



Patient Information Form

The following information is needed in order to better serve you. Please complete all questions.

First Name _____	Middle Name _____	Last Name _____
Nick Name _____		SSN _____

Email _____
 Send me appointment confirmations
 Send me office news and updates
Address _____
City _____
State _____ Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____

Gender Male Female
Birth Date _____
Occupation _____
Employer _____
Employers Address _____

Marital Status Married Single Divorced

How did you hear about us? Self-Referral Screening ECSC Website
 Yelp / Google Online Deal Insurance Website
 Existing Patient _____

Spouse's Name _____ Phone Number _____ Occupation _____
Spouse's Employer _____ Employer's Phone Number _____
Employer's Address _____



Patient Condition Form

The following information is needed in order to better serve you. Please complete all questions.

Please describe your main complaint and when this problem started:

<p>Which of the following makes the symptoms better?</p> <ul style="list-style-type: none"> <input type="radio"/> Rest <input type="radio"/> Medication <input type="radio"/> Sitting <input type="radio"/> Laying down <input type="radio"/> Standing <input type="radio"/> Other _____ <ul style="list-style-type: none"> <input type="radio"/> Heat <input type="radio"/> Stretching <input type="radio"/> Ice <input type="radio"/> Walking <input type="radio"/> Movement 	<p>Which of the following makes the symptoms worse?</p> <ul style="list-style-type: none"> <input type="radio"/> Rest <input type="radio"/> Medication <input type="radio"/> Sitting <input type="radio"/> Laying down <input type="radio"/> Standing <input type="radio"/> Other _____ <ul style="list-style-type: none"> <input type="radio"/> Heat <input type="radio"/> Stretching <input type="radio"/> Ice <input type="radio"/> Walking <input type="radio"/> Movement
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Describe your pain or symptoms	How often do you experience your symptoms?	Do the symptoms radiate anywhere?	How severe are the symptoms?	When do you experience symptoms?
<input type="radio"/> Sharp	<input type="radio"/> Constant (100-75%)	<input type="radio"/> Neck	<input type="radio"/> Minimal	<input type="radio"/> Morning
<input type="radio"/> Achy	<input type="radio"/> Frequent (74-50%)	<input type="radio"/> Shoulder	<input type="radio"/> Mild	<input type="radio"/> Afternoon
<input type="radio"/> Burning	<input type="radio"/> Intermittent (49%-25%)	<input type="radio"/> Arm	<input type="radio"/> Moderate	<input type="radio"/> Evening
<input type="radio"/> Stabbing	<input type="radio"/> Occasional (24-1%)	<input type="radio"/> Fingers	<input type="radio"/> Severe	<input type="radio"/> All the time
<input type="radio"/> Pin/Needles		<input type="radio"/> Leg		<input type="radio"/> Sporadically
<input type="radio"/> Fatigue		<input type="radio"/> Knee		
<input type="radio"/> Dizziness		<input type="radio"/> Ankle		
<input type="radio"/> Dull		<input type="radio"/> Toes		
<input type="radio"/> Other: _____				
When was the last time you experienced this? _____				
Is the condition:	<input type="radio"/> Improving	<input type="radio"/> Staying the same	<input type="radio"/> Worsening	

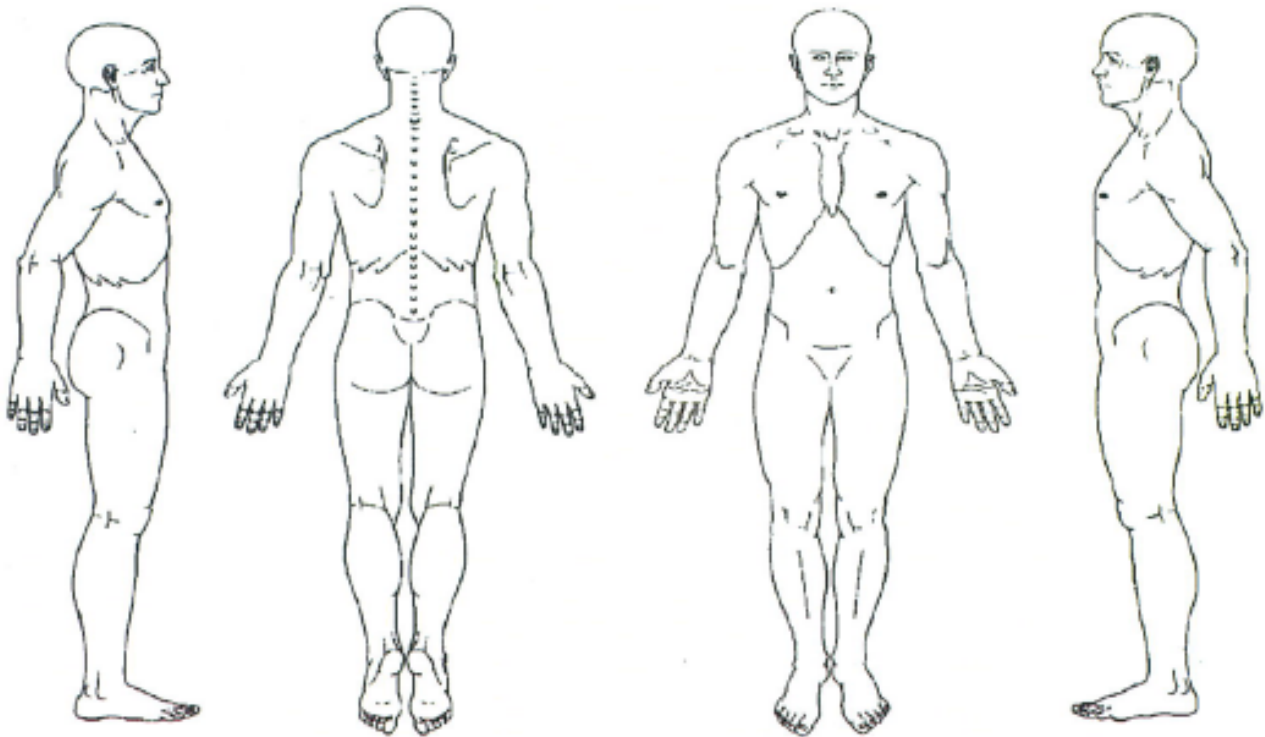


Patient Symptom Diagram

Indicate the location and type of symptoms that you are experiencing

Please mark on the diagram the following

Numbness = = = = =	Burning x x x x x
Pins/Needles o o o o o	Stabbing / / / / /
^ ^ ^ ^ ^	Aching a a a a a
(Please describe the symptom)	



Please indicate the region of pain (ie. shoulder, legs, etc.) and its severity, with 10 being incapacitated

1 2 3 4 5 6 7 8 9 10
 Region:

1 2 3 4 5 6 7 8 9 10
 Region:

1 2 3 4 5 6 7 8 9 10
 Region:

1 2 3 4 5 6 7 8 9 10
 Region:

Oswestry Disability Index

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 but it is very painful.
- I can look after myself normally but it is very painful.
- 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 my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, 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 positioned (i.e. 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 only 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 walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for 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 more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- 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 cause 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, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No
- Yes (if yes, please state the type of treatment you have received)

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

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

Section 4 – Reading

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

Section 5 – Headaches

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

Section 6 – Concentration

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

Section 7 – Work

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

Section 8 – Driving

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

Section 9 – Sleeping

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

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

0-4	No disability
5-14	Mild disability
15-24	Moderate disability
25-34	Severe disability
> 35	Complete disability



Please check the conditions you have or have had in the last year:

- | | | | | |
|---------------------------------|------------------------------------|--|---|---|
| <input type="radio"/> AIDS | <input type="radio"/> Cancer | <input type="radio"/> Diabetes | <input type="radio"/> High Blood Pressure | <input type="radio"/> Parkinson's Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Epilepsy | <input type="radio"/> Hypoglycemia | <input type="radio"/> Chronic Fatigue | <input type="radio"/> Depression |
| <input type="radio"/> Arthritis | <input type="radio"/> Polio | <input type="radio"/> Fibromyalgia | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Stroke | <input type="radio"/> Tuberculosis | <input type="radio"/> Rheumatoid Arthritis | | |

Please check the conditions you have or have had in the past six (6) months:

General History

- Trauma/Injuries
- Weight changes
- Fever/Chills/Sweats
- HIV Positive
- Allergies
- Anemia
- Bleeding/Bruising
- Malaise/Fatigue/Weakness

Family History

- Diabetes
- Thyroid disease
- Tuberculosis
- Kidney disease
- High blood pressure
- Heart disease/Stroke
- Musculoskeletal disease
- Cancer

Endocrine System

- Heat/Cold Intolerance
- Thyroid problems
- Diabetes
- Hormone Therapy

Eye/Ear/Nose/Throat

- Visual problems
- Eye irritation
- Pain in eyes
- Other eye problems
- Difficulty hearing / Deaf
- Ringing in the ears
- Dizziness
- Ear pain
- Nosebleeds
- Change in ability to smell
- Nose pain
- Sinusitis
- Other nose problems
- Difficulty swallowing
- Enlarged/Painful glands

Gastrointestinal System

- Change in appetite
- Food intolerance
- Nausea/Vomiting
- Indigestion/Heartburn
- Abdominal pain
- Abdominal swelling
- Gas
- Diarrhea/Constipation
- Hernia
- Gallbladder problems
- Liver disease
- Pancreatitis

Respiratory System

- Difficulty breathing
- Cough
- Wheezing/Asthma
- Tuberculosis/Exposure
- Pneumonia/Lung infection
- Cigarette smoking
- Toxic fume exposure



Please check the conditions you have or have had in the past six (6) months:

Cardiovascular System

- Shortness in breath
- Chest discomfort / Pain
- Palpitations
- Edema / Swelling
- Fainting
- Calf pain while walking
- High blood pressure
- Heart disease
- Cardiovascular surgeries
- Other problems _____

Urinary System

- Frequent urination
- Painful urination
- Changes in color
- Difficulty starting
- Difficulty holding
- Discharge
- Urinary tract infections
- Kidney disease
- Flank pain
- Pelvic pain
- Pelvic mass
- Other problems _____

Reproductive System

- Change in sex drive
- Pain during sex
- Birth control
- Other sexual difficulties

Neurological System

- Headaches
- Epileptic seizures
- Tics / Spasms
- Dizziness / Fainting
- Disturbances of sensation
- Unusual weakness
- Head trauma
- Stroke
- Other problems _____

Psychology History

- Anxiety
- Depression
- Hospitalization / Therapy
- Other problems _____

Musculoskeletal System

- Joint stiffness
- Joint pain
- Joint swelling
- Muscle cramps
- Muscle weakness
- Muscle wasting
- Neck pain
- Mid back pain
- Low back pain
- Sacroiliac pain
- Tailbone pain
- Arm problem
- Leg problem
- Fractures / Dislocations
- Sprains / Strains
- Other injuries

Examiner's Notes



Please fill out all applicable fields:

List any traumas and their dates (especially any head and neck injuries):

List any broken bones or dislocations:

List all surgeries and their dates:

Have you ever been unconscious, if so please explain:

List any other doctors seen, treatments, and results obtained: