Chad J Anderson D.C.

New Patient Health History Form

NAME: _____ DATE: ____/____/_____

DOB: ____/____/_____ AGE: _____ MARITAL STATUS: M / S / D / W

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL PHONE: _____

EMAIL: _____

EMERGENCY CONTACT: _____

PHONE#: _____ RELATIONSHIP: _____

REFERRED BY: _____

OCCUPATION (IF RETIRED, FORMER OCCUPATION):_____

EMPLOYER: _____

CURRENT MD: _____

PAST CHIROPRACTIC CARE? Y / N DR'S NAME: _____

_____

Please answer the following questions on this page if you have a current open Worker's Comp or Personal Injury Case. (IF YOU DO NOT HAVE AN OPEN CASE PLEASE GO TO PAGE 2)

Date of onset: _____ Body part injured: _____

Who is the worker's compensation carrier? _____

What is the reason you are seeking Chiropractic care today?

Primary Condition? _____

Secondary Condition? _____

Third Condition? _____

What caused the symptom(s)? _____

Date the symptom(s) began? _____

Instructions: Please circle the word or number that best answers the question being asked.

Did the symptom(s) start: Suddenly? Gradually? Over how long of period? _____

Is the symptom(s) getting: Better? Worse? Same?

What percentage (%) of the day is your symptom(s) present?

5, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80, 85, 90, 95, 100

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

HEADACHE NECK LOW BACK

NO PAIN_____WORST POSSIBLE PAIN

0 1 2 (3) 4 (5) 6 7 (8) 9 10

---

1. What is your pain level right now?

No Pain _____Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical average pain level (in a 24 hour period)?

No Pain _____Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its least (how close to zero "0" does the pain level get)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

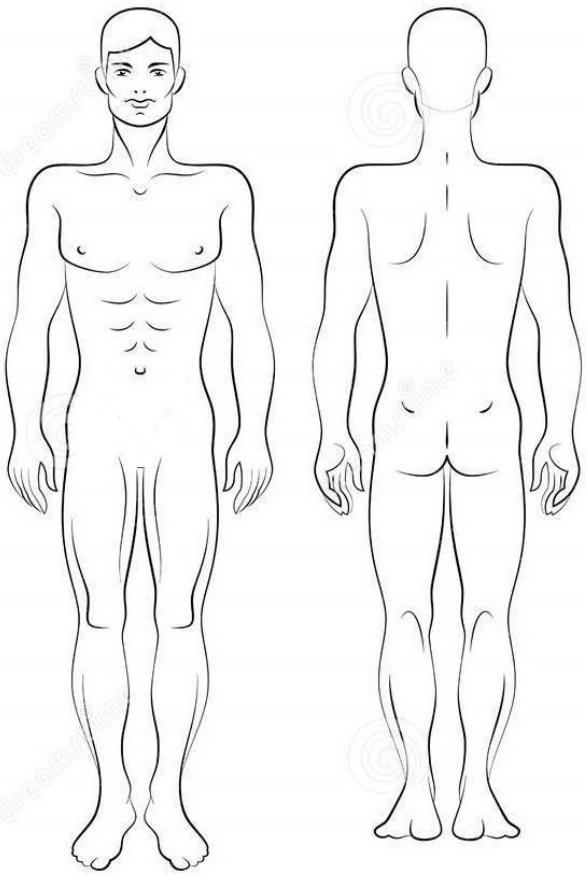
4. What is your pain level at its worst (how close to ten "10" does the pain level get)?

No Pain _____ Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

Anderson Chiropractic and Sports Clinic
411 Mill Beach Rd., Suite A, Brookings, OR 97415, (Mail) PO Box 7967 Brookings, OR 97415
Phone: (541) 469-2276, Fax: (541) 469-0489, Website: www.brookingschiro.com

On the Body Drawing below, mark where your pain is at describing the pain with the following letters:		
A= Achy Pain	**B= Burning Pain**	**D= Dull Pain**
N= Numbing Pain	**S= Sharp Pain**	**T= Traveling/Radiating Pain**



Is/Are your symptom(s) worse at a certain time of day? Y / N

_____ Morning, _____ Noon, _____ Afternoon, _____ Evening, _____ Night-Time

Have you had this symptom before? Y / N (If No, go to page 4)

If Yes;

When was it before? (Approx. Date, or Year) _____

Did you seek care? Y / N who did you see?

_____

_____

What was the outcome? (Please Circle): Resolved, Better, No Change, Worse, Needed Surgery, Other

If other; what was the outcome?

_____

WHAT MAKES THE SYMPTOM(S) WORSE?

(PLEASE CHECK ALL THAT APPLY)

Motion of the HEAD

_____ Head Down
_____ Head Up
_____ Turning Left
_____ Turning Right
_____ Tilting Left
_____ Tilting Right

Motion of the Low Back

_____ Bending Forward
_____ Bending Backwards
_____ Twisting Left
_____ Twisting Right
_____ Side Bend Left
_____ Side Bend Right

ACTIVITIES: (THAT YOU CANNOT DO OR IS PAINFUL TO DO)

_____ Standing
_____ Sitting
_____Getting out of a Chair
_____ Sit to Stand
_____ Putting on Socks
_____ Sleeping
_____ Dressing
_____ House Work
_____ Yard Work
_____ Bending
_____ Lifting
_____ Grooming
_____ Driving
_____ General Working
_____ Reading
_____ TV / Computer
_____ Walking
____ Other

If other, please describe: _____

_____

What makes the symptom(s) Better? (Less)

____ Nothing
____ Ice
____ Heat
____ Resting
____ Walking
____ Sitting
____ Laying Down
____ Stretching
____ Prescription Meds
____ OTC Pain Meds
____ Topical Gels
____ Other

If Other, please describe: _____

_____

Please describe the quality of the symptom(s). Check all that apply!

____ Dull
____Sharp
____ Achy
____Throbbing
____Pin-Needle
____Numbing
____ Burning
____Shooting
____ Spasm
____ Pressure

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Past Medical History (Illness, Fractures Past and Current)

1. _____
2. _____
3. _____
4. _____
5. _____

Past Surgical History

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies

1. _____
2. _____
3. _____

Medications (Please List)

Name of Medication	Reason Prescribed
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

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Social History:

Smoker Y / N Past Smoker Y / N Year Quit _____
Tobacco Y / N Alcohol Y / N Children _____
Exercise _____ Days/Week Type _____
Hobbies _____

_____

Family Health History

(Only Health History of your Parents, Grandparents, and Siblings Needed)

____ Cancer ____ Heart Disease ____RA ____Strokes
____ Migraines ____MS ____Parkinson's ____ None

Women Only

Are you currently Pregnant Y / N If YES, Due Date _____
Date of last menstrual cycle _____ # of Pregnancies _____

Pregnancy outcomes: ____ Natural birth ____ C-Section ____ Still Born ____ Aborted

Breast Augmentation Surgery Y / N Endometriosis Y / N
Pelvic Inflammatory Disease Y / N Fibroids Y / N

Low Back Disability Questionaire (Revised OSWESTRY)

Instructions: This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage your everyday activities. Please answer each section by marking the ONE CHOICE that most applies to you. We realize you may feel that more than one statement may relate to you.

PLEASE JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YUR PROBLEM RIGHT NOW

Section 1 – Pain Intensity o I can tolerate the pain without having to use painkillers o The pain is bad, but I can manage without having to take painkillers o Painkillers give me complete relief from pain o Painkillers give me moderate relief from pain o Painkillers give very little relief from pain o Painkillers have no effect on the pain and I do not use them	Section 6 – Standing o I can stand as long as I want without extra pain o I can stand as long as I want but it causes extra pain o Pain prevents me from standing more than 1 hour o Pain prevents me from standing more than 30 minutes o Pain prevents me from standing more than 10 minutes o Pain prevents me from standing at all
Section 2 – Personal Care (Washing, Dressing, etc) o I can look after myself normally without causing extra pain o I can look after myself normally but it causes extra pain o It is painful to look after myself and I am slow and careful o I need some help but manage most of my personal care o I need help every day in most aspects of self-care o I do not get dressed, I wash with difficulty and stay in bed	Section 7 – Sleeping o Pain does not prevent me from sleeping well o I can sleep well only by taking medication o Even when I take medication I sleep less than 6 hours o Even when I take medication I sleep less than 4 hours o Even when I take medication I sleep less than 2 hours o Pain prevents me from sleeping at all
Section 3 – Lifting o I can lift Heavy weights without extra pain o I can lift heavy weights but it causes extra pain o Pain prevents me from lifting weights off the floor, but I can manage if they are conveniently positioned, ie on a table o Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. o I can lift very light weights o I cannot lift anything at all	Section 8 – Social Life o My social life is normal and gives me no extra pain o My social life is normal but it increases the degree of pain o Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing o Pain has restricted my social life and I do not go out as often o Pain has restricted my social life to my home o I have no social life because of my pain
Section 4 – Walking o Pain does not prevent me from walking any distance o Pain prevents me from walking more than one mile o Pain prevents me from walking more than one-half mile o Pain prevents me from walking more than one-quarter mile o I can only walk using a stick, cane, or crutches o I am in bed most of the time and have to crawl to the toilet	Section 9 – Traveling o I can travel anywhere without extra pain o I can travel anywhere but it causes extra pain o Pain is bad but I manage journeys over 2 hours o Pain is bad but I manage journeys less than 1 hour o Pain restricts me to short necessary journeys under 30 minutes o Pain prevents me from traveling except to the doctor or hospital
Section 5 – Sitting o I can sit in any chair as long as I like o I can only sit in my favorite chair for as long as I like o Pain prevents me from sitting more than one hour o Pain prevents me from sitting for more than 30 minutes o Pain prevents me from sitting for more than 10 minutes o Pain prevents me from sitting all of the time	Section 10 – Changing Degree of Pain o My pain is rapidly getting better o My pain fluctuates but overall is definitely getting better o My pain seems to be getting better but the improvement is slow at best o My pain is neither getting better nor worse o My pain is gradually getting worse o My pain is rapidly getting worse

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Review of Systems:

Have you had any of the following health issues? (write C for current, P for past)

1. **Pulmonary**
   - ___ Asthma
   - ___ COPD
   - ___ Emphysema
   - ___ None

2. **Endocrine**
   - ___ Hormonal Replacement
   - ___ Diabetes
   - ___ Steroid Shots
   - ___ Thyroid Disease
   - ___ Adrenal
   - ___ Insulin Pump
   - ___ None

3. **Dermatomal (skin)**
   - ___ Significant Burns
   - ___ Significant Rashes
   - ___ Skin Grafts
   - ___ Psoriasis
   - ___ Melanomas
   - ___ Skin Cancer
   - ___ Plastic Surgery
   - ___ None

4. **Neurological (Nerve)**
   - ___ Vision Loss
   - ___ Lost Strength
   - ___ Lost Feeling
   - ___ Seizures
   - ___ Headaches
   - ___ Memory Loss
   - ___ Tremors
   - ___ Tremors
   - ___ Lost Smell
   - ___ Lost Taste
   - ___ Dizziness
   - ___ Vertigo
   - ___ None

5. **Hematological (Blood)**
   - ___ Anemia
   - ___ Anti-Inflammatory use (OTC, Aleve, Aspirin)
   - ___ HIV/AIDS
   - ___ Bleeding/Bruising
   - ___ Sickle-Cell Anemia
   - ___ Large Lymph Nodes
   - ___ Hemophilia
   - ___ Blood Clots
   - ___ Phlebitis
   - ___ None

6. **Cardiovascular (Heart)**
   - ___ Heart Attack
   - ___ Heart Surgery
   - ___ Stroke
   - ___ Congestive Heart Failure
   - ___ TIA's
   - ___ Angina
   - ___ Irregular Heart Beat
   - ___ High Blood Pressure
   - ___ High Cholesterol
   - ___ Heart Murmer
   - ___ Mitral Valve Replacement
   - ___ None

7. **Renal (Kidney)**
   - ___ Kidney Stones
   - ___ Blood in Urine
   - ___ Bladder Control
   - ___ Bladder Infections
   - ___ Dialysis
   - ___ Hard to Urinate
   - ___ Kidney Disease
   - ___ None

8. **Gastroenterological (Digestion)**
   - ___ Nausea
   - ___ Hard to Swallow
   - ___ Ulcerative Colitis
   - ___ Abdominal Pain
   - ___ Hiatal Hernia
   - ___ Constipation
   - ___ Gall Stones
   - ___ Pancreatic Disease
   - ___ IBS
   - ___ Heart Burn
   - ___ Bowel Incontinences
   - ___ None

9. **Musculo-Skeletal (Muscle and Bone)**
   - ___ Rheumatoid Arthritis
   - ___ Gout
   - ___ Osteoarthritis
   - ___ Osteopenia
   - ___ Osteoporosis
   - ___ Bone Fractures
   - ___ Spinal Fractures
   - ___ Spinal Surgery
   - ___ Scoliosis
   - ___ Metal Implants
   - ___ None