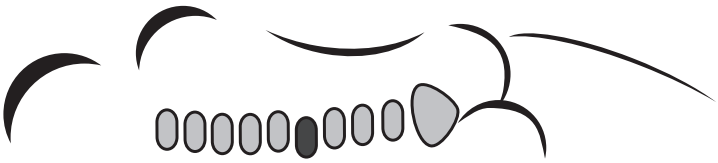


RUMPH
CHIROPRACTIC

Patient # _____

Date _____

NEW PATIENT LOG

NAME _____ BIRTH DATE_____ AGE_____SEX M F

ADDRESS _____

CITY _____ZIP_____

HOME PHONE _____CELL _____ WORK _____

MARITAL STATUS S M D W NUMBER OF CHILDREN _____

OCCUPATION _____SOCIAL SECURITY # _____

REFERRED BY _____DRIVERS LICENSE # _____

E-MAIL _____

IS THIS THE RESULT OF AN AUTO ACCIDENT? Y N

IS THIS THE RESULT OF A WORK RELATED INJURY? Y N

IF YES INDICATE DATE _____

CURRENT COMPLAINT HISTORY

Name_____ Patient #_____ Date _____

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.

Please list your present complaint(s) and mark your level of pain today for each complaint–If you have more than one area of complaint list them in order of most severe to least severe.

1. _____**Duration - (How Long / Date):** _____**# of Previous Episodes:** _____
   (Please circle one) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**
2. _____**Duration - (How Long / Date):** _____**# of Previous Episodes:** _____
   (Please circle one) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**
3. _____**Duration - (How Long / Date):** _____**# of Previous Episodes:** _____
   (Please circle one) **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Worst pain imaginable)**

Has anyone treated you for this episode? ❑ Yes ❑ No If yes, by whom? _____

How did your symptoms begin?

❑ Immediately after a specific incident ❑ After multiple incidents ❑ Gradually developed over time ❑ Other _____

What makes your symptoms better?

❑ Nothing ❑ Lying down ❑ Standing ❑ Sitting ❑ Movement/Exercise ❑ Other _____

What makes your symptoms worse?

❑ Nothing ❑ Lying down ❑ Standing ❑ Sitting ❑ Movement/Exercise ❑ Other _____

Are your symptoms?

❑ Decreasing ❑ Increasing
❑ Not Changing ❑ Other _____

Description of pain or symptoms:

❑ Sharp ❑ Shooting
❑ Dull ❑ Burning
❑ Ache ❑ Numb
❑ Weakness ❑ Tingling
❑ Throbbing ❑ Other _____

Does your pain move or radiate?

❑ No ❑ Yes Where _____

Check the best and worse time of the day for your pain:

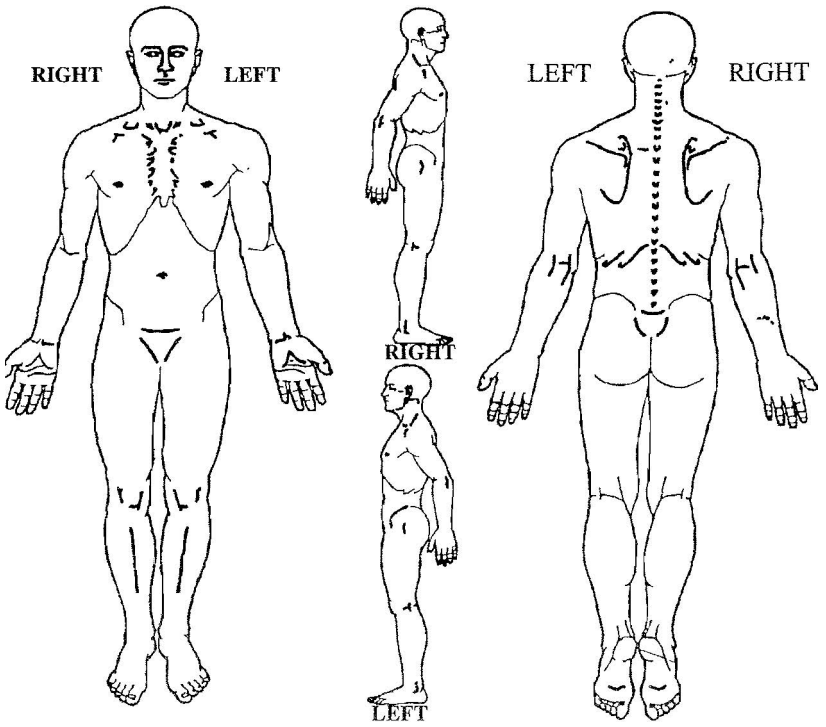
Worse	**Best**
❑ First Awake	❑ First Awake
❑ Morning	❑ Morning
❑ Afternoon	❑ Afternoon
❑ Evening	❑ Evening
❑ Other	❑ Other

Frequency of pain or symptoms:

❑ Constant (76 - 100%)
❑ Frequent (51 - 75%)
❑ Intermittent (26 - 50%)
❑ Occasional (25 - or less)

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE
THE TYPE AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS **P**=PINS & NEEDLES
S=STABBING **X**=STIFFNESS **T**=THROBBING **0**=OTHER



How many days out of an average week are you in pain? *(Please circle one)* 1 2 3 4 5 6 7

How much time during the day are you in pain?

❑ less than 1 hour ❑ 1 to 6 hours ❑ 6 to 12 hours ❑ 12 to 18 hours ❑ 18 to 24 hours ❑ 24 hours

Name_____ Patient #_____ Date _____

What is your current work status:

❑ Full time, no restrictions ❑ Full time, restrictions ❑ Full time Homemaker ❑ Full time Student
❑ Part time, no restrictions ❑ Part time, restrictions ❑ Retired ❑ Unemployed
❑ Off work due to restrictions ❑ Other _____

Restrictions:

Off work: ❑ Yes ❑ No ❑ Previously From:_____ to _____
Light Duty: ❑ Yes ❑ No ❑ Previously If yes, what are/were your restrictions?_____

Do/did you require outside help at home:

❑ Yes ❑ No If yes, what do/did you need? _____

Do you wear orthotics or heel lifts? ❑ Yes ❑ No Fitted by whom? _____

Are you presently taking any medication, prescription, over-the-counter, home remedies, vitamins, minerals, etc:

Please list: _____

_____

Is your condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other: _____

Have you ever been to a chiropractor before? ❑ Yes ❑ No Dr.'s Name: _____When: _____

Operations/Surgeries?_____

Broken Bones? _____

Bad falls?_____

Auto Accidents?_____

Hospitalized?_____

PLEASE CHECK THE FOLLOWING CONDITIONS THAT YOU HAVE NOW OR HAVE HAD IN THE PAST.

____ Allergies
____ Blurred Vision
____ Cancer
____ Depression
____ Diarrhea
____ Dizziness
____ Epilepsy
____ Fainting
____ Headache
____ Hearing Trouble
____ Unable to Sleep
____ Bursitis
____ Run Down Feeling (Malaise)
____ Ring or Buzzing in Ears
____ Neck Pain
____ Pain in Forearm, Elbow
____ Pain in Hand, Wrist
____ Pain in Head. Face
____ Sinus
____ Thyroid Trouble
____ Pins & Needles in Hand/Arm
____ Cold Hands
____ Carpal Tunnel Syndrome
____ Cold Sweats
____ Laryngitis

____ Arthritis
____ Poor Appetite
____ Asthma
____ Diabetes
____ Gas/Gas Pains
____ High Blood Pressure
____ Low Blood Pressure
____ Heart Pain
____ Heart Palpitations
____ Heart Attacks
____ Liver Trouble
____ Anemia
____ Stomach Trouble
____ Ulcers
____ Painful Joints
____ Swollen Joints
____ Pain Between Shoulders
____ Shortness of Breath
____ Gallbladder Troubles
____ Kidney Trouble
____ Indigestion
____ Colds
____ Difficulty Breathing
____ Bronchitis
____ Pneumonia

____ Abdominal Pain
____ Hip Pain (Sacroiliac)
____ Bed Wetting
____ Constipation
____ Cramps
____ Hemorrhoids
____ Injury Back Pain
____ Low Back Pain
____ Tailbone/Sacrum Pain
____ Pins & Needles in Legs
____ Gout
____ Cold Feet
____ Numbness in Legs
____ Swollen Ankles
____ Colitis
____ Appendicitis
____ Groin Pain
____ Menstrual Pain (PMS)
____ Pain in Lower Leg, Knees
____ Pain in Pelvic Region/Thigh
____ Muscle Spasm
____ Varicose Veins
____ Bladder Problems
____ Prostate Problems
____ Menstrual Irregularity

Would you like nutritional counseling? ❑ Yes ❑ No

Neck Index

ChiroCare of Wisconsin, Inc.

ChiroCare use Only rev 1/15/99

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ 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.

Personal Care

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

Sleeping

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

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty concentrating when I want.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☐ I can only do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Calculate Score

Neck Index Score ☐

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/15/99

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is very severe and does not vary much.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal sleep is reduced by less than 25%.
- ☐ Because of pain my normal sleep is reduced by less than 50%.
- ☐ Because of pain my normal sleep is reduced by less than 75%.
- ☐ Pain prevents me from sleeping at all.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases pain immediately.

Walking

- ☐ I have no pain while walking.
- ☐ I have some pain while walking but it doesn't increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel except that done while lying down.
- ☐ Pain restricts all forms of travel.

Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Changing degree of pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Calculate Score

Back Index Score ☐

STOP