# Berkeley Chiropractic Center

**PLEASE FILL OUT COMPLETELY**

**Check in PIN #:** _____
**(6 digits)**

**Patient Title:** *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev. Rank_____ Other_____

**First Name**_____ **Nick Name**_____

**Last Name** _____ **Middle Name** _____

**Address 1** _____

**Address 2** _____**City** _____

**State** _____ **Zip Code** _____ **Employer:** _____

**Primary Phone:** _____ **SSN:** _____

**Secondary Phone:** _____ **Mobile Phone:** _____

**Home Email:** _____ **Work Email:** _____

**By providing my email address, I authorize my doctor to contact me via the email address(es) provided**.*

**How were you referred to our office?** _____

**Your Date of Birth** ____/____/____ **Age** ____ **Gender** *(check on* ❑ Male ❑ Female ❑ Other

**Spouse's Name** _____ **Marital Status** *(check one)* ❑ Single ❑ Married ❑ Widowed ❑ Divorced

**Spouse's Date of Birth** _____ **Primary Care Providers Name** _____

**Race** *(check one)* ❑ White ❑ Black/African American ❑ Hispanic ❑ Asian ❑ Other _____ ❑ I choose not to specify

**I authorize** _____ **to receive any medical or billing information in my account.**

*Signature required at the bottom of this form for this authorization to be valid.*

**Have you had previous Chiropractic care?** ❑ Yes ❑ No If yes, when &where? _____

**What techniques were used** _____

**Have you had an X-ray, CT scan, or MRI of your back or neck in the past 12 months?** ❑ Yes ❑ No

**What activity do you enjoy that has become difficult due to this problem?** _____

**Other doctors seen for this problem (please list): Chiropractor:** _____

**Medical Doctor:** _____**Other:** _____

**PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELL-BEING**

_____ I am only concerned about relief of a particular symptom.
_____ I am only concerned about relief of a particular symptom and preventing its return.
_____ I want optimum health and well-being on every level available to me

**Today's Date** ____/____/____ **Signature of Patient** _____

**Review of Systems:** Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.

**Please put a check (☑) beside any condition that you've Had or currently Have.**

**Musculoskeletal**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Osteoporosis |
| ❑ | ❑ | Knee Injuries |
| ❑ | ❑ | Arthritis |
| ❑ | ❑ | Foot/ankle pain |
| ❑ | ❑ | Scoliosis |
| ❑ | ❑ | Shoulder problems |
| ❑ | ❑ | Neck Pain |
| ❑ | ❑ | Elbow/ wrist pain |
| ❑ | ❑ | Back problems |
| ❑ | ❑ | TMJ issues |
| ❑ | ❑ | Hip disorders |
| ❑ | ❑ | Cramping |
| ❑ | ❑ | Poor posture |
| ❑ | ❑ | Swelling/deformity of joints |

**Neurological**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Anxiety/ Panic |
| ❑ | ❑ | Depression |
| ❑ | ❑ | Headache/ Migraines |
| ❑ | ❑ | Dizziness |
| ❑ | ❑ | Pins and Needles |
| ❑ | ❑ | Numbness |
| ❑ | ❑ | *Epilepsy/ seizures* |
| ❑ | ❑ | Memory issues |
| ❑ | ❑ | Stroke |
| ❑ | ❑ | Weak muscles |
| ❑ | ❑ | Temporary loss of: Vision, smell, or hearing |

**Cardiovascular**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Blood clots |
| ❑ | ❑ | Chest pain/ tightness |
| ❑ | ❑ | Coronary artery disease |
| ❑ | ❑ | Heart attack |
| ❑ | ❑ | High blood pressure |
| ❑ | ❑ | High cholesterol |
| ❑ | ❑ | *Leg pain upon walking* |
| ❑ | ❑ | Low Blood Pressure |
| ❑ | ❑ | Lower extremity edema |
| ❑ | ❑ | Palpitations |

**Digestive**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Abdominal pain |
| ❑ | ❑ | Black/ bloody stool |
| ❑ | ❑ | Changes in bowel habits |
| ❑ | ❑ | Colon cancer or polyps |
| ❑ | ❑ | Constipation |
| ❑ | ❑ | Gastric reflux |
| ❑ | ❑ | *Heartburn* |
| ❑ | ❑ | IBS |
| ❑ | ❑ | Liver disease |
| ❑ | ❑ | Nausea/ vomiting |
| ❑ | ❑ | Diarrhea |
| ❑ | ❑ | Ulcer |

**Dermatological**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Psoriasis |
| ❑ | ❑ | Eczema |
| ❑ | ❑ | Excessive hair loss |
| ❑ | ❑ | Skin cancer |
| ❑ | ❑ | Skin trouble/ rashes |
| ❑ | ❑ | Change in hair/ nails |

**Respiratory**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Asthma |
| ❑ | ❑ | Emphysema |
| ❑ | ❑ | Shortness of Breath |
| ❑ | ❑ | Persistent cough |
| ❑ | ❑ | Wheezing |
| ❑ | ❑ | Breathing Difficulties |

**Endocrine**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Excessive thirst |
| ❑ | ❑ | Testosterone deficiency |
| ❑ | ❑ | Thyroid problems |

**Genitourinary**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Blood in the urine |
| ❑ | ❑ | Incontinence |
| ❑ | ❑ | Kidney stones |
| ❑ | ❑ | Urgency |
| ❑ | ❑ | Painful/frequent urination |

**Surgeries**, which may or may not have included hospitalization and **Dates**

- ❑ Bypass surgery _____
- ❑ Cancer _____
- ❑ Elective surgery _____
- ❑ Hysterectomy _____
- ❑ Pacemaker _____
- ❑ Spine _____
- ❑ Wisdom teeth _____
- ❑ Other: _____

**Head and ENT**

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Blurred/ double vision |
| ❑ | ❑ | Difficulty swallowing |
| ❑ | ❑ | Ear/ hearing problems |
| ❑ | ❑ | Sinus Trouble |
| ❑ | ❑ | Ringing in the ears |
| ❑ | ❑ | Swollen lymph nodes |

**Females only**

Are you pregnant?
❑ Yes ❑ No
If yes, how many weeks? ___
If no, is there a chance you might be pregnant? ___

**Social History** Tell us about your health habits and stress levels. Please write **N/A** if it doesn't apply to you.

**Employment Status**: Occupation _____ Hours per week _____ Change due to current problem _____

**Do you smoke? ____ Yes ____No How long? _____ Packs a day? ____**
**How long since you stopped smoking? _____**

**How interested are you in quitting? - Please Circle**: No 1 2 3 4 5 6 7 8 9 10 Yes

**Alcohol use** – ❑ None ❑ Social ❑ Light ❑ Moderate ❑ Heavy ❑ Alcoholic ❑ Recovering alcoholic

**Recreational Drug use** – ❑ None ❑ Social ❑ Light ❑ Moderate ❑ Heavy ❑ Drug addicted ❑ Recovering drug addict

**Caffeine use** – ❑ None ❑ 1cup/day ❑2-4cups/day ❑ 5+cups/day

**Exercise habits** – ❑ None ❑ Daily ❑ 2-3 times a week ❑ Weekly ❑ Occasionally **Type**? _____

**Is your diet restricted?** _____ Any recent change in diet?_____

**Any Change in social habits due to current issue?**_____

**Briefly list your main chief complaint** _____

**When did this problem start?** _____ **Have you had this problem before?** _____

**Problem is due to:** ❑Auto accident ❑Injury ❑Work related ❑Long-term problem ❑Other_____

**Intensity of current symptoms?** (better) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 (worst)

**Duration and Timing of pain?** ❑ Off & On ❑ Frequent ❑ Intermittent ❑Constant ❑Random ❑Recurring

**What is most affected?** ❑Employment ❑Homemaking ❑Personal Care ❑Sitting ❑Sleeping ❑Lifting

**How are the symptoms changing with time?** ❑Getting worse ❑Not changing ❑Getting better

**Quality of Symptoms**
(What does it feel like?)
- ❑ Achy
- ❑ Annoying
- ❑ Burning
- ❑ Deep
- ❑ Dull
- ❑ Heavy
- ❑ Intolerable
- ❑ Pulling
- ❑ Sharp
- ❑ Shock like
- ❑ Stabbing
- ❑ Stiffness
- ❑ Throbbing
- ❑ Tightness
- ❑ Tingling
- ❑ Other_____

**Relieving Factors** (What makes it better?)
- ❑ Chiropractic
- ❑ Heat
- ❑ Ice
- ❑ Exercise
- ❑ Support
- ❑ Massage
- ❑ Nothing
- ❑ OTC medication
- ❑ Rx medication
- ❑ Physical therapy
- ❑ Rest
- ❑ Stretching
- ❑ Work
- ❑ Other_____

**Aggravating Factors** (What makes it worse?)
- ❑ Any movement
- ❑ Bathing
- ❑ Bending
- ❑ Caring for family
- ❑ Carrying objects
- ❑ Climbing stairs
- ❑ Computer use
- ❑ Concentrating
- ❑ Coughing/sneezing
- ❑ Daily child/pet care
- ❑ Dressing self
- ❑Driving
- ❑ Eating
- ❑ Exercises
- ❑ Falling/staying asleep
- ❑ Getting in/out of car
- ❑ Getting up from lying down
- ❑ Grocery shopping
- ❑ Getting up from sitting
- ❑ Household chores
- ❑ Lifting
- ❑ Looking over shoulder
- ❑ Lying down
- ❑ Pushing
- ❑ Pulling
- ❑ Reaching
- ❑ Reading
- ❑ Resting
- ❑ Running
- ❑ Sitting
- ❑ Squatting
- ❑ Standing
- ❑ Stress
- ❑ Stretching
- ❑ Talking on the phone
- ❑ Turning
- ❑ Twisting
- ❑ Walking
- ❑ Working
- ❑ Yard work
- ❑ Other_____

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

| Had | Have | |
|---|---|---|
| ❑ | ❑ | Diabetes Type1__Type II___ |
| ❑ | ❑ | Stroke |
| ❑ | ❑ | Other: _____ |

**Injuries**: Have you ever...
- ❑ Had a fractured or broken bone. Date_____
- ❑ Had a spine or nerve disorder. Date _____
- ❑ Been knocked unconscious. Date _____
- ❑ Been injured in an accident. Date _____
- ❑ Used neck or back bracing. Date _____

**Family History:** Some health issues are hereditary. Tell us about the health of your immediate family members.

| Relative | Age | Illnesses | Age of death | Cause of death |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Sister | | | | |
| Brother | | | | |
| Children | | | | |
| Children | | | | |
| Children | | | | |

| Current Medications (Rx & OTC) | What medication is treating | Frequency & Dosage | Start date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

For re-ordering information, contact:
**ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317**
**Phone: (602) 224-0220; Facsimile (602) 224-0230**

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

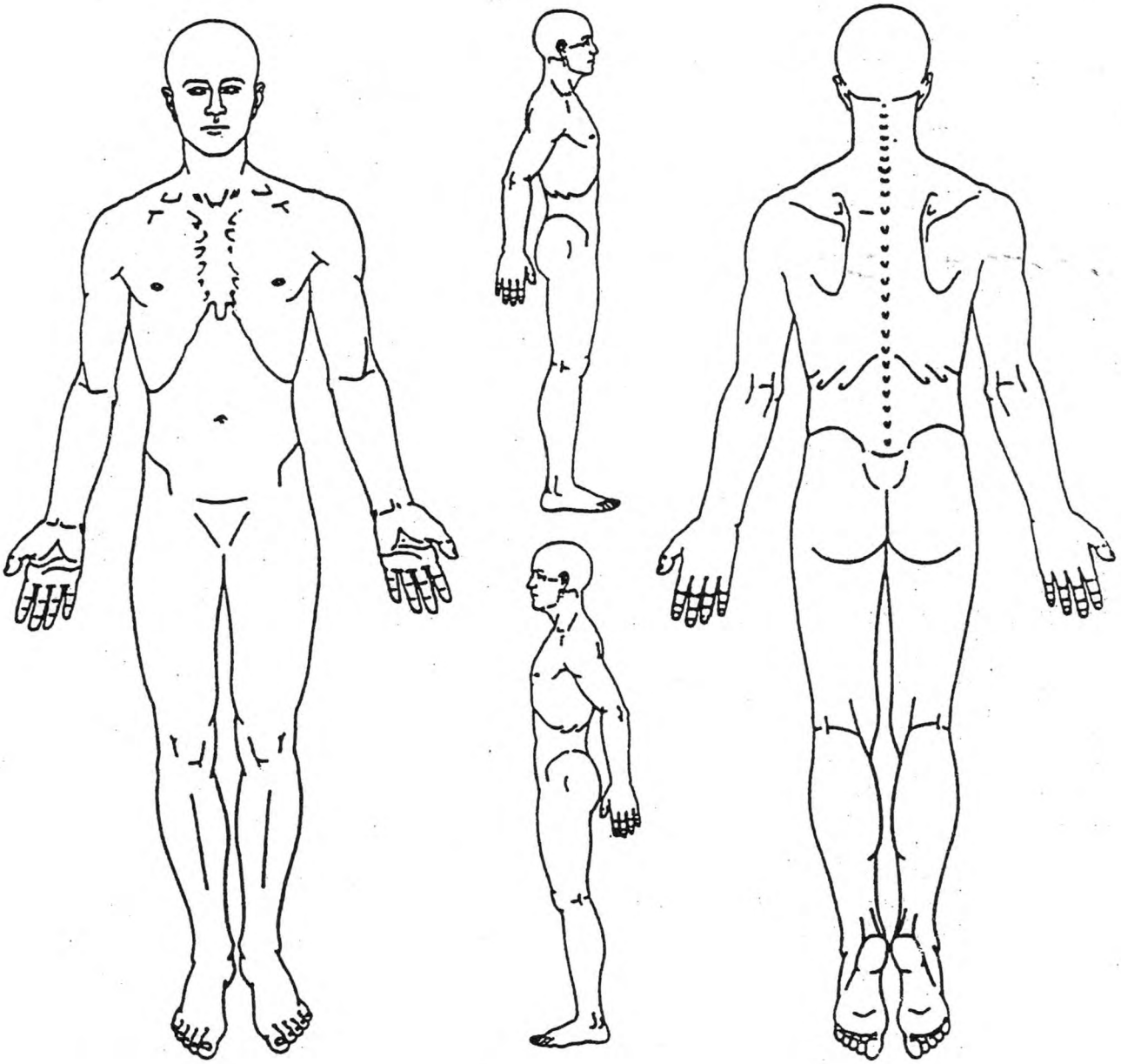
HOW LONG HAVE YOU HAD NECK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? ___YES ___NO

**USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW**

(Please remember to complete both sides of this form.)

KEY: A=ACHE B=BURNING N=NUMBNESS
P=PINS & NEEDLES S=STABBING O=OTHER



OVER PLEASE

# NECK PAIN DISABILITY INDEX QUESTIONNAIRE

**Please Read:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

## Section 1 — Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

## Section 2 — Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra 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, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can 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 to with no pain in my neck.
B I can read as much as I want to with 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 — Headaches

A I have no headaches 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.

*After Vernon & Mior, 1991*
*Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics*

## Section 6 — Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in 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 usual 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 any 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 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 of my recreational activities, with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual 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.

REVISED January 1, 1995

Comments: _____

_____

Patient Signature: _____ Date: _____

## REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

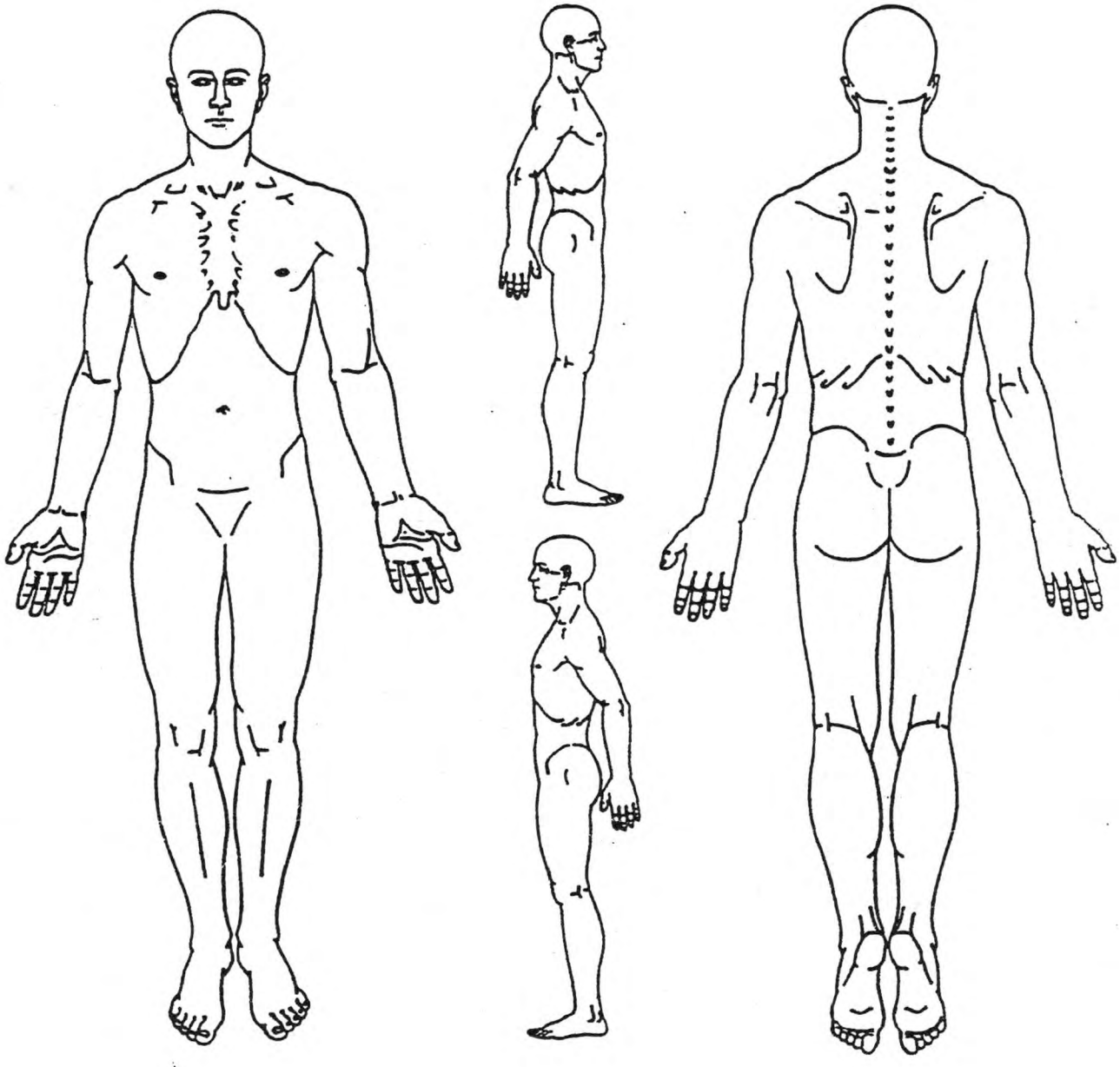
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

### USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
**P**=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE

# REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

**Please Read:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST 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 comes and goes and is severe.
F The pain is severe and does not vary much.

**SECTION 2 -- Personal Care**

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 of 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 causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., 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 only 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 one 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 while using a cane or on crutches.
F I am in bed most of the time and have to 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 one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

*From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989*

REVISED 9/11/92

**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 one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

**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 pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

**SECTION 8 -- Social Life**

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and 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 9 -- 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 traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while 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 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: _____

Patient Signature: _____ Date: _____

## HIPAA Privacy Practices

I acknowledge that I have received and/or have been given the opportunity to review this chiropractic office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name: _____

Patient Representative/Patient's Signature: _____

Date: _____

By signing below, I state that I have answered the questions on this form accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____ _____

Patient/Guardian Signature Date