Forsyth Chiropractic and Wellness

1330 East Arlin[illegible] Blvd., Suite B • Greenville, NC 27858 • Phon[illegible]52) 355-5353

Date: ____ / _____ / 20 ____

Last Name:_____ First Name: _____Middle Init.: _____

Do you have a preferred name or nickname? ☐No ☐Yes: _____

Date of Birth: (mm/dd/year) _____/_____/_____ SSN: _____ – _____ – _____

Address: _____ Apt./Unit #_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ – _____ Cell Phone: (_____) _____ – _____

Email Address: _____

Race/Ethnicity: American Indian Asian Black/African American Hispanic Pacific Islander White Multi-racial Other

Language: (Please Circle One) English Spanish Other: _____

Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Emergency Contact Person: _____ Emergency Contact Phone: (____) ____ – _____

Preferred Method of Communication: (Circle one) Home Phone Cell phone Email Text message

Your Employer: _____ ☐ Full Time Student

Your Occupation:_____ ☐ Part Time Student

Work Phone: (____) _____–_____ Extension: _____

Family Physician: _____

Address: _____ Phone: (____) _____–_____

***Do we have your permission to send office notes to your primary care physician**? ☐ Yes ☐ No

How were you referred to our office? (You may choose more than one.) ☐Friend ☐Relative ☐Co-Worker

☐Medical Doctor ☐Yellow Pages ☐Sign ☐Internet Site ☐Dr. McGee/Staff Member

☐Other: _____

Referrer's Name(s): _____

PRIMARY INSURANCE

Policy Holder: _____

Relationship to Patient: _____ Policy Holder's SSN: _____ – _____ – _____

Policy Holder Date of Birth: _____

Address (if different from above): _____

Policy Holder Employer: _____ Phone: (_____) _____ – _____

****

**** We file primary insurance weekly. We DO NOT file secondary insurance. If you need us to file secondary insurance, we can do so for a $10.00 filing fee.*** Are you covered by secondary insurance? □ Yes □ No

How will you be paying for today's visit? □ Cash □ Check □ Credit card □ Debit card

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Name: _____ Date: ____ / _____ / 20 ____

Are you a new or returning patient? ☐ New Patient ☐ Returning Patient

Tell us why you are being seen today. ☐Headache ☐Neck Pain ☐Upper Back Pain ☐Low Back Pain Other _____
Note - ♦If you have more than one problem area please describe each of them separately on the next page.♦

Location of your #1, primary problem/pain? _____Please Specify: ☐ Right ☐ Left ☐ Central

When did your #1 problem/pain start? Onset Date: _____ / _____ / _____ ☐ Not sure when it started.

Was there a specific event that caused the problem/pain? ☐ Yes ☐ No
If yes, describe: _____

What **aggravates** your problem/pain? ☐Lying down ☐Sitting ☐Standing ☐Coughing ☐Sneezing Other: _____ __ What

reduces your problem/pain? ☐Lying down ☐Sitting ☐Standing ☐Other: _____

Please describe what you are feeling:
☐Numbness ☐Pins & Needles ☐Burning Pain ☐Aching Pain ☐Stabbing Pain ☐Dull Ache ☐Stiffness

Does the pain/sensation spread or radiate to other areas? ☐ Yes ☐ No
If yes, please describe: _____

Please rate your pain/problem on a scale from 0 to 10. **0 = No Pain** **10 = most severe pain possible**

What is your pain right now?	0	1	2	3	4	5	6	7	8	9	10
What is your pain at its best? (Since your problem started)	0	1	2	3	4	5	6	7	8	9	10
What is your most severe pain since the onset?	0	1	2	3	4	5	6	7	8	9	10
What is your average pain? (Since your problem started)	0	1	2	3	4	5	6	7	8	9	10

Is your problem/pain worse during certain times of the day? ☐ No ☐ Yes Morning Afternoon Evening Nighttime

Have you had similar problems in the past? ☐ Yes ☐ No

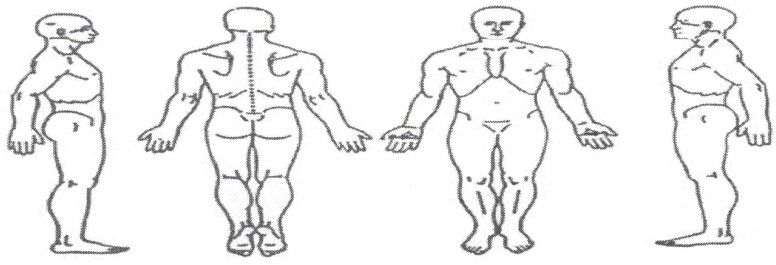
Is your problem/pain getting: ☐Worse ☐Better ☐Not Changing

How often do you experience your pain/problem?
☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day

Who have you seen for this problem/pain? ☐No One ☐Chiropractor ☐Medical Doctor ☐Physical Therapy

♦Using the symbols provided, please indicate where you have your pain/problem♦

Stabbing	/ / / / / /
Aching	△ △ △ △
Stiffness	S S S S S
Burning	X X X X X
Pins & Needles	o o o o
Numbness	= = = = =



Patient Signature: _____

Additional History of Present Illness

Complete this form only if you have more than one complaint/problem area.

Name: _____ Date: _____ / _____ / _____

 # 2 What else hurts? What is the next most important problem you would like us to address?

Location of your 2nd problem/pain? ☐Headache ☐Neck Pain ☐Upper Back Pain ☐Low Back Pain Other _____ Please Specify: ☐ Right side ☐ Left side ☐ Central

When did your 2nd problem/pain start? Onset Date: _____ / _____ / _____ ☐ Not sure when it started.

Was there a specific event that caused the 2nd problem/pain? ☐ yes ☐ no

If yes, describe: _____

What aggravates your 2nd problem/pain? ▫Lying down ▫Sitting ▫Standing ▫Coughing ▫Sneezing Other:_____ What lessens this problem/pain? ▫Lying down ▫Sitting ▫Standing ▫Coughing ▫Sneezing Other:_____ Please describe what you are feeling:

☐Numbness ☐Pins & Needles ☐Burning Pain ☐Aching Pain ☐Stabbing Pain ☐Dull Ache

Does the pain/sensation spread or radiate to other areas? ☐ Yes ☐ No

If yes, please describe: _____

Please rate your 2nd pain/problem on a scale from 0 to 10.	**0 = No Pain 10 = most severe pain possible**
What is your pain right now?	0 1 2 3 4 5 6 7 8 9 10
What is your pain at its best? (Since your problem started)	0 1 2 3 4 5 6 7 8 9 10
What is your most severe pain since the onset?	0 1 2 3 4 5 6 7 8 9 10
What is your average pain? (Since your problem started)	0 1 2 3 4 5 6 7 8 9 10

Is this problem/pain worse during certain times of the day? ☐ No ☐ Yes Morning Afternoon Evening Nighttime

Other: _____

Is this problem/pain getting: ☐Worse ☐Better ☐Not Changing How often do you experience the 2nd pain/problem?

☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day

#3 What else hurts? What is the next most important problem you would like us to address?

Location of your 3rd problem/pain? ☐Headache ☐Neck Pain ☐Upper Back Pain ☐Low Back Pain Other _____ Please Specify: ☐ Right side ☐ Left side ☐ Central

When did your 3rd problem/pain start? Onset Date: _____ / _____ / _____ ☐ Not sure when it started. Was there a specific event that caused the 3rd problem/pain? ☐ yes ☐ no

If yes, describe: _____

What aggravates your 3rd problem/pain? ▫Lying down ▫Sitting ▫Standing ▫Coughing ▫Sneezing Other:_____ What lessens your problem/pain? ▫Lying down ▫Sitting ▫Standing ▫Coughing ▫Sneezing Other:_____ Please describe what you are feeling:

☐Numbness ☐Pins & Needles ☐Burning Pain ☐Aching Pain ☐Stabbing Pain ☐Dull Ache

Does the pain/sensation spread or radiate to other areas? ☐ Yes ☐ No

If yes, please describe: _____

Please rate your 3rd pain/problem on a scale from 0 to 10.	**0 = No Pain 10 = most severe pain possible**
What is your pain right now?	0 1 2 3 4 5 6 7 8 9 10
What is your pain at its best? (Since your problem started)	0 1 2 3 4 5 6 7 8 9 10
What is your most severe pain since it started?	0 1 2 3 4 5 6 7 8 9 10
What is your average pain? (Since your problem started)	0 1 2 3 4 5 6 7 8 9 10

Is this problem/pain worse during certain times of the day? ☐ No ☐ Yes Morning Afternoon Evening Nighttime

Other: _____

Is this problem/pain getting: ☐Worse ☐Better ☐Not Changing How often do you experience this 3rd pain/problem?

☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day

Name: _____ Date: ____ / _____ / 20 ____ **Other Symptoms:**

Do you have any of the following symptoms?

☐ Shortness of breath ☐ Chest pain ☐Fever ☐ Difficulty walking ☐ Dizziness ☐Headache
☐ Recent changes in bowel or bladder habits ☐Joint noises/popping ☐ Muscle incoordination
☐ Unexplained weight gain or weight loss ☐ Muscle weakness ☐ Visual disturbance
☐ Frequent fatigue ☐ Abdominal pain ☐ None of these

Have you been treated by a physician for any healthcare problem in the past 12 months? ☐Yes ☐No

If yes, describe:

_____

__ **-Medical History-**

Indicate which of the following illnesses you have now or have had in the past.

Past or Current Conditions

☐Allergies/Sinus
☐Pollen ☐Environmental
☐Cancer _____
_____
☐Depression _____
☐Diabetes
☐Type I ☐Type II
☐Fibromyalgia _____
☐Headaches _____
☐Heart Disease ☐Pacemaker ☐Defibrillator
☐Pregnancies _____ ☐Currently Pregnant
Blood Thinner Medication? ☐Yes ☐No

Past or Current Conditions

☐Heart Attack _____
☐High Blood Pressure ☐ I take medication for this
☐Kidney Stones ☐ Kidney Disease
☐Asthma ☐Other Lung Disorder_____
☐Stroke _____
☐Hyperthyroid ☐Hypothyroid _____
☐Ulcers/Stomach _____
☐Prostate Condition _____
☐HIV _____
Other _____
_____

-Surgery-

Please indicate below the types of surgeries you have had. ☐ None

☐Low Back _____
☐Neck _____
☐Shoulder R or L _____
☐Hip R or L _____
☐OB/GYN _____
☐Lung/Chest_____
☐Foot/Ankle _____
☐Hernia _____
☐Gall Bladder _____
☐Heart _____
☐Knee R or L _____
☐Other _____

-Medications-

Please list all medications you are taking. ☐None

Start date	Name	Dose	For what condition?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? ☐ No ☐ Yes: _____
_____

Family History

Low Back Pain: Father Mother Sister Brother
Low Back Surgery: Father Mother Sister Brother
Diabetes: Father Mother Sister Brother
Heart Disease: Father Mother Sister Brother
Cancer: Father Mother Sister Brother
Sclerosis: Father Mother Sister Brother
Father Mother Sister Brother

Social History

Do you smoke? ☐No ☐Yes How much?___pk/day
Exercise regularly? ☐No ☐Yes
Number of hours of sleep per night _____
Job requires: ☐Sitting/Computer
☐Light Labor ☐Moderate Labor ☐Heavy Labor Multiple
☐Repetitive Movements ☐High Stress Job Arthritis:

Patient Signature:_____

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Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

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 imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 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 neck 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 they 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 car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car 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 car at all because of neck pain.

Recreation

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

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

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.

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 less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 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 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 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 doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way 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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

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 affect 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.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score