

Northern Lights Chiropractic

1116 Arsenal Street, Watertown, NY 13601 Tel: (315) 782-7166; Fax: (315) 782-0978

CONFIDENTIAL PATIENT QUESTIONNAIRE

Today's Date: _____

Dear Patient:

In order for us to better help you, we need this important confidential questionnaire answered completely by you for your health care. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for your health! Thank you.

Name _____ E-Mail _____ Prefer to be called _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Cell Phone _____
 Sex M F Marital Status Single Married Widowed Divorced Age _____ Date of Birth _____
 Occupation _____ Employer _____ Years Employed _____
 Employer's Address _____ City _____ State _____ Work Phone _____
 Spouse's Name _____ Occupation _____ Number of Children _____
 NCOIC Name: _____ Phone _____

Have you ever had Chiropractic Acupuncture care before? YES NO Name: _____ For what problem? _____
 What type of care/treatment are you seeking from this clinic? Chiropractic Massage Spinal Decompression Whatever Helps
 How were you referred to this clinic: Newspaper Ads Yellow pages Friend Sign Mall Kiosk Free Screening Raffle Talk
 TV Radio Other _____

What have you heard or experienced positive about chiropractic? _____
 What have you heard or experienced negative about chiropractic? _____

What is your major complaint for which you came to our clinic? _____

Other complaints: _____
 When was the very last episode of symptoms/discomforts experienced? _____

Please describe in detail how your present illness developed/started from first sign and/or symptom to the present (include time, place, reasons, courses, mode, results, etc.) _____

Have you done anything to try to help or relieve your complaint? Such as rest, heat, cold, aspirin, medication, sit, lie down, or other.
 YES NO If yes, please describe in detail: _____

Are your symptoms the result of an auto accident, work-related injury or other personal injury (slip and fall, etc.)? YES NO
 If you answered yes, please fill out accident specific form, available at the front desk.

General Symptoms—are you or have you experienced any of the following in the last six months:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache (___x week/___x month) | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Ears Ringing |
| <input type="checkbox"/> Migraine (___x week/___x month) | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Eating Disorder | |
| <input type="checkbox"/> Sciatica Rt/Lt/Both | <input type="checkbox"/> Weight Trouble | Stresses in your life: |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Pins & Needles (legs/feet) | <input type="checkbox"/> Childhood Stress |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles (arm/hand) | <input type="checkbox"/> Personal Stress |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness (fingers/feet) | <input type="checkbox"/> Relationship Stress |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other types of Stress _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold Hands | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold Feet | |

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Patient Name: _____ DOB: _____

Primary Complaint: _____ What causes it? _____

O: How long have you had this condition? _____ Did pain begin? Gradual Sudden

P: What makes your condition Worse or Better? (put W or B in appropriate area)

____ sitting ____ standing ____ lying down ____ bending

____ lifting ____ walking ____ Other

Q: What type of pain do you have? (check all that apply)

____ sharp ____ stabbing ____ aching ____ dull ____ radiating

____ numbing ____ burning ____ pins and needles ____ Other

R: Where does your pain radiate to? (check all that apply)

____ right shoulder ____ arm ____ elbow ____ hand

____ left shoulder ____ arm ____ elbow ____ hand

____ right buttock ____ hip ____ leg ____ knee ____ foot

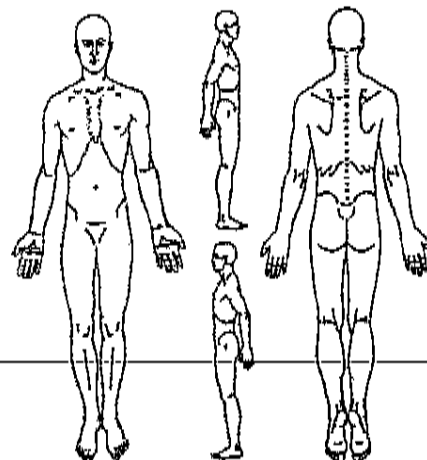
____ left buttock ____ hip ____ leg ____ knccc ____ foot

T: Is your pain? (check all that apply)

What is your pain/discomfort like today? 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

What is your least pain/discomfort? 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

What is your worst pain/discomfort? 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



Please mark areas of your complaint.

How much time during an average day are you in pain/discomfort?

Less than 1 hour per day

Between 4 and 8 hours per day

Almost any time when not lying down

Between 1 and 4 hours per day

Almost 24 hours per day

Other _____

Is your sleep disturbed by these symptoms? YES NO

Secondary Complaint: _____ What causes it? _____

O: How long have you had this condition? _____ Did pain begin? Gradual Sudden

P: What makes your condition Worse or Better? (put W or B in appropriate area)

____ sitting ____ standing ____ lying down ____ bending ____ lifting ____ walking ____ Other

Q: What type of pain do you have? (check all that apply)

____ sharp ____ stabbing ____ aching ____ dull ____ radiating ____ numbing ____ burning ____ pins and needles ____ Other

R: Where does your pain radiate to? (check all that apply)

____ right shoulder ____ arm ____ elbow ____ hand

____ left shoulder ____ arm ____ elbow ____ hand

____ right buttock ____ hip ____ leg ____ knccc ____ foot ____ left buttock ____ hip ____ leg ____ knccc ____ foot

T: Is your pain? (check all that apply)

What is your pain/discomfort like today? 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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How much time during an average day are you in pain/discomfort?

Less than 1 hour per day

Between 4 and 8 hours per day

Almost any time when not lying down

Between 1 and 4 hours per day

Almost 24 hours per day

Other _____

Is your sleep disturbed by these symptoms? YES NO

Please describe in detail how your health problem(s) disturbed/bothered you:

Do you have restrictions/limitations or have difficulties in any activities or performance at your home, activities of daily living or recreational activities because of your discomfort/pain? (such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.)

YES NO If yes, please describe in detail: _____

Are you restricted/limited or have difficulties in any activities or performance of your work because of your discomfort/pain?

YES NO If yes, please describe in detail: _____

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Patient Name: _____ DOB: _____

Do you participate in other exercises? (aerobics, walking, jogging, etc.)
 YES NO If yes, what type and how many times per week/month _____

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic?
 YES NO If yes, whom did you see? _____

Doctor's Name: _____ Specialty: _____
Address: _____ City: _____ State: _____ Phone: _____

When were you seen? From _____ to _____ Are you still under this doctor's care? YES NO
Were any of the following taken: X-ray MRI CAT Scan EMG Bone scan Others _____

What was the diagnosis? _____

What types of treatment(s) were received? Please list in detail all the treatments you received from this doctor (include medications, injections, surgeries, physical therapy, exercises, and others) _____

How much were your symptoms/discomforts helped? Please circle. _____ What are you currently doing? _____
No improvement 0-1-2-3-4-5-6-7-8-9-10 Full improvement

Have you seen a physical therapist for this problem?
 YES NO If yes, whom did you see? _____

Name _____ Address: _____

What types of therapies were received? _____
How much were your symptoms/discomforts helped? Please circle. _____
No improvement 0-1-2-3-4-5-6-7-8-9-10 Full improvement

Are you aware of any blood relatives with similar discomforts/problems? YES NO If yes, please describe: _____

Do you have any family history of diseases or death of parents, siblings, or children? (e.g. heart problems, diabetes, asthma, hereditary disease etc.)
 YES NO If yes, please describe and who was it: _____

Have you ever been involved in injuries from the following:

Automobile accident Worker's compensation Personal injuries (slip and fall, etc.)
 YES NO If yes, please list all of them with date, type, and legal status.

INJURY	DATE	SETTLED	NOT SETTLED	ATTORNEY'S NAME

Have you ever been knocked unconscious? YES NO or had a concussion? YES NO How _____ Age _____
What bones have you broken? 1) _____ How _____ Age _____
2) _____ How _____ Age _____

IF AN IMPACT IS STRONG ENOUGH TO DENT METAL, IT CAN CERTAINLY CAUSE SPINE AND NERVOUS SYSTEM DAMAGE WHETHER THAT IMPACT WAS MINOR OR MAJOR.

1) When was your most recent auto accident? Yr: _____ Speed: _____ Impact: Front Driver's Side Passenger's Side Back Roll Spin
 Driver Passenger Details: _____

Was any treatment received? YES NO _____

2) When was the auto accident just before that? Yr: _____ Speed: _____ Impact: Front Driver's Side Passenger's Side Back Roll Spin
 Driver Passenger Details: _____

Was any treatment received? YES NO _____

What accidents occurred at home or elsewhere that haven't been mentioned even if it was many years ago? (sports injuries, falls on ice or stairs, etc.)

- 1) _____ Year _____
- 2) _____ Year _____
- 3) _____ Year _____
- 4) _____ Year _____

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Patient Name: _____ DOB: _____

Please list all **surgeries/operations** you have ever had. Please also list when these were done, where they were done, who the surgeon was, and if you have had any remaining problems associated with these procedures. (Attach separate sheet if necessary.)

DATE	TYPE OF SURGERY	WHERE	SURGEON'S NAME	COMPLICATIONS	REMAINING PROBLEMS

Please list all **medications** (including birth control pills, aspirin, cortisone or vitamins), even if only occasionally, include how often you take the medication, how much you take, and how long you have taken it.

MEDICATION	HOW OFTEN	HOW MUCH	FOR HOW LONG

Are you allergic to anything? (medication, lotion, etc.) YES NO If yes, to what? _____

Do you smoke or use any tobacco products? YES NO If yes, how much & often? _____

Do you drink alcoholic beverages? YES NO If yes, how Much & often? _____

Do you drink caffeinated beverages? YES NO If yes, how much & often? _____

Please mark your level of formal education group:

- Less than High School Some College Advanced Degree
- High School Diploma or GED College Degree Vocational Training in _____

Have you missed any work as a result of this illness/pain?

YES NO If yes, how many days/wecks? _____ Dates of absence: _____ to _____

What type of physical activities or postures does your job involve? (prolonged sitting, standing, bending, computer work, etc.) _____

Women only:

- a. Are you pregnant or think you may be pregnant? YES NO
- b. Date of last menstrual period: _____
- c. Do you or have you suffered from any menstrual disorders? YES NO If yes, please describe _____

Who is filling out this questionnaire? Self Spouse Other _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature: _____ Date _____

Physician's Signature (upon review): _____ Date _____

PHYSICIAN'S NOTES:

HISTORY IS TAKEN FROM: Patient Spouse Other _____

INFORMATION IS: Reliable Not Reliable Satisfactory Not Satisfactory

ADDITIONAL COMMENT: YES NO _____