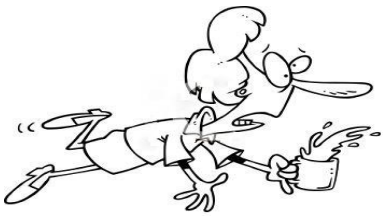


Van Roo Family Chiropractic

NEW EPISODE/INJURY FORM

Full Legal Name: _____ Date of Birth: _____

Street Address / P.O. Box _____ Home Phone: _____

City / State / Zip: _____ Mobile Phone: _____

Social Security Number: _____ Work Phone: _____

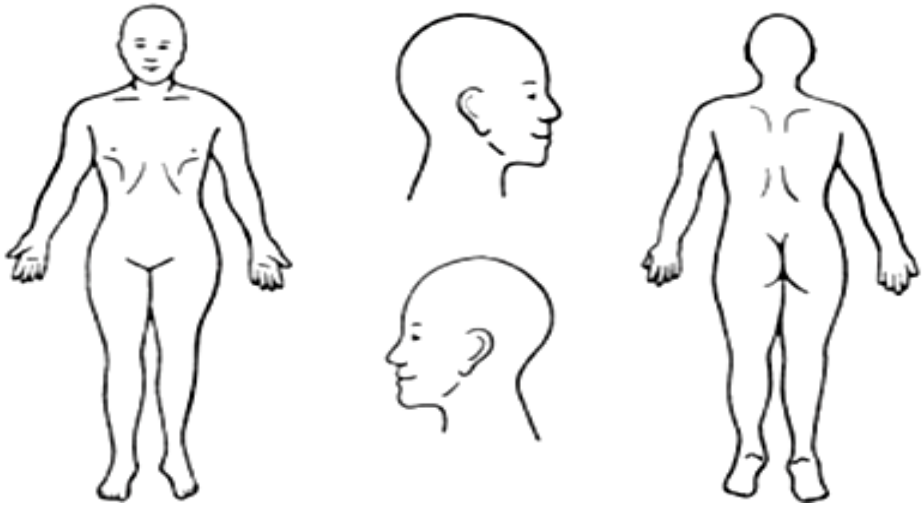
Your Employer: _____ Job Title: _____

History of Present Illness / Injury

Chief Complaint(s)

Fill out this section by marking the area with the described sensation using the appropriate symbols from the left.

X X X Burning Pain
((((Aching Pain
0 0 0 Pins & Needles
- - - - Numbness
: : : : Sharp Pain



Please Complete:

____ Constant
____ Come & Go
_____
____ Getting Better ___
____ Getting Worse ____
____ Staying Same ____
_____

Better:	Worse:
_____ AM	_____
_____ Mid-Day	_____
_____ PM	_____

Rate Your Discomfort/Symptom(s):

Enter the number below that corresponds with your degree of discomfort. **"0"** is NO pain/symptom(s), **"100"** is intolerable pain.

0 = No Pain/Symptoms, 100 = Intolerable Pain

Neck (0= No Pain):	**Mid Back** (0= No Pain):	**Low Back** (0= No Pain):	_____:	_____:
Now: _____/100	Now: _____/100	Now: _____/100	Now: _____/100	Now: _____/100
Best: _____/100	Best: _____/100	Best: _____/100	Best: _____/100	Best: _____/100
Worst: _____/100	Worst: _____/100	Worst: _____/100	Worst: _____/100	Worst: _____/100
Usual: _____/100	Usual: _____/100	Usual: _____/100	Usual: _____/100	Usual: _____/100

History of Presenting Injury/Illness:

Symptoms Developed From: ☐Work – Related Injury ☐Auto Accident ☐Other: _____

When Did Symptoms Begin? _____ Have You Missed Work? ☐Yes ☐No How Much? _____

Explain more about how the symptoms came on and/or describe the symptoms in more depth: _____

_____

What Makes the Condition Better?

Head / Neck _____ Shoulder, Arm, Hand _____

Mid Back _____ Hip, Leg, Foot _____

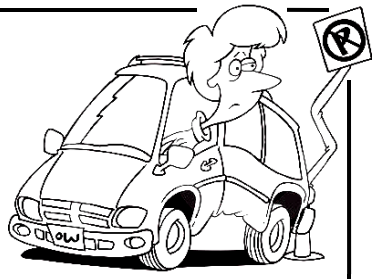
Low Back _____ Other _____

Activities of Daily Living

Indicate Your Ability to Perform the Following Activities. Please Use the Following Codes:

U – Unable L – Limited P – Painful D – Difficult N – Normal H – Haven't Tried

1. ____ Lying on Back	5. ____ Sexual Activity	9. ____ Bending Forward/Lifting	13. ____ Dressing Self
2. ____ Lying on Sides	6. ____ Getting In / Out of Car	10. ____ Prolonged Standing	14. ____ Walking
3. ____ Lying on Stomach	7. ____ Pushing / Pulling	11. ____ Using a Computer	15. ____ Cough / Sneeze/ Grunt
4. ____ Turning Over in Bed	8. ____ Up/Down Stairs	12. ____ Sitting/Driving/Riding	16. _____



NECK/BACK BOURNEMOUTH QUESTIONNAIRE

OVER THE PAST WEEK, ON AVERAGE, HOW WOULD YOU RATE YOUR PAIN? (0–NO PAIN, 10–WORST POSSIBLE PAIN) **/10**

OVER THE PAST WEEK, HOW MUCH HAS YOUR PAIN INTERFERED WITH YOUR DAILY ACTIVITIES (HOUSEWORK, DRESSING, LIFTING, DRIVING, ETC.)? (0 – NO INTERFERENCE, 10 – UNABLE TO PERFORM) **/10**

OVER THE PAST WEEK, HOW MUCH HAS YOUR PAIN INTERFERED WITH YOUR ABILITY TO TAKE PART IN RECREATIONAL, SOCIAL, & FAMILY ACTIVITIES? (0 – NO INTERFERENCE, 10 – UNABLE TO PERFORM) **/10**

OVER THE PAST WEEK, HOW ANXIOUS (TENSE, UPTIGHT, IRRITABLE, DIFFICULTY IN CONCENTRATING OR RELAXING) HAVE YOU BEEN FEELING? (0 – NOT AT ALL ANXIOUS, 10 – EXTREMELY ANXIOUS) **/10**

OVER THE PAST WEEK, HOW DEPRESSED (DOWN-IN-THE-DUMPS, SAD, IN LOW SPIRITS, PESSIMISTIC, UNHAPPY) HAVE YOU BEEN FEELING? (0 – NOT AT ALL DEPRESSED, 10 – EXTREMELY DEPRESSED) **/10**

OVER THE PAST WEEK, HOW HAVE YOU FELT YOUR WORK (BOTH INSIDE AND OUTSIDE THE HOME) HAS AFFECTED (OR WOULD AFFECT) YOUR PAIN? (0 – HAVE MADE IT NO WORSE, 10 – HAVE MADE IT MUCH WORSE) **/10**

OVER THE PAST WEEK, HOW MUCH HAVE YOU BEEN ABLE TO CONTROL (REDUCE/HELP) YOUR PAIN ON YOUR OWN? (0 – COMPLETELY CONTROLLED, 10 – NO CONTROL WHATSOEVER) **/10**

TOTAL POINTS: /70 TOTAL: %

NECK & HEADACHE QUESTIONS

DO YOU GET PAIN OR CRACKING IN THE JAW? ☐**YES** ☐**NO**

FREQUENCY OF HEADACHES: _____ PER _____

LOW BACK PAIN QUESTIONS

DOES PAIN RADIATE TO THE ABDOMEN AND/OR GROIN? ☐**YES** ☐**NO**

ANY IMPAIRMENT OF BOWEL OR BLADDER FUNCTION? ☐**YES** ☐**NO**

UPDATED PATIENT BACKGROUND INFORMATION

YES NO

☐ ☐ **PAST MEDICAL HISTORY** (NEW CONDITIONS, INJURIES, MEDICATIONS)? IF SO, WHAT? _____

☐ ☐ **SOCIAL HISTORY** (START/STOP SMOKING, DRINKING, CAFFEINE, HOBBIES, EXERCISE, ETC)? IF SO, WHAT? _____

☐ ☐ **WORK HISTORY** (NEW JOB/HOURS/RESPONSIBILITIES)? IF SO, WHAT? _____

☐ ☐ **FAMILY HEALTH HISTORY** (NEW CONDITIONS/HEALTH STATUS)? IF SO, WHAT? _____

☐ ☐ **HAS THERE BEEN ANY CHANGES TO YOUR BODY SYSTEMS** (EYES, EARS, CARDIOVASCULAR, RESPIRATORY, NEUROLOGICAL, ENDO-CRINE, GASTRO-INTESTINAL, GENITO-URINARY, MUSCULOSKELETAL, SKIN, OR PSYCHIATRIC)? IF SO, WHAT? _____

☐ ☐ **HAVE YOU ATTEMPTED ANY OTHER SELF-CARE REMEDIES TO ALLEVIATE YOUR CONDITION?** (E.G. MEDICINES, TOPICAL CREAMS, BRACING, ICE/HEAT, STRETCHING, PILLOW CHANGE, SUPPORT BELT, MASSAGE, ETC.) IF SO, WHAT? _____

TREATMENT OPTIONS (PLEASE SELECT ONE)

☐ MY GOAL IS TO GET JUST A FEW TREATMENTS UNTIL MY SYMPTOMS ARE GONE, THEN CALL AS NEEDED.

☐ I WISH TO CALM MY SYMPTOMS FULLY AND CONTINUE TO GET ADJUSTED UNTIL I'M FULLY STABILIZED & CORRECTED.

☐ NOT ONLY DO I WANT TO CALM MY SYMPTOMS AND CORRECT MY PROBLEM, BUT I'D LIKE REGULAR VISITS TO MAINTAIN MY GAINS.

☐ I'M NOT SURE YET. I WISH TO DISCUSS MY OPTIONS MORE WITH MY DOCTOR(S).

NOTES:

PLEASE PROVIDE:
HEIGHT: _____ **WEIGHT:** _____

DOCTOR WILL GATHER: TEMP: _____ **RESP:** _____
PULSE: _____ **BLOOD PRESSURE** _____/_____ **SIT/STAND**

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE AND TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARDIAN SIGNATURE: _____ **DATE:** _____

D.C. SIGNATURE: _____ **DATE:** _____