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

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

Birth Date (MM/DD/YYYY)

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 ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

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 ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

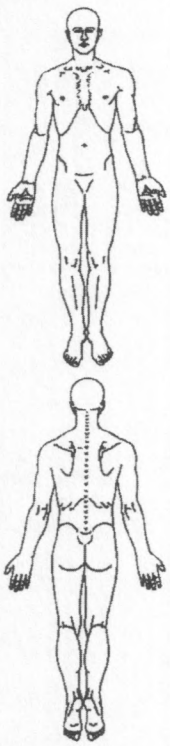
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

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 ◯ Acupuncture
- ◯ Over-the-counter drugs ◯ Chiropractic
- ◯ Homeopathic remedies ◯ Massage
- ◯ Physical therapy ◯ Ice
- ◯ Surgery ◯ Heat
- ◯ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" 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			

7. Allergies

Are you allergic to any medications?

Yes ○ No ○ If Yes please list: _____

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):

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

Consultation Notes

9. Family History

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

FAMILY

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: _____

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? _____

_____

Consultation Notes

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)

Doctor's Initials

Dr. James W. Brown

Worker's Comp Incident Form

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

Patient Name_____ Today's Date_____

Name of Compensation Carrier_____.

Name of Employer: _____.

The date of the work-related injury was: _____.

The time that the injury occurred was: _____ (am/pm)

The last date worked was: (month) _____/ (day) _____ / (year)_____.

Were you hospitalized? ____ Yes ____ No. If yes, please answer the questions below.

When were you hospitalized? ___ immediately ____ later same day ____ next day ___ date _____

How were you transported to the hospital? ___ ambulance ___ Life flight ___ private transportation

What did the hospital recommend? ___ no instructions ___ see this clinic ___ see DC

__ see own doctor ___see orthopedist ___ see neurologist ___ prescription medication

---

Did you have any x-rays taken? ____ Yes ____ No

If yes, what areas? _____

My current job status is (Please mark the appropriate response below)

___ off work as a result of the injuries sustained in the reported work accident.

___ working full duty.

___ working light duty.

I ___ have ____ have not been involved in previous work-related accidents/injuries.

If you have been involved in previous work-related accidents/injuries, please complete below.

Status of previous injuries:

___ treated and resolved

___ treated, unresolved, and located at an unrelated area to this accident

___treated, unresolved, same area as current injury

___ not treated and a completely different area than current injury

___not treated and still have residual symptoms

___ not treated and do not have any residual symptoms

This accident was: ___ not reported to the employer. ___ reported to the employer.

The name of the employee it was reported to was: _____

Employee's Job Title_____ Phone# (____) _____ -_____

The injury occurred at (location): _____

How many hours did you work that same day prior to the accident: _____

What type of work were you performing at time of injury: _____

_____

Describe the accident:

_____

_____

_____

I have:

___ been treated by another doctor for the injuries sustained in this accident.

___ not been treated by another doctor

If you have been treated by another doctor, please continue with the following questions.

List the doctor's name and current/past treatment:

_____

_____

_____

As a result of the treatment received thus far:

____ My condition has improved.

____ My condition has not improved.

____ My condition has worsened since the injury despite treatment received thus far.

This accident was: ____ not reported to the employer. ____ reported to the employer.

_____
(Name)

_____
(Patient #)

_____
(Doctor's Initials)
Dr. James 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

_____
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.....

Doctor's Initials

Dr. James W. Brown

Patient Pain Form

Dr. James W. Brown
Chiropractor
422 South Main Street
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)

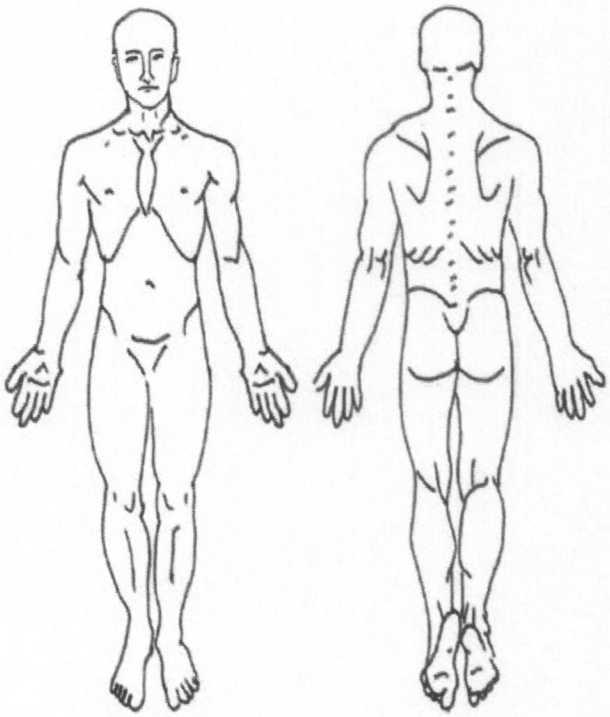
Absolutely Pain Free —1—2—3—4—5—6—7—8—9—10— Worse Pain You Could Ever Have

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