

Berkeley Chiropractic Center  
2902 Central Heights Rd. Suite E  
Goldsboro, NC 27534

Proper First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

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

Street Address & Number: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Social Security Number: \_\_\_\_\_ Marital Status: (circle one) Single Married Divorced Widowed # of Children: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Status:  Full Time  Part Time  
Student:  Full Time  Part Time

Drivers License #: \_\_\_\_\_ State: \_\_\_\_\_ How were you referred to our office? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

◆ Are today's problems related to:  Auto Injury  Workman's Compensation  Neither

◆ Describe your condition(s) beginning with the most severe. Please rate each condition on a scale of 1 to 10 (10 being worst)

1. \_\_\_\_\_ ( \_\_\_\_ / 10) 2. \_\_\_\_\_ ( \_\_\_\_ / 10)

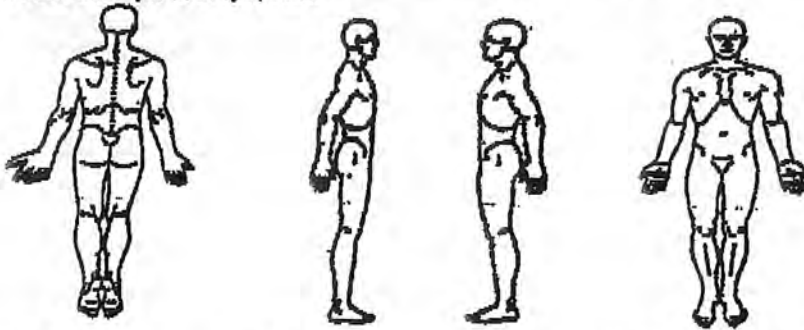
3. \_\_\_\_\_ ( \_\_\_\_ / 10) 4. \_\_\_\_\_ ( \_\_\_\_ / 10)

5. \_\_\_\_\_ ( \_\_\_\_ / 10) 6. \_\_\_\_\_ ( \_\_\_\_ / 10)

◆ How often do you experience pain?  Constantly (75-100%)  Frequently (50-75%)  Occasionally (25-50%)  Intermittently (1-25%)

◆ How would you describe the type of pain?  Ache  Dull  Burn  Sharp  Shooting  Numb  Other

◆ Please indicate on the diagram below where you have symptoms:



◆ How are your symptoms changing with time?  Getting Worse  Not Changing  Getting Better

◆ How much has your problem interfered with your work?  Not At All  A Little Bit  Moderately  Quite A Bit  Extremely

◆ How much has the problem interfered with your social activities?  Not At All  A Little Bit  Moderately  Quite A Bit  Extremely

◆ Who else have you seen for your problem?

Chiropractor  Neurologist  Primary Care Physician  ER Physician  No One  
 Orthopedist  Massage Therapist  Physical Therapist  Other: \_\_\_\_\_

Who? \_\_\_\_\_ Treatment? \_\_\_\_\_ Results: \_\_\_\_\_

◆ Who is your family physician? \_\_\_\_\_

◆ How long have you had this problem? \_\_\_\_\_

◆ How do you think your problem began? \_\_\_\_\_

◆ Do you consider this problem to be severe?  Yes  Yes, At Times  No

◆ What aggravates your problem? \_\_\_\_\_

◆ What makes your problem better? \_\_\_\_\_

• What concerns you the most about your problem what does it prevent you from doing? \_\_\_\_\_

♦ What is your: Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

♦ How would you rate your overall health?  Excellent  Very Good  Good  Fair  Poor

♦ What type of exercise do you do on a regular basis?  Strenuous  Moderate  Light  None

♦ Family History: Place an (X) if any family member has suffered from:

- |   |                                   |   |  |  |
|---|-----------------------------------|---|--|--|
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus          | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Heart Attacks       |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> ALS      | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Gout            | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Spinal Disorder | <input type="checkbox"/> Arthritis           |

♦ 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	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	<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorders	<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 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	<input type="checkbox"/>	<input type="checkbox"/> Other _____				
For Females Only:		<input type="checkbox"/>	<input type="checkbox"/> Birth Control	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy

♦ What activities do you do at work?

Sit:	<input type="checkbox"/> Most Of The Day	<input type="checkbox"/> Half The Day	<input type="checkbox"/> A Little Of The Day
Stand:	<input type="checkbox"/> Most Of The Day	<input type="checkbox"/> Half The Day	<input type="checkbox"/> A Little Of The Day
Computer Work:	<input type="checkbox"/> Most Of The Day	<input type="checkbox"/> Half The Day	<input type="checkbox"/> A Little Of The Day
On The Phone:	<input type="checkbox"/> Most Of The Day	<input type="checkbox"/> Half The Day	<input type="checkbox"/> A Little Of The Day
Driving:	<input type="checkbox"/> Most Of The Day	<input type="checkbox"/> Half The Day	<input type="checkbox"/> A Little Of The Day
Manual Labor:	<input type="checkbox"/> Most Of The Day	<input type="checkbox"/> Half The Day	<input type="checkbox"/> A Little Of The Day

♦ What activities do you do outside of work? \_\_\_\_\_

♦ List all prescription medications you are currently taking: \_\_\_\_\_

♦ List all over-the-counter medications you are currently taking: \_\_\_\_\_

♦ List all surgical procedures you have had: \_\_\_\_\_

♦ Have you ever been hospitalized?  No  Yes

If Yes, what were you hospitalized for? \_\_\_\_\_

♦ Have you seen a Chiropractor before?  No  Yes

If Yes, who? \_\_\_\_\_ When was your last visit? \_\_\_\_\_

♦ Have you had any other significant past trauma?  No  Yes

♦ Anything else pertinent to your visit today? \_\_\_\_\_

I hereby authorize Sylvia Chiropractic Center to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payments, or make payment directly to me. First day's fees are due and payable at the time of service.  
**BY SIGNING YOUR NAME BELOW, YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. SYLVIA FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.**

Signature of Patient, or of Guardian authorizing care \_\_\_\_\_

Date \_\_\_\_\_

# BERKELEY CHIROPRACTIC CENTER

## ACTIVITIES OF DAILY LIVING

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

**Activities of Daily Living:** The things we normally do in daily living including any daily activity we perform for self-care (such as feeding ourselves, bathing, dressing, grooming), work, homemaking, and leisure. The ability or inability to perform ADL's can be used as a very practical measure of ability/disability in many disorders.

Please place a check beside any/all of the following activities that you are **having trouble performing** on a normal daily basis **without pain**.

- |   |  |
|---|--|
| <input type="checkbox"/> Dressing                   | <input type="checkbox"/> Bathing               |
| <input type="checkbox"/> Lifting                    | <input type="checkbox"/> Grooming              |
| <input type="checkbox"/> Walking                    | <input type="checkbox"/> Oral Care             |
| <input type="checkbox"/> Sitting comfortably        | <input type="checkbox"/> Toileting             |
| <input type="checkbox"/> Sleeping through the night | <input type="checkbox"/> Climbing Stairs       |
| <input type="checkbox"/> Having energy              | <input type="checkbox"/> Eating                |
| <input type="checkbox"/> Driving                    | <input type="checkbox"/> Shopping              |
| <input type="checkbox"/> Reading                    | <input type="checkbox"/> Cooking               |
| <input type="checkbox"/> Working                    | <input type="checkbox"/> Housework             |
| <input type="checkbox"/> Running                    | <input type="checkbox"/> Doing Laundry         |
| <input type="checkbox"/> Bending                    | <input type="checkbox"/> Playing with Children |

OTHER: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WELCOME**  
**TO**  
**BERKELEY CHIROPRACTIC**  
**CENTER**

DO YOU HAVE A MEDICAL DOCTOR?

**PLEASE CIRCLE**

**YES**

**NO**

IF NO, WOULD YOU LIKE TO BE CONTACTED  
FOR AN APPOINTMENT AT THE  
MEDICAL CLINIC?

**PLEASE CIRCLE**

**YES**

**NO**

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: \_\_\_\_\_

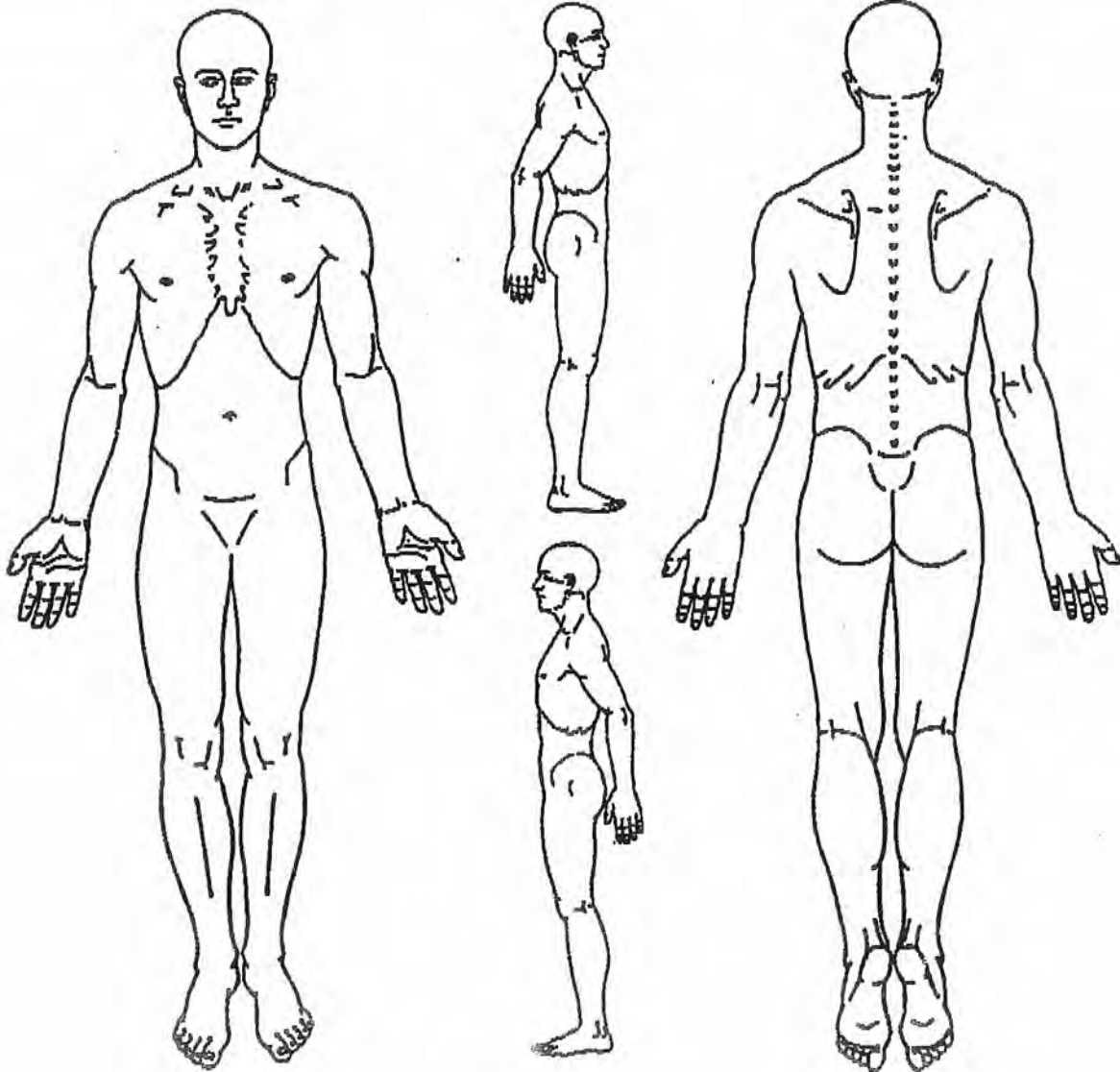
HOW LONG HAVE YOU HAD NECK PAIN? \_\_\_ YEARS \_\_\_ MONTHS \_\_\_ WEEKS

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 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 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 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 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 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 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 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 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.

### 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.

*After Vernon & Mior, 1991*

*Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics*

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

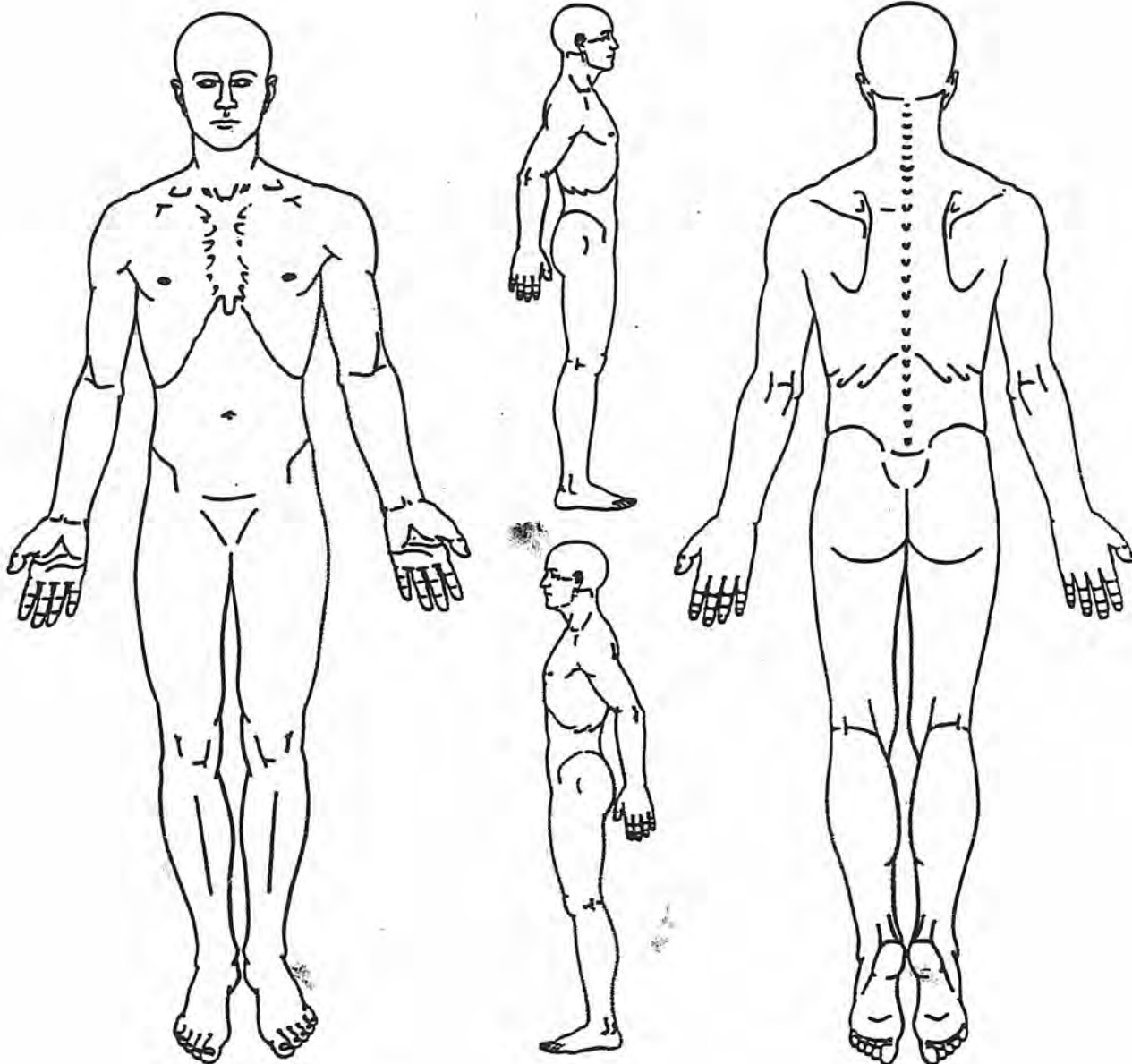
B=BURNING

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*

### 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.

REVISED 9/11/82

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

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