# CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

**Dr. James W. Brown**
**Chiropractor**
**432 South Main Street**
**Mansfield, Ohio 44907-5002**
**Phone 419-522-4672**
**Fax 419-522-2652**

**Today's Date (MM/DD/YYYY)**

**Have you consulted a chiropractor before?**
○ No ○ Yes

**When?**

**Patient Number** (office use only)

**Whom may we thank for referring you?**

**If so, whom?**

**Age**

**Gender**
○ Male ○ Female

**Birth Date (MM/DD/YYYY)**

**Race**
○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American
○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White
○ Decline to answer

**Ethnicity**
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to specify

**Your Last Name**

**Your Social Security Number**

**Your First Name**

**Your Middle Name (or Initial)**

**Smoking Status (age 13 and over)**
○ Never A Smoker ○ Former Smoker
○ Current Every Day Smoker ○ Current Some Day Smoker
○ Heavy Smoker ○ Light Smoker

**Address**

**Marital Status** ○ Married
○ Single ○ Divorced
○ Widowed ○ Separated

**City** | **State/Province** | **ZIP/Postal Code** | **Preferred Language**

**Home Phone** | **Cell Phone** | **Spouse's Name**

**Email Address** | **Child's Name and Age**

**Emergency Contact** | **Emergency Contact's Phone** | **Child's Name and Age**

**Your Occupation** | **Child's Name and Age**

**Your Employer** | **Work Phone**

**Address**

**May we contact you at work?**
○ Yes ○ No

**City** | **State/Province** | **ZIP/Postal Code**

**Preferred method of contact?**
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

**Primary Care Provider's Name**

**Insurance Carrier** | **Policy Number**

**Insured's Last Name** | **Birth Date (MM/DD/YYYY)**

**Who carries this policy?**
○ Self ○ Spouse ○ Parent

**Insured's First Name** | **Insured's Middle Name (or Initial)**

**Insured's Employer**

**Address**

**City** | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

**Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.**

**Primary Complaint**
The primary symptom that prompted me to seek care today is: _____

**And are the result of (darken circle):**
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

**Onset** (When did you first notice your current symptoms?) _____

**Prior interventions** (What have you done to relieve the symptoms?)
- ○ Prescription medication
- ○ Over-the-counter drugs
- ○ Homeopathic remedies
- ○ Physical therapy
- ○ Surgery
- ○ Other _____
- ○ Acupuncture
- ○ Chiropractic
- ○ Massage
- ○ Ice
- ○ Heat

**Secondary Complaint**
The secondary symptom that prompted me to seek care today is: _____

**And are the result of (darken circle):**
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

**Onset** (When did you first notice your current symptoms?) _____

**Prior interventions** (What have you done to relieve the symptoms?)
- ○ Prescription medication
- ○ Over-the-counter drugs
- ○ Homeopathic remedies
- ○ Physical therapy
- ○ Surgery
- ○ Other _____
- ○ Acupuncture
- ○ Chiropractic
- ○ Massage
- ○ Ice
- ○ Heat

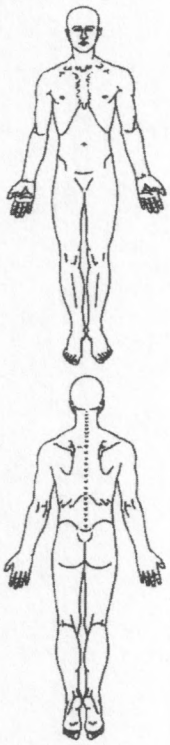
**Additional Complaint**
The additional symptom that prompted me to seek care today is: _____

**And are the result of (darken circle):**
- ○ An accident or injury
  - ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

**Onset** (When did you first notice your current symptoms?) _____

**Prior interventions** (What have you done to relieve the symptoms?)
- ○ Prescription medication
- ○ Over-the-counter drugs
- ○ Homeopathic remedies
- ○ Physical therapy
- ○ Surgery
- ○ Other _____
- ○ Acupuncture
- ○ Chiropractic
- ○ Massage
- ○ Ice
- ○ Heat

**Location**
(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



**1. What else should Dr. Brown know about your current condition?** _____

**2. How does your current condition interfere with your:**

**Work or career:** _____

**Recreational activities:** _____

**Household responsibilities:** _____

**Personal relationships:** _____

**3. Review of Systems**
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

**a. Musculoskeletal**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Osteoporosis | ○ | ○ | Arthritis | ○ | ○ | Scoliosis | ○ | ○ | Neck pain | ○ | ○ | Back problems | ○ | ○ | Hip disorders |
| ○ | ○ | Knee injuries | ○ | ○ | Foot/ankle pain | ○ | ○ | Shoulder problems | ○ | ○ | Elbow/wrist pain | ○ | ○ | TMJ issues | ○ | ○ | Poor posture |

NONE ○ Initials ____

**b. Neurological**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Anxiety | ○ | ○ | Depression | ○ | ○ | Headache | ○ | ○ | Dizziness | ○ | ○ | Pins and needles | ○ | ○ | Numbness |

NONE ○ Initials ____

**c. Cardiovascular**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | High blood pressure | ○ | ○ | Low blood pressure | ○ | ○ | High cholesterol | ○ | ○ | Poor circulation | ○ | ○ | Angina | ○ | ○ | Excessive bruising |

NONE ○ Initials ____

**d. Respiratory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Asthma | ○ | ○ | Apnea | ○ | ○ | Emphysema | ○ | ○ | Hay fever | ○ | ○ | Shortness of breath | ○ | ○ | Pneumonia |

NONE ○ Initials ____

**e. Digestive**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Anorexia/bulimia | ○ | ○ | Ulcer | ○ | ○ | Food sensitivities | ○ | ○ | Heartburn | ○ | ○ | Constipation | ○ | ○ | Diarrhea |

NONE ○ Initials ____

**f. Sensory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Blurred vision | ○ | ○ | Ringing in ears | ○ | ○ | Hearing loss | ○ | ○ | Chronic ear infection | ○ | ○ | Loss of smell | ○ | ○ | Loss of taste |

NONE ○ Initials ____

**g. Skin**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Skin cancer | ○ | ○ | Psoriasis | ○ | ○ | Eczema | ○ | ○ | Acne | ○ | ○ | Hair loss | ○ | ○ | Rash |

NONE ○ Initials ____

_____
**Patient name**

_____
**Patient Number**
**(office use only)**

_____
**Doctor's Initials**

**Dr. James W. Brown**

*(Continued from previous page)*

**h. Endocrine**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Thyroid issues | ○ | ○ | Immune disorders | ○ | ○ | Hypoglycemia | ○ | ○ | Frequent infection | ○ | ○ | Swollen glands | ○ ○ Low energy |

Initials ____

**i. Genitourinary**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Kidney stones | ○ | ○ | Infertility | ○ | ○ | Bedwetting | ○ | ○ | Prostate issues | ○ | ○ | Erectile dysfunction | ○ ○ PMS symptoms |

Initials ____

**j. Constitutional**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Fainting | ○ | ○ | Low libido | ○ | ○ | Poor appetite | ○ | ○ | Fatigue | ○ | ○ | Sudden weight gain/loss (circle one) | ○ ○ Weakness |

Initials ____

**Patient name** _____

**Patient Number** (office use only) _____

○ All other systems negative

## Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

### 4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

| Had | Have | | Had | Have | |
|---|---|---|---|---|---|
| ○ | ○ | AIDS | ○ | ○ | Tuberculosis |
| ○ | ○ | Alcoholism | ○ | ○ | Typhoid fever |
| ○ | ○ | Allergies | ○ | ○ | Ulcer |
| ○ | ○ | Arteriosclerosis | ○ | ○ | Other: _____ |
| ○ | ○ | Cancer | | | _____ |
| ○ | ○ | Chicken pox | | | |
| ○ | ○ | Diabetes | | | |
| ○ | ○ | Epilepsy | | | |
| ○ | ○ | Glaucoma | | | |
| ○ | ○ | Goiter | | | |
| ○ | ○ | Gout | | | |
| ○ | ○ | Heart disease | | | |
| ○ | ○ | Hepatitis | | | |
| ○ | ○ | HIV Positive | | | |
| ○ | ○ | Malaria | | | |
| ○ | ○ | Measles | | | |
| ○ | ○ | Multiple Sclerosis | | | |
| ○ | ○ | Mumps | | | |
| ○ | ○ | Polio | | | |
| ○ | ○ | Rheumatic fever | | | |
| ○ | ○ | Scarlet fever | | | |
| ○ | ○ | Sexually transmitted disease | | | |
| ○ | ○ | Stroke | | | |

### 5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- _____
- _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____
- _____
- _____
- _____

### 6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

| Past | Currently | |
|---|---|---|
| ○ | ○ | Acupuncture |
| ○ | ○ | Antibiotics |
| ○ | ○ | Birth control pills |
| ○ | ○ | Blood transfusions |
| ○ | ○ | Chemotherapy |
| ○ | ○ | Chiropractic care |
| ○ | ○ | Dialysis |
| ○ | ○ | Herbs |
| ○ | ○ | Homeopathy |
| ○ | ○ | Hormone replacement |
| ○ | ○ | Inhaler |
| ○ | ○ | Massage therapy |
| ○ | ○ | Physical therapy |
| ○ | ○ | Medications |

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

_____

_____

_____

_____

_____

_____

### 7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

_____

_____

_____

_____

_____

### 8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

### 9. Family History

Some health issues are hereditary. Tell Dr. Brown about the health of your immediate family members.

| Relative | Age (if living) | State of health | | Illnesses | Age at death | Cause of death | |
|---|---|---|---|---|---|---|---|
| | | Good | Poor | | | Natural | Illness |
| Mother | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Father | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Sister 1 | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Sister 2 | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Brother 1 | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Brother 2 | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| _____ | _____ | ○ | ○ | _____ | _____ | ○ | ○ |

### 10. Are there any other hereditary health issues that you know about? _____

_____

### 11. Social History

Tell Dr. Brown about your health habits and stress levels.

SOCIAL

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcohol use | ○ Daily | ○ Weekly | How much? _____ | Prayer or meditation? | ○ Yes | ○ No |
| Coffee use | ○ Daily | ○ Weekly | How much? _____ | Job pressure/stress? | ○ Yes | ○ No |
| Tobacco use | ○ Daily | ○ Weekly | How much? _____ | Financial peace? | ○ Yes | ○ No |
| Exercising | ○ Daily | ○ Weekly | How much? _____ | Vaccinated? | ○ Yes | ○ No |
| Pain relievers | ○ Daily | ○ Weekly | How much? _____ | Mercury fillings? | ○ Yes | ○ No |
| Soft drinks | ○ Daily | ○ Weekly | How much? _____ | Recreational drugs? | ○ Yes | ○ No |
| Water intake | ○ Daily | ○ Weekly | How much? _____ | | | |

Hobbies: _____

*Consultation Notes*

**Doctor's Initials**

**Dr. James W. Brown**

**12. Activities of Daily Living**

How does this condition currently interfere with your life and ability to function?

| | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Sitting | ○ | ○ | ○ | ○ |
| Rising out of chair | ○ | ○ | ○ | ○ |
| Standing | ○ | ○ | ○ | ○ |
| Walking | ○ | ○ | ○ | ○ |
| Lying down | ○ | ○ | ○ | ○ |
| Bending over | ○ | ○ | ○ | ○ |
| Climbing stairs | ○ | ○ | ○ | ○ |
| Using a computer | ○ | ○ | ○ | ○ |
| Getting in/out of car | ○ | ○ | ○ | ○ |
| Driving a car | ○ | ○ | ○ | ○ |
| Looking over shoulder | ○ | ○ | ○ | ○ |
| Caring for family | ○ | ○ | ○ | ○ |

| | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Grocery shopping | ○ | ○ | ○ | ○ |
| Household chores | ○ | ○ | ○ | ○ |
| Lifting objects | ○ | ○ | ○ | ○ |
| Reaching overhead | ○ | ○ | ○ | ○ |
| Showering or bathing | ○ | ○ | ○ | ○ |
| Dressing myself | ○ | ○ | ○ | ○ |
| Love life | ○ | ○ | ○ | ○ |
| Getting to sleep | ○ | ○ | ○ | ○ |
| Staying asleep | ○ | ○ | ○ | ○ |
| Concentrating | ○ | ○ | ○ | ○ |
| Exercising | ○ | ○ | ○ | ○ |
| Yard work | ○ | ○ | ○ | ○ |

**13. What is the major stressor in your life?** _____

**14. How much sleep do you average per night?** _____ **Hours**

**15. What is the type and approximate age of your mattress and pillow?** _____

**16. What is your preferred sleeping position?** _____

**17. Describe your typical eating habits:** ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

**18. What would be the most significant thing that you could do to improve your health?** _____

_____

**19. In addition to the main reason for your visit today, what additional health goals do you have?** _____

_____

**Acknowledgements**

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

_____ _____

Patient (or Guardian's) signature Date (MM/DD/YYYY)

**Patient name**

**Patient Number**
**(office use only)**

*Consultation Notes*

**Doctor's Initials**

**Dr. James W. Brown**

# Auto Accident Report

**Dr. James W. Brown**
**Chiropractor**
**422 South Main Street**
**Mansfield, OH 44907-5002**
**Phone 419-522-4672**
**Fax 419-522-2652**

Name: _____ Patient # _____ Date: _____

Date of Accident: _____ Time of Accident: _____ AM PM

Location of Accident: City _____ County _____ State _____

Accident occurred: □ intersection □ sidewalk □ 2-lane highway □ multi-lane highway

What events occurred to cause the accident? _____

_____

How did this accident happen (detailed description)? _____

_____

What happened to you personally (how did you feel)? _____

_____

Were you able to walk? □ Yes □ No Did someone pick you up and carry you? □ Yes □ No

Were you burned? □ Yes □ No Bleeding? □ Yes □ No Where? _____

Any broken bones? □ Yes □ No Which? _____

Were you unconscious? □ Yes □ No For how long? _____

Aware of any bruises? □ Yes □ No Sprains? □ Yes □ No Where? _____

Patient was located: □ Driver □ Passenger-middle front □ Passenger-right front
□ Passenger-left rear □ Passenger-middle rear □ Passenger-right rear

Patient Vehicle Type: □ Compact □ Mid-size □ Full-size □ Pick-up □ Motorcycle

Second Vehicle Type: □ Compact □ Mid-size □ Full-size □ Pick-up □ Motorcycle

Third Vehicle Type: □ Compact □ Mid-size □ Full-size □ Pick-up □ Motorcycle

Road Conditions: □ Clear □ Dark □ Dry □ Foggy □ Icy □ Wet

Road Type: □ Asphalt □ Concrete □ Dirt □ Gravel

Were you aware the accident was going to occur? □ Yes □ No

Were you wearing a seatbelt? □ Yes □ No Did your airbag deploy? □ Yes □ No

Did your car have a head rest?? □ Yes □ No Position of the head rest ? □ Up □ Middle □ Down

Patient's Head Position: □ Looking Straight Ahead □ Left Level □ Left Up □ Left Down
□ Right Level □ Right Up □ Right Down □ Looking Up □ Looking Down

*Accident Details*

Number of people in your vehicle? _____ Number of vehicles involved in the accident? _____

Was **your** vehicle braking? □ Yes □ No Was **your** vehicle moving? □ Yes □ No

If yes, how fast (mph)? □ <5 □ 6-10 □ 11-15 □ 16-20 □ 21-30 □ 31-40 □ 41-50 □ 51-60 □ 61-70 □ >70

Was the **second** vehicle braking? □ Yes □ No Was the **second** vehicle moving? □ Yes □ No

If yes, how fast (mph)? □ <5 □ 6-10 □ 11-15 □ 16-20 □ 21-30 □ 31-40 □ 41-50 □ 51-60 □ 61-70 □ >70

Was the **third** vehicle braking? □ Yes □ No Was the **third** vehicle moving? □ Yes □ No

If yes, how fast (mph)? □ <5 □ 6-10 □ 11-15 □ 16-20 □ 21-30 □ 31-40 □ 41-50 □ 51-60 □ 61-70 □ >70

Who was at fault? □ You □ Other driver

Was your car under control? □ Yes □ No Was the other party's? □ Yes □ No

*Collision Details*

First Impact: □ hit by other vehicle □ hit other vehicle □ hit by object □ hit object

Impact Location: □ front □ front-right □ front-left □ left

□ right □ right-rear □ left-rear □ rear □ top

*Collision Results*

**Body was thrown** □ forward □ backward □ left □ right □ can't remember

**Head hit:** □ airbag □ front windshield □ rearview mirror □ steering wheel

□ dashboard □ back of front seat □ side window/door □ another person's body □ headrest

**Chest hit:** □ airbag □ steering wheel □ dashboard □ back of front seat

□ side window/door □ another person's body

**Shoulders hit:** □ shoulder harness □ side window/door □ back of front seat □ another person's body

**Knees hit:** □ steering wheel □dashboard □ back of front seat

□ door panel □ center console □ another person's body

**Hips hit:** □ steering wheel □dashboard □ back of front seat

□ door panel □ center console □ another person's body

*Vehicle Damage*

**Patient Vehicle:** □ totaled □ significant damage □ light damage □ no damage

**Second Vehicle:** □ totaled □ significant damage □ light damage □ no damage

**Third Vehicle:** □ totaled □ significant damage □ light damage □ no damage

_____

Patient #

_____

Doctor's Initials

**Dr. James W. Brown**

*Previous Care*

What care have you had for this condition? _____

| | | | | | |
|---|---|---|---|---|---|
| Worn Brace? | □ Yes □ No | Corset? | □ Yes □ No | Cast? | □ Yes □ No |
| Therapy? | □ Yes □ No | Surgery? | □ Yes □ No | Used Crutches? | □ Yes □ No |
| Wheelchair? | □ Yes □ No | Traction? | □ Yes □ No | Walker? | □ Yes □ No |
| Intensive Bed Care? | □ Yes □ No | Private Nurse? | □ Yes □ No | Other? | _____ |

*Disability*

Able to work now? □ Yes □ No Last date worked: _____ Returned to work? □ Yes □ No

What changes have there been in your ability to work? _____

Have you had to change jobs? □ Yes □ No Are you able to work without difficulty? □ Yes □ No

*Insurance*

Name/Address of your insurance company:

_____

_____

_____

Agent's Name: _____

Agent's Phone Number: _____

Notified your insurance company? □ Yes □ No

Name/Address of other party's insurance company:

_____

_____

_____

Agent's Name: _____

Agent's Phone Number: _____

Other driver notified insurance co.? □ Yes □ No

Are you hiring an attorney? □ Yes □ No

Attorney's Name: _____

Has your attorney been notified? □ Yes □ No

Attorney's Phone Number: _____

*Check symptoms you have noticed since accident:*

| | | | | |
|---|---|---|---|---|
| □ Headache | □ Irritability | □ Numbness in Toes | □ Face Flushed | □ Feet Cold |
| □ Neck Pain | □ Chest Pain | □ Shortness of Breath | □ Buzzing in Ears | □ Hands Cold |
| □ Neck Stiff | □ Dizziness | □ Fatigue | □ Loss of Balance | □ Stomach Upset |
| □ Sleeping Problems | □ Head seems too heavy | □ Depression | □ Fainting Spells | □ Constipation |
| □ Back Pain | □ Pins & Needles in Arms | □ Light Bothers Eyes | □ Loss of Smell | □ Cold Sweats |
| □ Nervousness | □ Pins & Needles in Legs | □ Loss of Memory | □ Loss of Taste | □ Fever |
| □ Tension | □ Numbness in Fingers | □ Ears Ring | □ Diarrhea | □ _____ |

_____

Patient #

_____

Doctor's Initials

**Dr. James W. Brown**

# Low Back Disability Index

**Dr. James W. Brown**
**Chiropractor**
**422 South Main Street**
**Mansfield, OH 44907-5002**
**Phone 419-522-4672**
**Fax 419-522-2652**

**Patient Name:**_____ **Patient #:**_____ **Date:**_____

**Please Read**: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage everyday life. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem *right now*.**

**Section 1 – Pain Intensity**
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is comes and goes and is severe.
F. The pain is severe and does not vary much.

**Section 2 – Personal Care (Washing, Dressing, etc.)**
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way or washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help
F. Because of the pain, I am unable to do any washing or dressing without help.

**Section 3 – Lifting**
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned eg on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can lift very light weights, at the most.

**Section 4 – Walking**
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than 1/2 mile.
D. Pain prevents me from walking more than 1/4 mile.
E. I can only walk using a stick and crutches.
F. I am in bed most of the time ; crawl to the toilet.

**Section 5 – Sitting**
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1 hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me at all.

**Section 6 – Standing**
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than 1/2 hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

**Section 7 – Sleeping**
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of the pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of the pain, my normal night's sleep is reduced by less than one-half.
E. Because of the pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

**Section 8 – Traveling**
A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while I am traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while I am traveling, which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

**Section 9 – Social Life**
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests eg dancing, etc.
D. Pain has restricted my social life; I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

**Section 10 – Changing Degree of Pain**
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Comments.....

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*Doctor's Initials*

**Dr. James W. Brown**

# Neck Disability Index

**Dr. James W. Brown**
**Chiropractor**
**422 South Main Street**
**Mansfield, OH 44907-5002**
**Phone 419-522-4672**
**Fax 419-522-2652**

**Patient Name:**_____ **Patient #:**_____ **Date:**_____

**Please Read**: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage every day activities. Please answer each section by circling the **ONE CHOICE** that most applies to you we realize you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem *right now*.**

**Section 1 – Pain Intensity**
A. I have no pain at the moment.
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe and comes and goes.
F. The pain is severe and does not vary much.

**Section 2 – Personal Care (Washing, Dressing, etc.)**
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

**Section 3 – Lifting**
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights normally but it causes pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example, on a table.
D. Pain prevents me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

**Section 4 – Reading**
A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with only slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

**Section 5 – Headache**
A. I have no headache at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

**Section 6 – Concentration**
A. I can concentrate when I want to with no difficulty.
B. I can concentrate when I want to with slight difficulty.
C. I have a fair degree of difficulty concentrating when I want to.
D. I have a lot of difficulty concentrating when I want to.
E. I have a great deal of difficulty concentrating when I want to.
F. I cannot concentrate at all.

**Section 7 – Work**
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

**Section 8 – Driving**
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

**Section 9 – Sleeping**
A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

**Section 10 – Recreation**
A. I am able to engage in all recreational activities with no pain in my neck at all.
B. I am able to engage in all recreational activities with some pain in my neck.
C. I am able to engage in most, but not all recreational activities because of pain in my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

Comments.....

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*Doctor's Initials*

**Dr. James W. Brown**

# Patient Pain Form

**Dr. James W. Brown**
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**Mansfield, OH 44907-5002**
**Phone 419-522-4672**
**Fax 419-522-2652**

Name: _____

Date: _____ Date of Injury: _____ Patient #:_____

***Please circle on the line below the level or intensity of pain you are presently experiencing:***

**Complaint #1:** ( □ Neck □ Upper Back □ Lower Back □ Pelvis □ Sacrum )

Absolutely Pain Free —1—2—3—4—5—6—7—8—9—10— Worse Pain You Could Ever Have

**Complaint #2:** ( □ Neck □ Upper Back □ Lower Back □ Pelvis □ Sacrum )

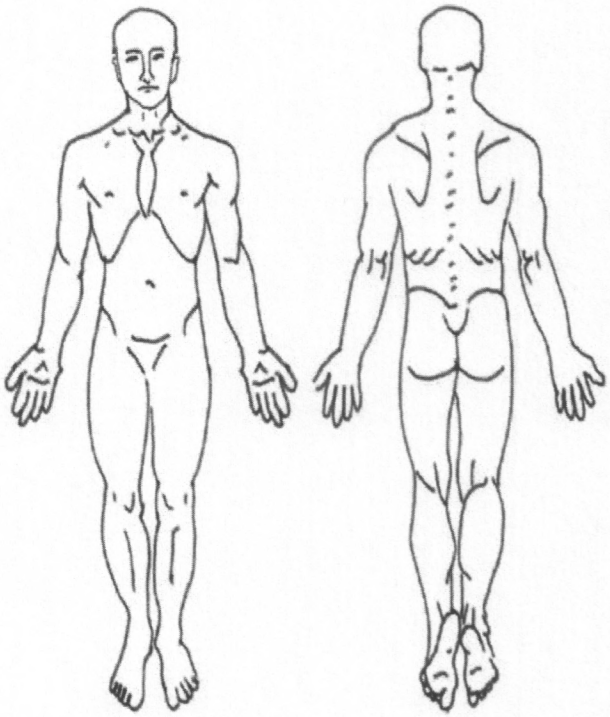
Absolutely Pain Free —1—2—3—4—5—6—7—8—9—10— Worse Pain You Could Ever Have

**Complaint #3:** ( □ Neck □ Upper Back □ Lower Back □ Pelvis □ Sacrum )

Absolutely Pain Free —1—2—3—4—5—6—7—8—9—10— Worse Pain You Could Ever Have

***Using the symbols listed below, mark on the two drawings which areas on your body where you feel the described sensations:***

| | | | |
|---|---|---|---|
| Numbness | = = = | Sharp Stabbing | / / / |
| Dull Ache | O O O | Pins and Needles | + + + |
| Hot Burning | X X X | Other _____ | * * * |



RIGHT LEFT LEFT RIGHT

Examination Notes

Signature: _____ Date: _____

Doctor's Initials
**Dr. James W. Brown**