



First & Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ E-mail \_\_\_\_\_

Employer's Name \_\_\_\_\_ Position \_\_\_\_\_

Employer's Address \_\_\_\_\_

Marital Status – circle one: {S M W D} Number of Children \_\_\_\_\_ Are You Insured? Y / N

Ins. Company \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Do you have AFLAC accident insurance? Y / N

Spouse's Name \_\_\_\_\_ Are you Pregnant? Y / N

Referred by \_\_\_\_\_ If minor, Parents Names \_\_\_\_\_

1. Is today's problem caused by an automobile accident or work accident/injury?  No  Yes  
*(If YES, Please Notify Front Desk Assistant)*

2. Indicate on the drawings below where you have pain/symptoms:

**Main Complaint:**

\_\_\_\_\_

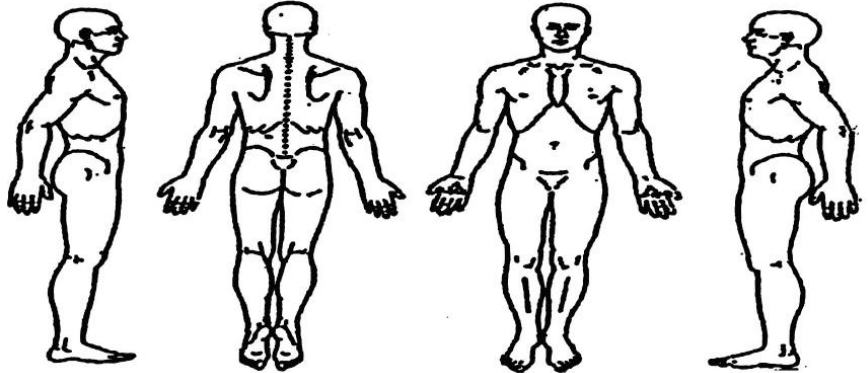
**Other Complaints:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



3. What concerns you the most about your problem?  
\_\_\_\_\_

4. Do you consider this problem to be severe?

- Yes  Yes, at times  No

5. How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

6. How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

7. Who else have you seen for your problem?

- Chiropractor  Neurologist  Primary Care Physician
- ER physician  Orthopedist  Other: \_\_\_\_\_
- Massage Therapist  Physical Therapist  No one

8. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

9. How would you rate your overall Health?  Excellent  Very Good  Good  Fair  Poor

10. What type of exercise do you do?  Strenuous  Moderate  Light  None

11. Indicate if you have any immediate family members with any of the following:

- |   |                                   |                                |
|---|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Cancer   | <input type="checkbox"/> ALS   |

12. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		<b>For Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular In coordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		

13. List all prescription medications you are currently taking: \_\_\_\_\_

14. List all of the over-the-counter medications and/or supplements you are currently taking: \_\_\_\_\_

15. List all surgical procedures you have had: \_\_\_\_\_

16. What activities do you do at work?

- |   |  |                                       |  |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |

17. What activities do you do outside of work? \_\_\_\_\_

18. Have you ever been hospitalized?  No  Yes

If yes, why \_\_\_\_\_

19. Have you had any past falls, traumas, or automobile accidents?  No  Yes

If yes, explain \_\_\_\_\_

20. Have you ever been diagnosed with osteoporosis or osteopenia?  No  Yes

21. Have you ever been diagnosed with cancer?  No  Yes

If yes, explain \_\_\_\_\_

22. List 3 activities that you are find difficult or are unable to perform due to this condition.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Has this condition affected your bowel or bladder habits?  No  Yes

If yes, how \_\_\_\_\_

24. Have you visited a chiropractor before?  No  Yes

If yes, when was your last visit? \_\_\_\_\_

25. Anything else pertinent to your visit today? \_\_\_\_\_

**Financial Policy:** Full Payment is due at the time of service. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that when my account becomes 45 days past due, it is the policy of this office to forward it to TekCollect for collection. At such time, I will be subject to collection charges and further collection activity.

If I am a patient with insurance coverage, I understand and agree that medical insurance policies are an arrangement between my insurance company and myself - not my insurance company and this office. I authorize this office to release any medical information and complete any usual and customary reports and forms at no charge, to assist in collecting from my insurance company. Not all insurance pays all of the charges, and the patient will be responsible for his/her portion at the time the services are rendered. If my insurance company deems care not medically necessary, the balance will be my responsibility. I understand that I am ultimately responsible for payment in full.

I have read this financial policy. I understand and agree to all the terms of this policy.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent signature if minor)*

**Consent to X-Ray:** I herby authorize Baker Chiropractic & Rehab, LLC and whomever the clinician my designate as his assistant(s) to take any needed x-rays. If I am a female, I herby state that I am not pregnant. *(If for any reason you may possibly be pregnant, please discuss this with the doctor before signing below.)* I understand that if I request, copies of my x-rays may be made at a \$20 copy charge. X-rays may be sent to any location at a shipping and handling fee of \$15.

**I herby consent to x-ray.**

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_  
*(Parent signature if minor)*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the letter of the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **ONLY** circle the **one choice** which closely describes your problem right now.

## Neck Disability Index

### 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 but 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 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 causes extra 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 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 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--Headache

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

Raw Score: \_\_\_\_\_

DISABILITY INDEX SCORE: \_\_\_\_\_%

### 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 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 engage in all recreational activities with no pain in my neck at all.
- B. I am able engage in all recreational activities with some pain in my neck.
- C. I am able engage in most, but not all recreational activities because of pain in my neck.
- D. I am able 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.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient:** This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage everyday activities. Please answer each Section by circling the letter of the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **ONLY** circle the **one choice** which closely describes your problem right now.

## Back Disability Index

DISABILITY INDEX SCORE: \_\_\_\_\_ %

### 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 severe but comes and goes.
- 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 increase the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do any 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 the 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. I have some pain on walking but it does not increase with distance.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevents me from walking more than 1/2 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.

Raw Score \_\_\_\_\_

### 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 ½ hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right 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.
- 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. Pain prevents me from sleeping at all.

### 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.