SOLELY CHIROPRACTIC

Dr. J.L. Porter, B.Sc., D.C.
Doctor of Chiropractic

Name___________________________________
Address_________________________________
City_________________Prov_____ PC_________
Phone #_________________________________
E-mail _________________________________
Date of Birth: D_____ M _____ Y___________

Occupation______________________________
Marital Status S M D W
Spouse's Name___________________________
No. of children__________
Health Insurance ________________________
Referred By_____________________________

Chiropractic History

Have you previously seen a chiropractor? ☐yes ☐no Reason______________ Did they take x-rays? ☐ yes ☐no
If yes, when was your last visit and how long did you receive care? ______________________________

Current Health Condition ☐ I'm here for wellness and I have no complaints

Reason for today's visit ____
When did pain or issue start? _____________Why do ***you*** think the problem/pain started?____________
Pain is: ☐ Sharp ☐Dull ☐Constant ☐Intermittent Pain is interfering with: ☐Work ☐Sleep ☐Routine ☐Other
What activities aggravate your condition/pain? ____________________________
What activities lessen your condition/pain? ______________________________
Is it worse during certain time of the day? ____________ Is this condition getting progressively worse?__________
Other doctors seen: ____________________ Any at home remedies? ______________________

Other symptoms

☐Headaches	☐Pins and Needles in Legs	☐Difficulty Swallowing	☐Nausea	Other diseases/
☐Neck Pain	☐Pins and Needles in Arms	☐Loss of Memory	☐Ear Infections	conditions or
☐Back Pain	☐Numbness in Fingers	☐Fever	☐Asthma	concerns:
☐Sleeping Problems	☐Numbness in Toes	☐Fainting	☐Allergies	____________
☐Nervousness	☐Shortness of Breath	☐Cold Sweats	☐Frequent Colds/Flu	____________
☐Tension	☐Fatigue	☐Loss of Smell	☐Menstrual Problems	____________
☐Irritability	☐Anxiety	☐Loss of Taste	☐Multiple Sclerosis	____________
☐Chest Pains	☐Depression	☐Loss of Balance	☐IBS/Crohn's	____________
☐Dizziness	☐Light Bothers Eyes	☐Diarrhea	☐High Blood Pressure	
☐Double Vision	☐Ear Ring/Buzz	☐Constipation	☐Low Blood Pressure	

Accidents/Trauma/Injury History

Number of car accidents:_________ Approximate dates:______________________________
Any Work, Sports or other injuries: ____
Medications you are currently taking: ____
Have you had surgery? ☐yes ☐no What type? ______________________When_____________
Any significant family medical conditions/history ____________________________________
Give a brief description of the physical nature of your work: __________________________
Rate your occupational stress (1-10) 10 being the most stressful _________
What types of physical, emotional and chemical stressors have you experienced? ________________

Do you smoke? ☐yes ☐no How many per day? ________ Do you drink alcohol? ☐ yes ☐no How many per week? ________
What would I like to see change in my life as a result of my chiropractic care? ____________________
I would like to: (check all that apply)

☐Feel better quickly ☐Have a healthier spine and better postural alignment
☐Improve function and performance ☐ Have a better quality of life

Signature ______________________________ Date _______________

Neck Pain and Disability Index (Vernon-Mior)

Patient Name: ______________________ **File #**____________ **Date:**__________

Please read instructions:

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

SECTION 1 - PAIN INTENSITY

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

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 - READING

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

SECTION 5 - 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.

SECTION 6 - CONCENTRATION

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

SECTION 7 - WORK

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

SECTION 8 - DRIVING

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

SECTION 9 - SLEEPING

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

SECTION 10 - RECREATION

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Pain Scale:

Rate the Severity of your pain by checking one box on the following scale

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: ______________________ File # ____________ Date: ____________

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the 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
- ☐ 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 severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE
- ☐ I would 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 increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase 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.

SECTION 3 - 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 manage if they are conveniently positioned (e.g. 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 only lift very light weights at the most.

SECTION 4 - WALKING
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one km. without increasing pain.
- ☐ I cannot walk more than 1/2 km. without increasing pain.
- ☐ I cannot walk more than 1/4 km. without increasing pain.
- ☐ I cannot walk at all without increasing pain.

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 half hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 - STANDING
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one 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 the pain straight away.

SECTION 7 - 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 night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE
- ☐ My social life is normal and gives me no 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, 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.

SECTION 9 - TRAVELLING
- ☐ I get no pain whilst travelling.
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

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 present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Pain Severity Scale:

Rate the Severity of your pain by checking one box on the following scale

No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain