Confidential Injury Questionnaire

Patient's Name: Date:

Please complete section A first. For a job-related injury, complete section B. For an automobile injury, complete section C

SECTION A: *(please check symptoms you have noticed since the accident)*

❑ Headache	❑ Dizziness	❑ Loss of Memory	❑ Feet Cold
❑ Neck Pain	❑ Head Seem Too Heavy	❑ Ears Ring	❑ Hands Cold
❑ Neck Stiff	❑ Pins & Needles in Arms	❑ Face Flushed	❑ Stomach Upset
❑ Sleeping Problems	❑ Pins & Needles in Legs	❑ Buzzing in Ears	❑ Constipation
❑ Back Pains	❑ Numbness in Fingers	❑ Loss of Balance	❑ Cold Sweats
❑ Nervousness	❑ Shortness of Breath	❑ Fainting	❑ Fever
❑ Tension	❑ Fatigue	❑ Loss of Smell	❑ Other Symptoms:
❑ Irritability	❑ Depression	❑ Loss of Taste	_____
❑ Chest Pain	❑ Light Bothers Eyes	❑ Diarrhea	_____

Other Symptoms (cont'd):

Did you go to the Emergency Room? ❑ Yes ❑ No Were you hospitalized? ❑ Yes ❑ No

If yes, Name of Hospital:

Other Doctors Seen:

Have you lost time from work? ❑ Yes ❑ No If so, please list dates... from: until :

Have you been contacted by an insurance adjuster or company representative about this claim? ❑ Yes ❑ No

Do you have an attorney advising you on this case? ❑ Yes ❑ No

SECTION B: *(please complete ONLY if the injury is JOB-RELATED)*

Occupation: Duties:

Date of Injury: Time: Location:

Description of Accident:

Workman's Compensation Case#: Insurance Company Case #:

Insurance Co.: Address:

Employer: Address:

SECTION C: *(please complete ONLY if the injury is due to an AUTO ACCIDENT)*

Date of Injury: Time: Location:

How did accident occur? ❑ Auto Collision ❑ Other (please describe):

If auto accident, were you: ❑ Driver ❑ Passenger ❑ Pedestrian

If collision, were you struck from: ❑ Behind ❑ Right Side ❑ Left Side ❑ Front ❑ Auto was Parked

Did your car strike the other(s) involved? ❑ Yes ❑ No Did the other car strike your? ❑ Yes ❑ No ❑ Undetermined

Were traffic citations issued to you? ❑ Yes ❑ No To the driver of your car? ❑ Yes ❑ No To the driver of the other car? ❑ Yes ❑ No

Your Insurance Company: Insurance Co. of person responsible for injury:

Dr. Mary's & Dr. Joyce's Office 403 Willis Ave, Williston, NY 11596 516-742-2442 Fax: 516-742-6807

Confidential Patient Questionnaire

Welcome to our office. Please provide as much information as possible, the better to help us understand your background and condition. In accordance with the law, all information provided will be held in the strictest confidence.

PLEASE PRINT:

Name _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Work Phone _____ Occupation _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Whom may we thank for referring you? _____

In case of emergency, whom should we contact?

Name _____ Relation _____ Home Phone _____ Cell Phone _____

Is this condition due to a work-related injury? ❑ Yes ❑ No

Is this condition due to an automobile accident? ❑ Yes ❑ No

IMPORTANT QUESTION FOR WOMEN:

Are you pregnant or is there any possibility that you might be pregnant? ❑ Yes ❑ No

I understand and agree that health and accident insurance policies are arrangements between me and my insurance company(ies). I further understand and agree that any amount authorized to be paid directly to Dr. Mary's & Dr. Joyce's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature _____ Date _____ Guardian or Spouse's Signature _____ Date _____

Dr. Mary's & Dr. Joyce's Office 403 Willis Ave, Williston, NY 11596 516-742-2442 Fax: 516-742-6807

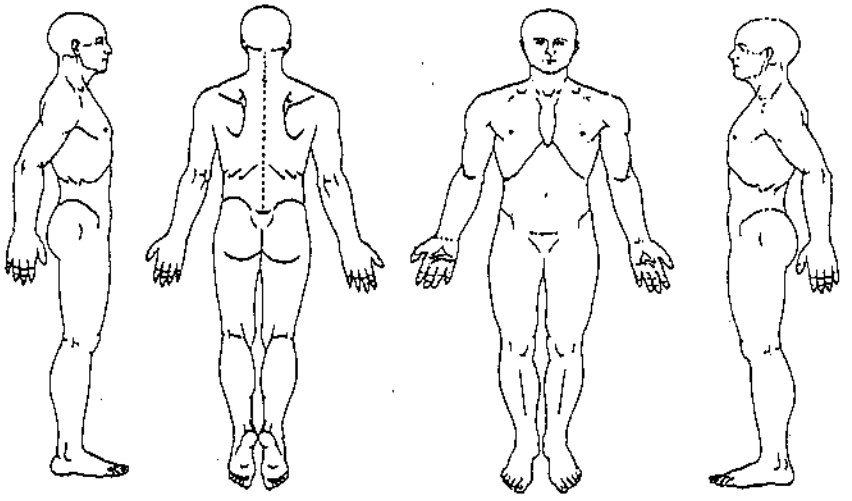
Patient Health Questionnaire

Internal Use Only

Patient Name _____ *Date* _____

Describe your symptoms, when they started and how they began: _____

Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?

- ○ 1-Constantly (76-100% of the day)
- ○ 2-Frequently (51-75% of the day)
- ○ 3-Occasionally (26-50% of the day)
- ○ 4-Intermittently (0-25% of the day)

What describes the nature of your symptoms?

○ Sharp	○ Shooting	○
○ Dull ache	○ Burning	○
○ Numb	○ Tingling	○

How are your symptoms changing?

- ○ 1-Getting Better
- ○ 2-Not Changing
- ○ 3-Getting Worse

How bad are your symptoms at their:

	None										*Unbearable*
worst:	○	○	○	○	○	○	○	○	○	○	○
best:	○	○	○	○	○	○	○	○	○	○	○
	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
No complaints	*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*			*Severe, no activity possible*

What activities make your symptoms worse: _____

What activities make your symptoms better: _____

Who have you seen for your symptoms?

- ○ 1-No One
- ○ 2-Other Chiropractor
- ○ 3-Medical Doctor
- ○ 4-Physical Therapist
- ○ 5-Other
- ○

When and what treatment? _____

What tests have you had for your symptoms?

- ○ 1-Xrays
- ○ 2-CT Scan
- ○ 3-MRI Scan
- ○ 4-Other

Have you had similar symptoms in the past?

- ○ 1-Yes
- ○ 2-No

If you have received treatment in the past for the same or similar symptoms, who did you see?

- ○ 1-This Office
- ○ 2-Other Chiropractor
- ○ 3-Medical Doctor
- ○ 4-Physical Therapist
- ○ 5-Other
- ○

What is your occupation?

_____

- ○ 1-Professional/Executive
- ○ 2-White Collar/Secretarial
- ○ 3-Tradesperson
- ○ 4-Laborer
- ○ 5-Homemaker
- ○ 6-FT Student
- ○ 7-Retired
- ○ 8-Other

If you are not retired, a homemaker, or a student, what is your current work status?

- ○ 1-Full-time
- ○ 2-Part-time
- ○ 3-Self-employed
- ○ 4-Unemployed
- ○ 5-Off work
- ○ 6-Other

What do you hope to get from your visit/treatment:

- ○ 1-Reduce symptoms
- ○ 2-Resume/increase activity
- ○ 3-Explanation of condition/treatment
- ○ 4-Learn how to take care of this on my own
- ○ 5-How to prevent this from occurring again
- ○

Patient Signature _____ *Date* _____

Neck Disability Index Questionnaire

Patient Name: _____ Todays Date:_____

Please complete this questionaire by circling *one* answer in each section. It is designed to give us information as to how your neck trouble has affected your ability to manage in everyday life

Pain Intensity

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain is moderate at the moment
3 The pain is fairly severe at the moment
4 The pain is severe at the moment
5 The pain is worst imaginable at the moment

Lifting

0 I can lift heavy weights without extra pain
1 I can lift heavy weight, but it gives me extra pain
2 Pain prevents me from lifting heavy weights off the floor, but I can lift heavy weights off a table
3 Pain prevents me from lifting heavy weights off the floor, but I can lift moderate wieghts off a table.
4 I can lift only very light weights
5 I cannot lift and/or carry anything at all

Headaches

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

Personal Care (Washing, Dressing)

0 I can look after myself normally without extra pain
1 I can look after myself normally but it causes extra pain
2 It is painful to look after myself & I am slow & careful
3 I need some help everyday in most aspects of self care
4 I need help everyday in most aspects of self care
5 I do not get dressed and stay in bed because of the difficulty

Reading

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

Concentration

0 I can concentrate fully with no difficulty
1 I can concentrate fully with slight difficulty
2 I have a fair degree of concentrating
3 I have a lot of difficulty concentration
4 I have a great deal of difficulty in concentrating
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 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 can't hardly do any work at all

Sleeping

0 I have no trouble sleeping
1 My sleep is slightly disturbed (less than 1hr sleepless)
2 My sleep is mildly disturbed (1-2 hr's sleepless)
3 My sleep is moderately disturbed (2-3 hr's sleepless)
4 My sleep is greatly disturbed (3-5 hr's sleepless)
5 My sleep is completely disturbed (5-7 hr's sleepless)

Driving

0 I can drive my car without neck pain
1 I can drive as long as I want with slight pain
2 I can drive as long as I want with moderate pain
3 I can't drive as long as I want due to moderate pain
4 I can hardly drive at all because of severe neck pain
5. I can't drive my car at all

Recreation

0 I engage in all my recreation activities with no pain
1 I can engage in all my activities with slight pain
2 I engage in most of my recreation activities but not all because of neck pain
3 I engage in few activies but not all due to neck pain
4 I engage in hardly any activities because of neck pain
5. I engage in no recreational activies

On a scale from 0 to 10, with 0 being no pain & 10 being the worst pain, mark on the scale below your current pain level...

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No Pain — Worst Imaginable Pain

Patient Signature_____

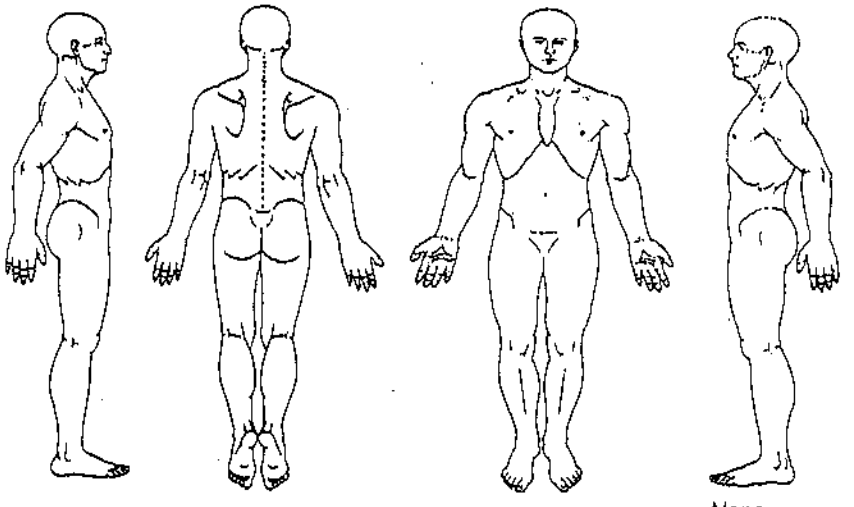
Patient Health Questionnaire

Internal Use Only

Patient Name _____ *Date* _____

Describe your symptoms, when they started and how they began: _____

Indicate on the pictures below where you have pain or other symptoms



How often do you experience your symptoms?

- ○ 1-Constantly (76-100% of the day)
- ○ 2-Frequently (51-75% of the day)
- ○ 3-Occasionally (26-50% of the day)
- ○ 4-Intermittently (0-25% of the day)

What describes the nature of your symptoms?

○ Sharp	○ Shooting	○
○ Dull ache	○ Burning	○
○ Numb	○ Tingling	○

How are your symptoms changing?

- ○ 1-Getting Better
- ○ 2-Not Changing
- ○ 3-Getting Worse

How bad are your symptoms at their:

	None										*Unbearable*
worst:	○	○	○	○	○	○	○	○	○	○	○
best:	○	○	○	○	○	○	○	○	○	○	○
	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
No complaints	*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*			*Severe, no activity possible*

What activities make your symptoms worse: _____

What activities make your symptoms better: _____

Who have you seen for your symptoms?

- ○ 1-No One
- ○ 2-Other Chiropractor
- ○ 3-Medical Doctor
- ○ 4-Physical Therapist
- ○ 5-Other
- ○

When and what treatment? _____

What tests have you had for your symptoms?

- ○ 1-Xrays
- ○ 2-CT Scan
- ○ 3-MRI Scan
- ○ 4-Other

Have you had similar symptoms in the past?

- ○ 1-Yes
- ○ 2-No

If you have received treatment in the past for the same or similar symptoms, who did you see?

- ○ 1-This Office
- ○ 2-Other Chiropractor
- ○ 3-Medical Doctor
- ○ 4-Physical Therapist
- ○ 5-Other
- ○

What is your occupation?

_____

- ○ 1-Professional/Executive
- ○ 2-White Collar/Secretarial
- ○ 3-Tradesperson
- ○ 4-Laborer
- ○ 5-Homemaker
- ○ 6-FT Student
- ○ 7-Retired
- ○ 8-Other

If you are not retired, a homemaker, or a student, what is your current work status?

- ○ 1-Full-time
- ○ 2-Part-time
- ○ 3-Self-employed
- ○ 4-Unemployed
- ○ 5-Off work
- ○ 6-Other

What do you hope to get from your visit/treatment:

- ○ 1-Reduce symptoms
- ○ 2-Resume/increase activity
- ○ 3-Explanation of condition/treatment
- ○ 4-Learn how to take care of this on my own
- ○ 5-How to prevent this from occurring again
- ○

Patient Signature _____ *Date* _____

Oswestry Disability Index Questionnaire

Patients Name:_____ Todays Date:_____

Please complete this questionaire by circling *one* answer in each section. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Pain intensity

0 The pain comes & goes & it is very mild
1 The pain is mild and does not vary much
2 The pain comes & goes & 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

Walking

0 Pain does not prevent me from walking any distance
1 Pain prevents me from walking more than a mile
2 Pain prevents me from walking more than more than ½ mile
3 Pain prevents me from walking more than ¼ mile
4 I can only walk using a cane or crutches
5 I am in bed most of the time & I have to crawl to the toilet

Standing

0 I can stand as long as I want with no extra pain
1 I can stand as long as I want but it gives me extra pain
2 Pain prevents me from standing for more than an hour
3 Pain prevents me from standing for more than ½ hour
4 Pain prevents me from standing for more than ten minutes
5 Pain prevents me from standing at all

Lifting

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

Sitting

0 I can sit in any chair as long as I like without pain
1 I can only sit in my favorite chair as long as I like
2 Pain prevents me from sitting more than an hour
3 Pain prevents me from sitting for more than half an hour
4 Pain prevents me from sitting more than ten minutes
5 Pain prevents me from sitting at all

Sleeping

0 My sleep is disturbed by pain
1 My sleep is slightly disturbed (less than 1hr sleepless
2 My sleep is mildly disturbed (1-2 hr's sleepless)
3 My sleep is moderatly disturbed (2-3 hr's sleepless
4 My sleep is greatly disturbed (3-5 hr's sleepless)
5 Pain prevents me from sleeping at all

Personal Care

0 I can look after myself normally without any extra pain
1 I can look after myself normally but it is painful
2 It is painful to look after myself & I am slow & careful
3 I need some help but manage more of my personal care
4 I need help everyday in most aspects of self care
5 I do not get dressed, wash with difficulty & stay in bed

Traveling

0 I can travel anywhere without pain
1 I can travel anywhere but it gives me extra pain
2 Pain is bad but I manage journeys over two hours
3 Pain restricts me to journeys of less than one hour
4 Pain restricts me to journeys of less than 30 minutes
5 Pain prevents me from traveling except to receive treatment

Social Life

0 My social life is normal & 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 (i.e dancing, etc)
3 Pain has restricted my social life & I do not go out as often
4 Pain has restricted social life to my home
5 I have no social life because of the pain

Changing Degree of Pain

0 My pain is rapidly getting better
1 My pain fluctuates, but overall is definitly 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

On a scale from 0 to 10, with 0 being no pain & 10 being the worst pain, mark on the scale below your current pain level...

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

No Pain Worst Imaginable Pain

Patient Signature_____

Patient Health Questionnaire - page 2

Internal Use Only

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ○ 1-None ○ 2-Light ○ 3-Moderate ○ 4-Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

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	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	***Other Health Problems/Issues***		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature **Date**