Advanced Chiropractic of Mankato

Patient Health Questionnaire

Name: _____ Birth Date: ___/___/____

Address: _____ Phone: _____

City, State, Zip: _____ Soc. Sec#: _____

1. Please Describe Your Complaint: _____

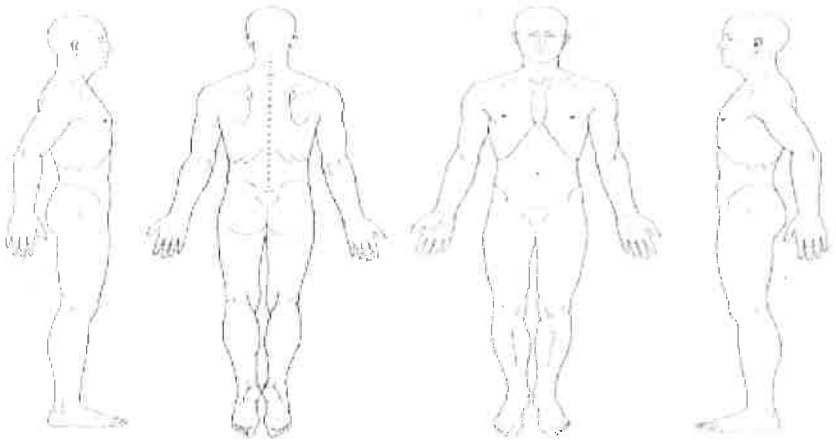
_____

_____

a. Description
- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Gripping
- ☐ Burning
- ☐ Tingling

b. Frequency
- ☐ Constant (76-100%)
- ☐ Frequent (51-75%)
- ☐ Occasional (26-50%)
- ☐ Intermittent (25% or less)

Mark on the picture where you have pain or other symptoms



c. Indicate the intensity of your pain at its lowest and highest level: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

d. Your symptoms are: ☐ decreasing ☐ not changing ☐ increasing

e. Your symptoms are worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Increases during the day ☐ Same all day

2. When did your problem begin (specific date if possible)? _____
Describe how your problem began: _____

_____

3. Have you been treated for this episode? ☐ Yes ☐ No
If yes, by whom? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical therapist ☐ Occupational therapist ☐ Other: _____
Are you currently being seen? ☐ Yes ☐ No
When and what treatment? ___/___/___ _____

_____

4. In the past have you been treated for the same or similar problem? ☐ Yes ☐ No
If yes, who did you see for that episode? ☐ Chiropractor ☐ MD ☐ Osteopath ☐ Physical therapist ☐ Occupational therapist ☐ Other
When and what treatment? ___/___/___ _____

_____

5. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

6. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Inactivity

7. How would you rate your general stress level? ☐ Little or no stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

8. General physical activity? ☐ No Regular Exercise ☐ Light Exercise ☐ Moderate Exercise ☐ Strenuous Exercise

9. Are your complaints affecting your ability to be active?
- ☐ No Effect
- ☐ Some physical restrictions (able to perform light duty work and household tasks)
- ☐ Need limited assistance with common everyday tasks
- ☐ Need assistance often
- ☐ Have a significant inability to function without assistance
- ☐ Am totally disabled (impaired). Cannot care for self.

10. Physical activity at work: ☐ Sitting more than 50% of day ☐ Light manual labor ☐ Manual labor ☐ Heavy manual labor ☐ Repeated motion

11. Occupation: _____ ☐ FT ☐ PT Has your work status changed because of this complaint? ☐ Yes ☐ No

Patient's Signature: _____ Date: _____/_____/_____

Advanced Chiropractic of Mankato

Patient Health Questionnaire

Past	Present	
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Pain in upper arm or elbow
☐	☐	Hand Pain
☐	☐	Wrist Pain
☐	☐	Upper Back Pain
☐	☐	Lower Back Pain
☐	☐	Pain in upper leg or hip
☐	☐	Pain in lower leg or knee
☐	☐	Pain in ankle or foot
☐	☐	Jaw Pain
☐	☐	Swelling/Stiffness of joints
☐	☐	Fainting
☐	☐	Visual disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular incoordination
☐	☐	Tinnitus
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Abnormal weight ☐ Gain ☐ Loss
☐	☐	Excessive thirst
☐	☐	Chronic cough
☐	☐	Chronic sinusitis
☐	☐	General fatigue
☐	☐	Irregular Menstrual flow
☐	☐	Profuse Menstrual flow
☐	☐	Breast soreness/lumps
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular Bowel Habits
☐	☐	Difficulty swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Depression

Past	Present	
☐	☐	Pregnancy
☐	☐	Birth Control Pills
☐	☐	Hormonal/ Estrogen Replacement
☐	☐	Medications _____
		_____
☐	☐	Hospitalizations/Surgical procedures
		_____

Past	Present	
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Prostate Problems
☐	☐	Blood Disorders
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver/ Gallbladder problems
☐	☐	Hepatitis
☐	☐	Kidney Stones
☐	☐	Bladder Infection
☐	☐	Kidney Disorders
☐	☐	Colitis
☐	☐	Irritable Bowel
☐	☐	HIV/AIDS
☐	☐	Systemic Lupus
☐	☐	Other: _____

If a family member has had any of the following please make the appropriate box

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back problems
☐ Diabetes	☐ Chronic headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other: _____
☐ High Blood Pressure	_____

Yes	No	
☐	☐	Do you have a permanent disability rating?
☐	☐	Location? _____
☐	☐	Date rating received ___/___/___
		Rating percentage _____%

Past	Present	
☐	☐	Tobacco – amount _____
☐	☐	Alcohol – amount _____
☐	☐	Drug/Alcohol dependence
☐	☐	Coffee/Tea/Caffeinated soft drinks
		Cups per day: _____

Present Weight _____ lbs. Height ___feet ___ inches

Patient's Signature: _____ Date: ____/____/____

Additional Doctor Comments:

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 ☐

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.

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.

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).

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.

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.

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.

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.

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.

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.

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 _____

Advanced Chiropractic of Mankato

Exam Form

Name: _____ Date: ___/___/___

Email : _____ Cell phone: _____

Preferred language: English Other _____

Race:

American Indian or Alaska Native

Asian

Black or African American

Hispanic or Latino

Native Hawaiian or Pacific Islander

White

Some Other Race

Multi-Racial

Current Medications	Strength	Frequency

Do you have medication allergies? ☐ No ☐ Yes Please List _____

_____

Do you have food allergies? ☐ No ☐ Yes Please List _____

_____

Do you have environmental allergies? ☐ No ☐ Yes Please List _____

_____

Smoking Status (age 13 and over)

____ Current every day smoker
____ Current some day smoker
____ Former Smoker
____ Never Smoked

Staff Use Only

Height: _____ft_____in
Weight: _____lbs
Blood Pressure: _____/_____
Heart Rate:_____

GENERAL EXAMINATION

Height (Ft. | Inches) ☐☐☐ Weight (Lbs.) ☐☐☐ Blood Pressure ☐☐☐ / ☐☐☐ (√R ☐) Temp. ☐☐☐☐ Pulse ☐☐☐

Body Type
- ☐ Ectomorph
- ☐ Endomorph
- ☐ Mesomorph
- ☐ Obese

Systems Review	WNL	Deferred	Significant Findings:
EENT	☐	☐	
CV System	☐	☐	
Resp System	☐	☐	
GI/Abdominal Eval	☐	☐	
GU	☐	☐	

Vascular Tests

VBI [+][−] /Peripheral: ____

PATIENT REPORT FORM - Page 2

Observations

AP Curve	WNL	Decreased	Increased
Cervical			
Thoracic			
Lumbar			

Scoliosis	Convex		Absent	Mild	Moderate	Marked
Cervical	L	R				
Thoracic	L	R				
Lumbar	L	R				
Other/	L	R				

Postural Symmetry	Left	Right	Absent
Head Tilt	L	R	A
High Shoulder	L	R	A
Rib Hump	L	R	A
High Iliac Cr.	L	R	A

	Left	Right	Anterior	Lumbar	Cervical
Antalgic Lean			A	L	C

Angle of Trunk Rotation ______

Spinal Palpation (Tenderness) 1–4

Level	L	M	R	Level	L	M	R

Soft Tissue Evaluation
List Region/Muscle

Region/Muscle			Hypertonicity	(Atrophy)	Tender	Trig Pts.		Strength
	L	R	0 1 2 3 4 5		1 2 3 4	A	L	0 1 2 3 4 5 B
	L	R	0 1 2 3 4 5		1 2 3 4	A	L	0 1 2 3 4 5 B
	L	R	0 1 2 3 4 5		1 2 3 4	A	L	0 1 2 3 4 5 B
	L	R	0 1 2 3 4 5		1 2 3 4	A	L	0 1 2 3 4 5 B

Additional Info: ____

CERVICAL ROM ☐ WNL

	Active*	Passive*						Level/Area
Flex (50°)		A	D	S	L	M	R	
Ext (70°)		A	D	S	L	M	R	
Lt. Lat. Flex (45°)		A	D	S	L	M	R	
Rt. Lat. Flex (45°)		A	D	S	L	M	R	
Lt. Rot. (85°)		A	D	S	L	M	R	
Rt. Rot. (85°)		A	D	S	L	M	R	

THORACIC ☐ WNL

							Level/Area
Flex/Ext (60°)	A	D	S	L	M	R	
Lt. Trunk Rot. (45°)	A	D	S	L	M	R	
Rt. Trunk Rot. (45°)	A	D	S	L	M	R	

LUMBOPELVIC ☐ WNL

							Level/Area
Flex (90°)	A	D	S	L	M	R	
Ext (30°)	A	D	S	L	M	R	
Lt. Lat. Flex (35°)	A	D	S	L	M	R	
Rt. Lat. Flex (35°)	A	D	S	L	M	R	
Lt. Rot. (30°)	A	D	S	L	M	R	
Rt. Rot. (30°)	A	D	S	L	M	R	

ORTHOPEDIC/NEUROLOGICAL

CERVICAL

Stretch Tests			Dull	Sharp	Left	Midline	Right	Cervical	Shoulder	Arm/Hand	Thoracic
Lt. Shoulder Depression	+	−	D	S							
Rt. Shoulder Depression	+	−	D	S							
Soto-Hall Test	+	−	D	S							
Compression Tests											
Lt. Cervical Comp.	+	−	D	S							
Rt. Cervical Comp.	+	−	D	S							
Lt. Adson's	+	−									
Rt. Adson's	+	−									
Distraction Tests											
Cervical	+	−									
Lt. Bakody	+	−	D	S							
Rt. Bakody	+	−	D	S							

REFLEXES (0-5)

	L	R
Biceps		
Brachio		
Triceps		
Patellar		
Achilles		

NEURO/CRANIAL

Romberg	+	−
Finger to Nose	+	−

PATHO REFLEXES

Wrist Clonus	+	−
Babinski	+	−
Hoffman	+	−

SENSORY

Location	WNL	Left	Right	Anesthesia	Hypesthesia	Hyperesthesia	Analgesia	Hyperalgesia	Hypalgesia

LOW BACK

Stretch Tests	Degrees			Dull	Sharp	Left	Midline	Right	Lumbar	Gluteal	Above Knee	Below Knee
Lt. SLR		+	−	D	S							
Rt. SLR		+	−	D	S							
Lt. Braggard's		+	−	D	S							
Rt. Braggard's		+	−	D	S							
Lt. Bechterew's Test		+	−	D	S							
Rt. Bechterew's Test		+	−	D	S							
Compression Tests												
Lt. Kemp's		+	−	D	S							
Rt. Kemp's		+	−	D	S							
Milgrams		+	−	D	S							
Valsalva Test		+	−	D	S							
Mechanical Tests												
Lt. Gaenslen's		+	−	D	S							
Rt. Gaenslen's		+	−	D	S							
Lt. Fabere		+	−	D	S							
Rt. Fabere		+	−	D	S							
Lt. Yeoman's		+	−	D	S							
Rt. Yeoman's		+	−	D	S							

Subluxation: ____

Additional/Other Tests: ____

RADIOGRAPHIC EVALUATION

____ VIEWS TAKEN ___/___/___ DATE ____ WHERE IF NOT THIS CLINIC ____ ADDITIONAL VIEWS REQUESTED

Subluxation (level) ____

Scoliosis Location/Apex			Cobbs	Lovett	
/	L	R		+	-
/	L	R		+	-
/	L	R		+	-

	↑	↓	R
AP Cervical Curve:			
Thoracic:			
AP Lumbar Curve:			

Sacral Base Angle ____
Left Short Leg (mm) ____
Rt. Short Leg (mm) ____

DDD	DJD	Level	Mild	Moderate	Marked

Osteoporosis:

Other Findings/Recommendations: ____

Comments/Add'l clinical information ____

All the information provided above is a true, accurate and complete representation of this patient's condition: ____ D.C. SIGNATURE ___/___/___ DATE

Pt. Name: ____