GREENVILLE
FAMILY CHIROPRACTIC, LLC.

Welcome!

NEW PATIENT

DATE _____ HOW DID YOU HEAR ABOUT US? _____

PATIENT

TITLE: ☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR. ☐ OTHER _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER _____

FIRST NAME M.I. LAST NAME

DATE OF BIRTH GENDER: ☐ MALE ☐ FEMALE SOCIAL SEC. #:

ADDRESS CITY ST ZIP

PHONE NUMBERS: HOME ( ) WORK ( ) CELL ( )

EMAIL

NAME OF SPOUSE / EMERGENCY CONTACT :

PHONE NUMBERS: HOME ( ) WORK ( ) CELL ( )

EMPLOYMENT / INSURANCE ☺ *PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD* ☺

STATUS: ☐ EMPLOYED ☐ SELF-EMPLOYED ☐ UNEMPLOYED ☐ FT/PT STUDENT ☐ MILITARY ☐ RETIRED ☐ DISABLED

WHO IS RESPONSIBLE FOR YOUR BILL?

☐ SELF ☐ HEALTH INSURANCE ☐ SPOUSE ☐ WORKER'S COMP ☐ AUTO INS. ☐ MEDICARE ☐ MEDICAID ☐ OTHER _____

EMPLOYMENT

NAME OF EMPLOYER OCCUPATION

Mark the categories that best describe your job.

☐ Business owner ☐ Administrator ☐ Administrative assistant ☐ Executive / Legal ☐ Data processing
☐ Heavy equipment operator ☐ Childcare ☐ Construction ☐ Health care ☐ Food service
☐ Heavy manual labor ☐ Medium manual labor ☐ Light manual labor ☐ Manufacturing ☐ Home services
☐ OTHER: _____

How much does your condition interfere with your job performance?

☐ Has no effect ☐ Allows normal activity ☐ Slightly limits activity
☐ Moderately hinders duties ☐ Significantly hinders duties ☐ Prevents duties

Are you currently pregnant, or is there a chance you could be pregnant? ☐ YES ☐ NO

Are you currently under the care of a physician? ☐ YES ☐ NO If so, may we contact him / her? ☐ YES ☐ NO

Medical Group: _____ Doctor's name: _____

☐ YES ☐ NO Have you ever been hospitalized or had major surgery? _____
☐ YES ☐ NO Have you ever had a serious head, back, or neck surgery? _____
☐ YES ☐ NO Do you have any allergies? _____
☐ YES ☐ NO Are you currently taking any medications? (Please list) _____

PATIENT NAME_____ DATE _____

MEDICAL CONDITIONS: Please mark all that apply to you.

☐ AIDS / HIV	☐ Allergy shots	☐ Anemia	☐ Anorexia	☐ Appendicitis	☐ Asthma
☐ Bleeding	☐ Breast lump	☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts
☐ Chicken Pox	☐ Depression	☐ Diabetes	☐ Emphysema	☐ Epilepsy	☐ Fractures
☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout	☐ Heart disease	☐ Hepatitis
☐ Hernia	☐ Herniated disc	☐ Herpes	☐ High cholesterol	☐ Kidney disease	☐ Liver disease
☐ Measles	☐ Migraines	☐ Miscarriage	☐ Mono	☐ M.S.	☐ Mumps
☐ Osteoporosis	☐ Parkinson's	☐ Polio	☐ Pacemaker	☐ Pneumonia	☐ Prostate
☐ Tumors	☐ Ulcers	☐ V.D.	☐ Whooping cough	☐ Chronic fatigue	☐ High blood pressure
☐ Fibromyalgia	☐ Other _____				

SOCIAL HISTORY: Please mark all that apply to you.

CAFFEINE USE:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
ALCOHOL USE:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
EXERCISE:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
CHEW TOBACCO:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
CIGARETTES:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
WEAR SEAT BELT:	☐ Never	☐ Occasionally	☐ Always

OTHER: _____

FAMILY HISTORY: Please mark all that apply to members of your immediate family.

ARTHRITIS:	☐ Parent	☐ Sibling	HIGH BLOOD PRESS:	☐ Parent	☐ Sibling
CANCER:	☐ Parent	☐ Sibling	STROKE:	☐ Parent	☐ Sibling
DIABETES:	☐ Parent	☐ Sibling	Thyroid Disease:	☐ Parent	☐ Sibling
HEART DISEASE:	☐ Parent	☐ Sibling	OTHER: _____	☐ Parent	☐ Sibling

Have you ever been treated by another chiropractor? ☐ YES ☐ NO If so, was it a positive experience? ☐ YES ☐ NO

IF "NO" PLEASE EXPLAIN: _____

_____

Mark any symptoms you have experienced in the last six months.

☐ Headaches (Frequency: _____)

☐ Neck pain	☐ Sleeping problems	☐ Numbness in feet	☐ Numbness in hands	☐ Dizziness	☐ Weakness in arms or legs
☐ Stiff neck	☐ Loss of balance	☐ Back pain	☐ Tension	☐ Fainting	☐ Shoulder / neck / arm pain
☐ Cold hands	☐ Cold feet	☐ Arthritis	☐ Muscle spasms	☐ Joint pain / swelling	

Briefly describe your current symptoms: _____

_____

How did your symptoms start? _____

_____

Average pain intensity:

Last 24 hours	NO PAIN	1	2	3	4	5	6	7	8	9	10	WORST PAIN
Past week	NO PAIN	1	2	3	4	5	6	7	8	9	10	WORST PAIN

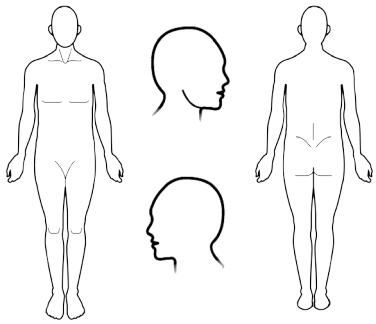
How often do you experience your symptoms?

☐ CONSTANTLY ☐ FREQUENTLY ☐ OCCASIONALLY ☐ INTERMITTENTLY

How much have your symptoms interfered with your usual daily activities?

☐ NOT AT ALL ☐ A LITTLE BIT ☐ MODERATELY ☐ QUITE A BIT ☐ EXTREMELY

MARK THE LOCATION OF YOUR SYMPTOMS



How is your condition changing, since care at THIS facility?

☐ N/A (1ST VISIT) ☐ MUCH WORSE ☐ A LITTLE WORSE ☐ NO CHANGE ☐ A LITTLE BETTER ☐ BETTER ☐ MUCH BETTER

How would your rate your overall health right now?

☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

PATIENT SELF-ASSESSMENT

PATIENT NAME_____ DATE _____

ACTIVITIES OF DAILY LIFE (ADL)

Rate how your symptoms affect your daily activities.

BENDING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
CARRYING GROCERIES:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
CHANGING POSITION (SIT - STAND):	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
CLIMBING STAIRS:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
DRIVING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
EXTENDED COMPUTER USE:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
EATING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
HOUSEHOLD CHORES:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
KNEELING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
LIFTING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
PET CARE:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
READING (CONCENTRATION):	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
SELF CARE - BATHING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
SELF CARE - DRESSING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
SELF CARE - SHAVING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
SEXUAL ACTIVITIES:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
SLEEPING:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
SITTING OVER 30 MINUTES:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
STANDING OVER 30 MINUTES:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
WALKING	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform-
YARD WORK:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform

RECREATION

Rate how your symptoms affect your recreational activities.

PLAY WITH CHILDREN OR PETS:	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
SPORT:_____	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
HOBBY: _____	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform
OTHER: _____	☐ No effect	☐ Mild: Painful (Can do)	☐ Moderate: Painful (Limited)	☐ Severe: Unable to Perform

HIPAA PRIVACY PRACTICES

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

PATIENT'S NAME (PLEASE PRINT) _____ DATE _____

PATIENT'S SIGNATURE_____

NECK INDEX

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

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain comes and goes and is moderate.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imagineable at the moment.

SLEEPING

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

READING

- 0 I can read as much as I want with no neck pain.
- 1 I can read as much as I want with slight neck pain.
- 2 I can read as much as I want with moderate pain.
- 3 I cannot read as much as I want because of moderate neck pain.
- 4 I can hardly read at all because of severe neck pain.
- 5 I cannot read at all because of neck pain.

CONCENTRATION

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

WORK

- 0 I can do as much work as I want.
- 1 I can only do my usual work but no more.
- 2 I can only 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 cannot do any work at all.

PERSONAL CARE

- 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 I 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.

LIFTING

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

DRIVING

- 0 I can drive my vehicle without any neck pain.
- 1 I can drive my vehicle as long as I want with slight neck pain.
- 2 I can drive my vehicle as long as I want with moderate neck pain.
- 3 I cannot drive my vehicle as long as I want because of moderate neck pain.
- 4 I can hardly drive at all because of severe neck pain.
- 5 I cannot drive my vehicle at all because of neck pain.

RECREATION

- 0 I am able to engage in all my recreational activities without neck pain.
- 1 I am able to engage in all my usual recreational activities with some neck pain.
- 2 I am able to engage in most but not all my usual recreational activities because of neck pain.
- 3 I am only able to engage in a few of my usual recreational activities because of neck pain.
- 4 I can hardly do any recreational activities because of neck pain.
- 5 I cannot do any recreational activities at all.

HEADACHES

- 0 I have no headaches at all.
- 1 I have slight headaches which come infrequently.
- 2 I have moderate headaches which come infrequently.
- 3 I have moderate headaches which come frequently.
- 4 I have severe headaches which come frequently.
- 5 I have headaches almost all the time.

NECK INDEX SCORE:

$$\text{Index Score} = \left(\frac{\text{sum of all statements selected}}{\text{\# of sections with a statement selection x 5}} \right) \times 100$$

BACK INDEX

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

- [0] The pain comes and goes, and is very mild.
- [1] The pain is mild and does not vary much.
- [2] The pain comes and goes and is moderate.
- [3] The pain is moderate and does not vary much.
- [4] The pain comes and goes, and is very severe.
- [5] The pain is very severe and does not vary much.

CHANGING DEGREE OF PAIN

- [0] My pain is rapidly getting better.
- [1] My pain fluctuates, but over all is definitely getting better.
- [2] My pain seems to be getting better, but improvement is slow.
- [3] My pain is neither getting better nor worse.
- [4] My pain is gradually worsening.
- [5] My pain is rapidly worsening.

SLEEPING

- [0] I get no pain in bed.
- [1] I get pain in bed, but it does not prevent me from sleeping well.
- [2] Because of pain my normal sleep is reduced by up to 25%.
- [3] Because of pain my normal sleep is reduced by up to 50%.
- [4] Because of pain my normal sleep is reduced by up to 75%.
- [5] The pain prevents me from sleeping at all.

SITTING

- [0] I can sit in any chair as long as I please.
- [1] I can only sit in my favorite chair as long as I please.
- [2] Pain prevents me from sitting more than one hour.
- [3] Pain prevents me from sitting more than 30 minutes.
- [4] Pain prevents me from sitting more than ten minutes.
- [5] I avoid sitting because it increases pain immediately.

STANDING

- [0] I can stand as long as I want without pain.
- [1] I have some pain while standing, but it does not increase with time.
- [2] I cannot stand for longer than one hour without increasing pain.
- [3] I cannot stand for longer than 30 minutes without increasing pain.
- [4] I cannot stand for longer than ten minutes without increasing pain.
- [5] I avoid standing because it increases pain immediately.

WALKING

- [0] I have no pain while walking.
- [1] I have some pain while walking, but it does not increase with distance.
- [2] I cannot walk more than one mile without increasing pain.
- [3] I cannot walk more than a half-mile without increasing pain.
- [4] I cannot walk more than a quarter mile without increasing pain.
- [5] I cannot walk at all without increasing pain.

PERSONAL CARE

- [0] I do not have to change my ways of washing and dressing to avoid pain.
- [1] I do not normally alter my ways of washing or dressing even though it causes some pain.
- [2] Washing and dressing increases the pain, but I manage not to change my ways of doing it.
- [3] Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
- [4] Because of the pain, I am unable to do some washing and dressing without help.
- [5] Because of the pain, I am unable to do any washing and dressing without help.

LIFTING

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

TRAVELING

- [0] I get no pain while traveling.
- [1] I get some pain while traveling, but none of my usual forms of travel make it worse.
- [2] I get extra pain while traveling, but it does not cause me to seek alternate forms of travel.
- [3] I get extra pain while traveling which causes me to seek alternate forms of travel.
- [4] Pain restricts all forms of travel except that done while lying down.
- [5] Pain restricts all forms of travel.

SOCIAL LIFE

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

BACK INDEX SCORE:

$$\text{Index Score} = \left(\frac{\text{sum of all statements selected}}{\text{\# of sections with a statement selection x 5}} \right) \times 100$$