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:

Which of the following makes the symptoms better?

- ○ Rest
- ○ Medication
- ○ Sitting
- ○ Laying down
- ○ Standing
- ○ Other _____
- ○ Heat
- ○ Stretching
- ○ Ice
- ○ Walking
- ○ Movement

Which of the following makes the symptoms worse?

- ○ Rest
- ○ Medication
- ○ Sitting
- ○ Laying down
- ○ Standing
- ○ Other _____
- ○ Heat
- ○ Stretching
- ○ Ice
- ○ Walking
- ○ Movement

Describe your pain or symptoms

- ○ Sharp
- ○ Achy
- ○ Burning
- ○ Stabbing
- ○ Pin/Needles
- ○ Fatigue
- ○ Dizziness
- ○ Dull
- ○ Other: _____

How often do you experience your symptoms?

- ○ Constant (100-75%)
- ○ Frequent (74-50%)
- ○ Intermittent (49%-25%)
- ○ Occasional (24-1%)

Do the symptoms radiate anywhere?

- ○ Neck
- ○ Shoulder
- ○ Arm
- ○ Fingers
- ○ Leg
- ○ Knee
- ○ Ankle
- ○ Toes

How severe are the symptoms?

- ○ Minimal
- ○ Mild
- ○ Moderate
- ○ Severe

When do you experience symptoms?

- ○ Morning
- ○ Afternoon
- ○ Evening
- ○ All the time
- ○ Sporadically

When was the last time you experienced this? _____

Is the condition: ○ Improving ○ Staying the same ○ Worsening

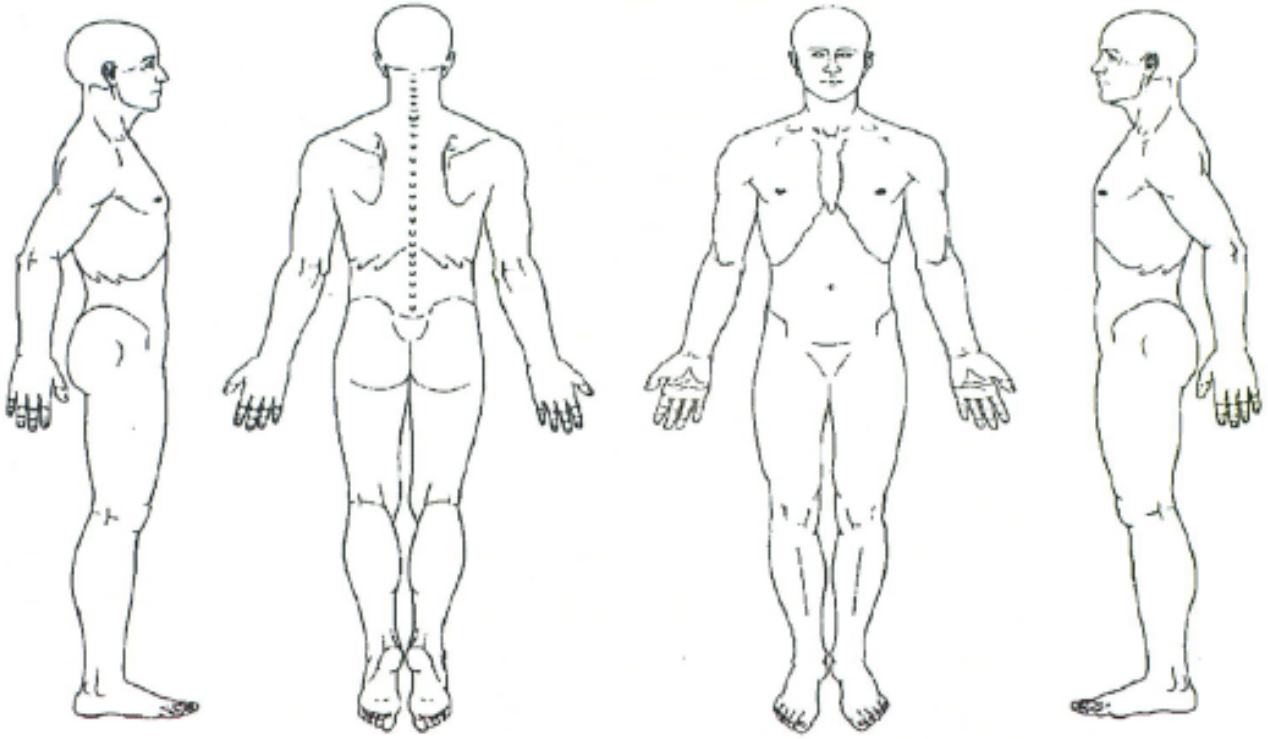
Patient Symptom Diagram

Indicate the location and type of symptoms that you are experiencing

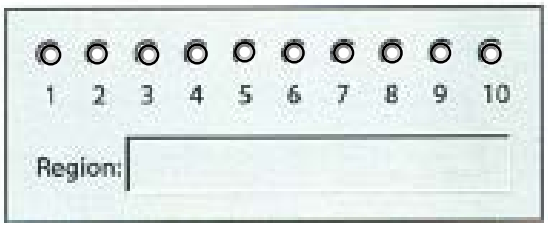
Please mark on the diagram the following

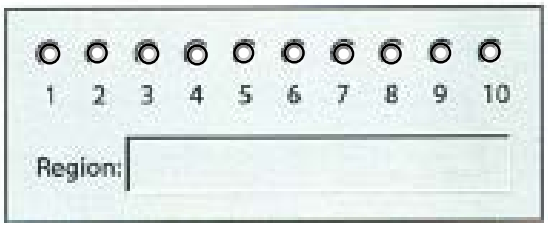
Numbness	= = = = =	Burning	x x x x x
Pins/Needles	o o o o o	Stabbing	/ / / / /
_____	^ ^ ^ ^ ^	Aching	a a a a a

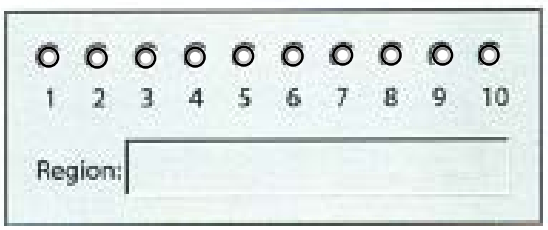
(Please describe the symptom)

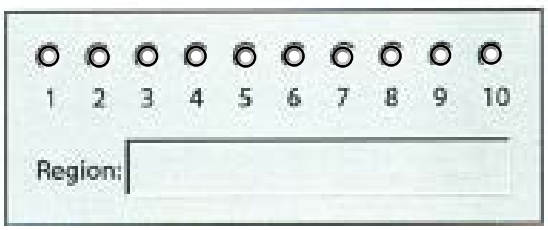


Please indicate the region of pain (ie. shoulder, legs, etc.) and its severity, with 10 being incapacitated









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 1mile.
- 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 limitingmy 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:

○ AIDS	○ Cancer	○ Diabetes	○ High Blood Pressure	○ Parkinson's Disease
○ Anemia	○ Epilepsy	○ Hypoglycemia	○ Chronic Fatigue	○ Depression
○ Arthritis	○ Polio	○ Fibromyalgia	○ Multiple Sclerosis	○ Rheumatic Fever
○ Stroke	○ Tuberculosis	○ Rheumatoid Arthritis		

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

General History

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

Family History

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

Endocrine System

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

Eye/Ear/Nose/Throat

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

Gastrointestinal System

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

Respiratory System

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

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

Cardiovascular System

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

Urinary System

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

Reproductive System

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

Neurological System

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

Psychology History

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

Musculoskeletal System

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

Examiner's Notes

Patient Health History

Use this space to further describe any of the conditions/symptoms listed previously or any condition other than that for which you are now consulting us:

For female patients only:

Menarche (1st period) Age _____ Year _____ Days in cycle: _____

Menstrual Cramping Pain
0 1 2 3 4 5

Menstrual Flow:
Scant ☐ Light ☐
Moderate ☐ Heavy ☐

Duration: _____

☐ Post-Menopausal bleeding ☐ Abdominal/Painful premenstrual fluid retention ☐ Other female problems

☐ Difficult delivery ☐ PMS ☐ Hysterectomy

Please list all medications you are currently taking (prescription or OTC) and the reason for taking them):

Name of medication:	Reason for taking medication:

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:

Emerald City
Spinal Care

Patient Legal Name		Ethnicity	
Today's Date	Date of Birth		
Address		Age	Gender
Height Weight Email		Cell Number	

Supplements: Please list the supplements and vitamins you currently take.

	SUPPLEMENT	DOSE	FREQUENCY	START DATE (MM/YR)	REASON FOR USE
1.					
2.					
3.					
4.					
5.					

Medications: Please list the **Prescribed AND Over-the-Counter** medications you currently take.

	MEDICATION	DOSE	FREQUENCY	START DATE (MM/YR)	REASON FOR USE
1.					
2.					
3.					
4.					
5.					

Previous Diagnosis: Please list the Medical Conditions you have been diagnosed with including cancer and autoimmune disease.

	CONDITION	YEAR DIAGNOSED		CONDITION	YEAR DIAGNOSED
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

General:

	YES	NO	
Pregnant or breastfeeding?	○	○	If yes, how far along are you?
Was your gallbladder removed?	○	○	If yes, when was it removed?
Was your thyroid removed?	○	○	If yes, why was it removed?
Are you a Vegan/Vegetarian?	○	○	If yes, which one?

Beginning Date of Last Menstrual Cycle

Please list any known allergies (food/medication/environment)