History Form

Date_____

Waterfront Chiropractic Stacy J Aslan, D.C. 146 N. New York Avenue Huntington, NY. 11743

Name_____ Address_____

City_____ State_____ Zip_____ Home #_____

Cell #(for confirming apt. schedule):_____ Carrier: Verizon ATT wireless Sprint Other_____

E-mail address (for confirming apt. schedule) _____ SS# _____

Date of birth__/__/__ Age_____ Height_____ Weight_____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced

# of children____ Name of spouse/parent _____

Employer_____ Address_____

City_____ State____ Zip_____ Work #_____ Occupation_____

How were you referred to our office?_____

Name of family physician_____ What city are they located in?_____

Have you had chiropractic care? ❑ yes ❑ no Dr. name_____ Date of last vt__/__/__

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints, please list in order of severity

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?_____

On a scale of 0-10, rate your pain on average using the scale below_____

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

no pain unbearable pain

In the past week on average how often have the symptoms been present?

❑ Occasional 0-25% ❑ 26-50% ❑ 51-75% ❑ 76-100%

Has the problem been getting worse or staying the same?_____

What activities, incidents, or events may have caused these complaints?_____

List other drs. consulted for these conditions 1._____ 2._____

Is this ❑ Work related? ❑ Auto related? ❑ NA Date of injury? __/__/__ Is case currently open? ❑ yes ❑ no

Attorney name_____ Attorney phone #_____

If due to an auto accident, how many other passengers were in the car with you? _____

If due to an auto accident, what is the name of your auto insurance company?_____

Have you ever had any surgeries/hospitalization? ❑ yes ❑ no If yes, please list_____

Please list any current or past injuries and illnesses not listed above_____

Please circle all medications (over the counter and/or prescribed) you are currently taking:

Aspirin/Tylenol Pain Killers Muscle Relaxer Insulin Birth Control Pills Sleeping Pills Anti-depressants

Others_____

Health insurance co. _____ Policy Holder_____

Policy Holder's date of birth__/__/__ Policy number _____ Secondary ins. Co. _____

How much is your health condition (pain and/or symptoms) preventing you from doing what you would normally do, and from doing it as well as you normally would? Respond to EACH category by indicating how the overall pain impacts your life, and not just when the pain is at its worst.

For EACH of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR CURRENT TYPICAL LEVEL OF ACTIVITIES AS THEY ARE NOW.

0 meaning NO DISABILITY at all & 10 meaning you CANNOT PERFORM those activities at all.

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

completely able to function — totally unable to function

Family/Home Responsibilities: activities related to the home or family chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____

Recreation: hobbies, sports, and other similar leisure time activities _____

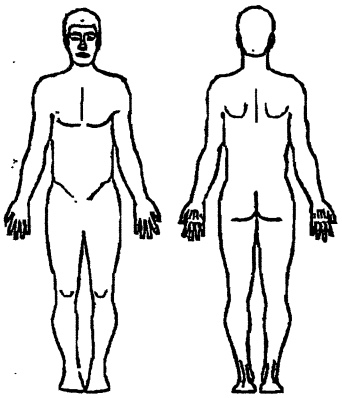
Social Activity: activities which involve participation with friends, and acquaintances other than family members including parties, theater, concerts, dining out and other social functions _____

Occupation: activities that are a part of or directly related to one's job including non-paying jobs as well, such as that of a homemaker or volunteer _____

Self Care: activities which involve personal maintenance and dependent daily living (taking a shower, driving, getting dressed, etc.) _____

Life support activity: basic life supporting behaviors such as eating, sleeping, and breathing _____

Mark an X on the picture where you have pain or other symptoms:



Please check all that apply to you: ❑ None apply

No	Yes	Conditon
❑	❑	History of recent infection
❑	❑	Recent fever
❑	❑	HIV/AIDS
❑	❑	Diabetes
❑	❑	Corticosteroid use
❑	❑	Birth control pills
❑	❑	High Blood Pressure
❑	❑	Stroke (date)_____
❑	❑	Dizziness/fainting
❑	❑	Numbness in groin/buttocks
❑	❑	Urinary retention
❑	❑	Aortic aneurism
❑	❑	Cancer/tumor
❑	❑	Osteoporosis

No	Yes	Conditon
❑	❑	Prostate problems
❑	❑	Frequent urination
❑	❑	Currently pregnant, #weeks____
❑	❑	Abnormal weight ❑ gain ❑ loss
❑	❑	Epilepsy/seizures
❑	❑	Visual disturbances
❑	❑	Low back/mid back pain
❑	❑	Neck pain
❑	❑	Arthritis
❑	❑	History or alcohol use
❑	❑	History of tobacco use
❑	❑	Nocturnal pain (pain at night)
❑	❑	Digestive issues
❑	❑	Recent trauma_____

Method of payment for today's charges: ❑ CASH ❑ CHECK ❑ CREDIT CARD _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. NY State law requires us to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient Signature _____ Date_____

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 car 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____