YOU HAVE HAD IN THE PAST SIX MONTHS:

GENERAL SYMPTOMS

___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Loss of Balance
___ Convulsions
___ Loss of sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Allergies (Type: _____)
___ Wheezing
___ Nerve Pain/Neuralgia
___ Loss of Memory/Concentration
___ Anxiety or Depression

GASTRO-INTESTINAL

___ Poor appetite
___ Poor Digestion
___ Excessive hunger or thirst
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Pain over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids
___ Liver Trouble
___ Jaundice
___ Gout
___ Gall Bladder Trouble
___ Hernia (type: _____)

EYE/EAR/NOSE/THROAT

___ Poor Vision
___ Crossed eyes
___ Pain in eyes
___ Deafness or Hearing Loss
___ Ear Noises
___ Earache
___ Ear Discharges
___ Nasal Obstruction
___ Nosebleeds
___ Sore throat
___ Hoarseness
___ Frequent colds
___ Sinusitis/Sinus trouble
___ Tonsilitis

SKIN

___ Skin Erruptions
___ Itching
___ Bruising easily
___ Dryness
___ Boils
___ Sensitive skin
___ Hives or skin allergy
___ Eczema or Psoriasis

MUSCLE & JOINTS

___ Stiffness (where:_____)
___ Neck pain
___ Upper back pain
___ Low back pain
___ Hip pain
___ Pain over tailbone
___ Nerve pain (where:_____)
___ Swollen joints
___ Tremors
___ Foot troubles
___ Weakness
___ Twitching
___ Carpal tunnel (L or R or B)
___ Scoliosis/Spinal Curvature

CARDIO-VASCULAR

___ Irregular Heart rate (Slow or Fast)
___ Low blood pressure
___ High blood pressure
___ Previous heart trouble or attack
___ Palpitations
___ Chest pain
___ Pain over heart
___ Poor circulation
___ Varicose veins
___ Previous stroke (when:_____)

GENITO-URINARY

___ Bedwetting
___ Frequent or infrequent urination
___ Infection
___ Painful urination
___ Impotence
___ Blood in urine
___ Kidney problems/infection

RESPIRATORY

___ Chronic cough
___ Difficulty breathing
___ Spitt/Coughing blood
___ Spit/Coughing phlegm
___ Chest pain

WOMEN ONLY

___ Menopause
___ Painful periods
___ Irregular periods/cycles
___ Excessive flow
___ Hot flashes
___ Cramping
___ Vaginal discharge
___ Miscarriage (when: _____)
Currently Pregnant (due date:_____)
Last PAP Smear (Date: _____)
Last period (Date: _____)

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

___ Appendicitis
___ Measles
___ Mumps
___ Chicken pox
___ Shingles
___ Alcoholism
___ Venereal infection
___ Influenza
___ Arthritis
___ Pneumonia
___ Rheumatic fever
___ Polio
___ Tuberculosis
___ Whooping cough
___ Diabetes
___ Cancer (type/stage:_____)
___ Epilepsy
___ Mental disorder
___ Lumbago
___ Asthma
___ Goiter
___ Anemia
___ Heart Disease

FAMILY HISTORY

___ Diabetes (Who: _____)
___ Heart (Who: _____)
___ Kidney (Who: _____)
___ Cancer (Who: _____)
___ Arthritis (Who: _____)
___ Scoliosis (Who: _____)
___ Other (What & Who: _____)

PERSONAL HABITS

SMOKING(check one) ___ packs/day
DRINKING/ALCOHOL ___ drinks/day
COFFEE ___ cups/day
EXERCISE (circle one) None Moderate Daily

I understand that the information provided will be used for the sole purpose of diagnosis and treatment by Mission Chiropractic Family Center and will remain confidential. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand this office will prepare any necessary reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my treatment, I am responsible for all uncovered services rendered me, requiring immediate payment. I understand Mission Chiropractic Family Center has a 2% recurring late fee that will be administered to all charges over 30 days past due and can turn my account over to a collections agency after 90 days past due. By signing this form, I consent to receive treatment today from Mission Chiropractic Family Center.

Patient/Authorized Representative's Signature: _____ Date: _____

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