UPDATE FORM & CASE HISTORY

C.A.F.E. OF LIFE CHIROPRACTIC

Last Name________________________ First__________________________ Date___________

Email:________________________

List Any Changes to Your:

Address ____________________________ City __________________ State______ Zip ________

Phone: (H) ________________ (W) ______________ (C) ____________________________

Employer____ Work phone_____________________

Insurance Name_____________________________ ID #_________________________________

Marital Status____________

In order for us to best serve you, we must have all available information regarding your present health. To bring up your original case history up to date please provide us with the following.

Reason for Visit: ❒ Spinal and Nervous System Check up
❒ Other: ____

Health Complaints

What is your **primary** Complaint? ____

____

How long have you been experiencing this **primary** complaint? ______________________

Pain or Problem started on ____

How does the primary complaint feel? ❒ Sharp ❒ Numb ❒ Dull/achy ❒ Burning ❒ Cold

How often do you experience the primary complaint? ❒ Constant or ❒ Intermittent

And is condition ❒ Daily ❒ Weekly ❒ Monthly ❒ Yearly

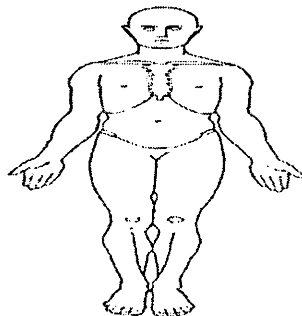
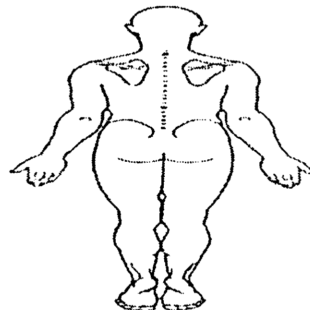
List other health complaints (2-3) below and Rate # 1-10 ❒ Check here if none

2__________________________Rate #_____ 3___________________________Rate #_____

Using the scale below, rate how your primary complaint affects your life. (**Circle** only one below)

1	2	3	4	5	6	7	8	9	10
Mild, noticeable pain. Mostly don't think about it.	Minor pain. Annoying. Occasional stronger twinges.	Pain is noticeable& distracting. Get used to it and adapt	Moderate pain that is distracting my daily activities	Moderate pain that prevents performing some of my daily activities	Moderately strong pain interferes w/ normal activities. Difficulty concentratin g	Severe pain. Social activities affected. Interferes w/ sleep.	Intense pain limits physical activity. Conversing requires great effort	Excruciating pain. Inability to have Conversation Crying out/ moaning constantly	Unspeakable pain. Bedridden and possibly delirious.

Please mark the areas of all your complaints on the diagrams on the right. include any descriptors or comments, concerning your health complaints that were not mentioned above.

Patient Case History

What activities aggravate your primary condition/pain? ________________________________

What activities lessen your primary condition/pain? __________________________________

Is primary condition worse during certain times of the day? ❒ Morning ❒ afternoon ❒ evening ❒ bedtime

Is this primary condition interfering with work? __________ Sleep? __________ Routine? __________ Other? ___________

Is this primary condition getting progressively worse? Yes _____ No______

Other Doctors seen for this primary condition Yes____ No_____

Any home remedies? Yes: If so List: ____________________________________ No________

What Is The Most Important Aspect In Your Life That This Complaint Has Interfered With & Why? Be Specific! (Examples: Golf, Picking Up Kids, Work Performance, Losing Weight, Anxiety, Etc...

List Here → ____

System review:

General: I....☐ DENY any general issue(s)

☐ consistent fainting ☐ dizziness ☐ tension ☐ depression
☐ loss of sleep ☐ fatigue ☐ fever ☐ headache
☐ loss or weight gain ☐ nervousness ☐ night sweats ☐ wheezing
☐ pins & needles in arm/legs ☐ numbness in toes/fingers ☐ loss of smell/taste ☐ loss of balance

Gastro-Intestinal: I....☐ DENY any Gastro-Intestinal issue(s)

☐ constipation ☐ diarrhea ☐ stomach pain ☐ hemorrhoids
☐ gall bladder/liver problems ☐ nausea ☐ poor appetite ☐ jaundice
☐ rectal bleeding ☐ vomiting ☐ poor digestion ☐ vomiting blood

Eyes/Ears/Nose/Throat: I....☐ DENY any Eyes/Ears/Nose/Throat issue(s)

☐ asthma ☐ enlarged thyroid ☐ pain in eyes ☐ poor vision
☐ ear noises ☐ nose bleeds ☐ earache ☐ ear discharge
☐ sore throat ☐ frequent colds ☐ hay fever ☐ sinusitis

Respiratory: I....☐ DENY any Respiratory issue(s)

☐ chest pain ☐ chronic cough ☐ difficulty breathing ☐ spitting phlegm

Muscles/Joints/Bones: I....☐ DENY any Muscles/Joints/Bones issue(s)

☐ backache ☐ foot problems ☐ pain bet. Shoulders ☐ stiff neck
☐ spinal curvature ☐ swollen joints ☐ twitching ☐ weakness

Cardio-Vascular: I....☐ DENY any Cardio-Vascular issue(s)

☐ ankle swelling ☐ low blood pressure ☐ heart trouble ☐ pain over heart
☐ poor circulation ☐ slow/rapid heart ☐ strokes ☐ high blood pressure

Skin or Allergies: I....☐ DENY any Skin or Allergies issue(s)

☐ bruise easily ☐ dryness ☐ eczema ☐ hives
☐ sensitive skin ☐ itching

Women I....☐ DENY any Women issue(s)

☐ cramps ☐ hot flashes ☐ pregnant ☐ irregular cycle ☐ painful periods

Male: I....☐ DENY any Male issue(s)

☐ Burning / Frequent / Retention Urination ☐ Erectile Dysfunction ☐ Hesitancy/Dribbling ☐ Prostate Problems

List Medications ☐ Check if none	Reason	How Long?	Any Side Effects?
1.__________	__________	______	__________
2.__________	__________	______	__________
3.__________	__________	______	__________

Describe Any Medical &/or Chiropractic Care you Have had since your Last Visit Here? ☐ Check here if none

____

____

Describe Any Injuries/Falls/Accidents Since your Last Visit Here? ☐ Check here if none

____

____

Is there a family history of: ☐ Check if no history.

	Heart Disease	Arthritis	Cancer	Diabetes	Kidneys	Other ________
Father's Side	☐	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐	☐

I understand and agree to the following: It is my responsibility to complete the clinic's forms accurately. I have not left out any information regarding my health care condition that will enable the doctor to make an accurate assessment of my condition. It is my responsibility to notify the doctor if any of my information has changed or requires updating.

________________________________ Signature

________________ Date

Neck Pain Disability Index

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | *Unbearable pain*

Name______________________________________ **Date**____________________

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 mark the **ONE NUMBER** in each section, which most closely describes your problem. We realize you may consider that two of the statements in any one section relate to you, but only mark the box, which most closely describes your problem.

Section 1 – Pain Intensity Section
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

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

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
3. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want to with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I can't read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all.

Section 5 – Headaches
0. I have no headaches at all.
1. I have slight headaches, which come in-frequently.
2. I have moderate headaches, which come in-frequently.
3. I have moderate headaches, which come frequently.
4. I have severe headaches, which come frequently.
5. I have headaches almost all the time.

6 – Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7 – Work
0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I can't do any work at all.

Section 8 – Driving
0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I can't drive my car as long as I want because of moderate pain in my neck.
4. I can't drive my car as long as I want because of moderate pain in my neck.
5. I can't drive my car at all because of the pain.

Section 9 – Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hr. sleepless).
2. My sleep is mildly disturbed (1-2 hrs. sleepless).
3. My sleep is moderately disturbed (2-3 hrs. sleepless).
4. My sleep is greatly disturbed (3-5 hrs. sleepless).
5. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation
0. I am able to engage in all my recreation activities with no neck pain at all.
1. I am able to engage in all my recreation activities with some pain in my neck.
2. I am able to engage in most, but not all my recreation activities with some pain in my neck.
3. I am able to engage in a few of my usual recreation activities because of pain in my neck.
4. I can hardly do any recreation activities because of pain in my neck.
5. I can't do any recreation activities at all because of pain in my neck.

TOTAL____________

Patient's Name______________________ Number__________ Date______________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only 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 can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ 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 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.

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, for example 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 very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ 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 only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score___ x 2) / (____Sections x 10) = ____________%ADL

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 extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – 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 effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – 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 at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments______________________________

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204