

Patient Name _____ Birthdate _____ Sex M / F
Address _____ City _____ Status: S M W D |
State _____ Zip _____ Telephone (____) _____ CellPhone _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan: _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ Email Address _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

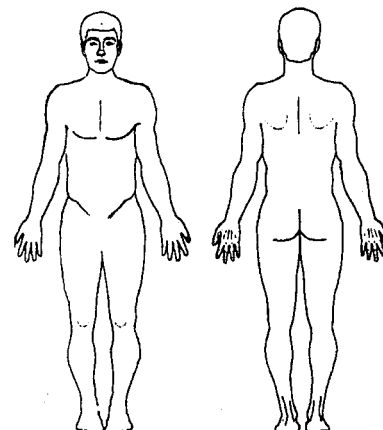
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Headache Neck Pain Mid-back Pain Low Back Pain
 Other _____

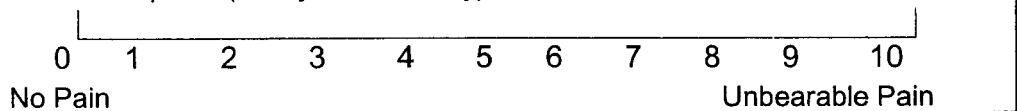
Is this? Work Related Auto Related N/A

Date Problem Began: _____

How Problem Began: _____



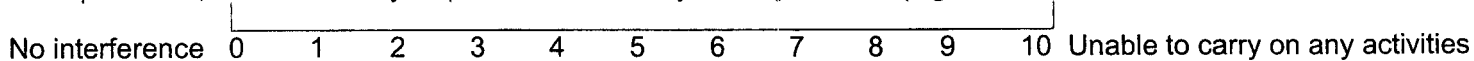
Current complaint (how you feel today):



How often are your symptoms present?

(Intermittent) 0 – 25% 26 – 50% 51 – 75% 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken: _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Cancer/Tumor (explain) _____ | <input type="checkbox"/> Visual Disturbances |
| _____ | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Epilepsy/Seizures | _____ |
| <input type="checkbox"/> Other Health Problems (explain) _____ | <input type="checkbox"/> Medications _____ |
| _____ | _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature _____ Date _____

Who Referred you to our office? Friend Family Physician Phone Book Other Name: _____

Barger Chiropractic
Symptom Intensity and Frequency Form

Date: _____ Patient: _____

SECTION 1: Describe on a scale of 1-10 how intense your pain is currently

0-No Symptoms exists

1 to 3-Mild, pain that is an annoyance

4 to 7-Moderate, pain that restricts or limits your ability to perform activities

8 to 10-Severe, pain disables you from doing anything

SECTION 1 CURRENT PAIN INTENSITY LEVELS

Pain Intensity	None	Mild Discomfort Ache/Stiff			Moderate Hurts/Sore/Bearable Sensation				Severe Sharp/Intense Pain		
		1	2	3	4	5	6	7	8	9	10
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand <i>R/L</i>	0	1	2	3	4	5	6	7	8	9	10
Mid Back	0	1	2	3	4	5	6	7	8	9	10
Low Back	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot <i>R/L</i>	0	1	2	3	4	5	6	7	8	9	10

SECTION 2a: CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	Occasional		Intermittent			Frequent			Constant	
		10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Neck	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand <i>R/L</i>	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low-Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot <i>R/L</i>	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

SECTION 2b: CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury of applicable circle the frequency (if less than 1 week) you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

Headache Frequency	None	1 per Week	2 per Week	3 per Week	4 per Week	5 per Week	6 per Week	Daily
Headache Duration (in hours)								

Signature: _____

FUNCTIONAL RATING INDEX

For use With Neck and/or Back Problems Only

Patient Name _____

In order to properly assess your condition, we must understand how much your **Neck and or/Back** problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. **Pain Intensity**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
No pain Mild pain Moderate pain Severe pain Worst possible pain

2. **Sleeping**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
Perfect sleep Mildly disturbed Moderately disturbed Greatly disturbed Totally disturbed

3. **Personal Care (washing, dressing, etc.)**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
No Pain, Mild Pain Moderate Pain Moderate Pain Severe Pain
no restriction no restrictions need to go slowly need assistance need 100% assistance

4. **Travel (driving, etc.)**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
No pain on Mild pain on Moderate pain on Moderate pain on Severe pain on
long trips long trips long trips short trips short trips

5. **Work**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
Can do usual work Can do usual work Can do 50% Can do 25% Cannot
plus unlimited extra work no extra work of usual work of usual work work

6. **Recreation**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
Can do all Can do most Can do some Can do a few Cannot do any
activities activities activities activities Activities

7. **Frequency of Pain**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
No Pain Occasional pain Intermittent pain Frequent pain Constant pain
25% of day 50% of day 75% of day 100% of day

8. **Lifting**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
No pain with Increased pain with Increased pain with Increased pain with Increased pain with
heavy weight heavy weight moderate weight light weight Any weight

9. **Walking**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
No pain Increased pain after Increased pain Increased pain Increased pain
any distance 1 mile after 1/2 mile After 1/4 mile with all walking

10. **Standing**

|0 _____ |1 _____ |2 _____ |3 _____ |4 _____
No pain after Increased pain Increased pain Increased pain Increased pain
Several hours After several hours after 1 hour After 1/2 hour with any standing

Patient Signature _____

Date _____