Parkhurst Chiropractic

MIND BODY HEALTH

Patient Health Information:

Appt Date & Time: _____

Address Label # 4

Patient:

Parkhurst Chiropractic is trying to get a better sense of the overall diversity of our patient population. This will give us a better understanding of your needs as a patient. This confidential information is for quality monitoring purposes and is protected by HIPAA Guidelines:

Patient Race: Caucasian African American Latin American Native American Asian Pacific Islander Prefer not to Answer

Marital Status: _____ Height: _____ Approx Weight: _____

Occupation _____ Employer _____

Primary Care Physician: _____

Emergency Contact & Phone: _____

Tobacco Use: Yes No Former High Blood Pressure: Yes No

Drug Allergies: _____

Current Prescriptions: _____

_____

CHIEF COMPLAINTS:

Please mark an "X" on your current chief complaints:			
Low back pain		Neck pain	
Low back spasm/stiffness		Headaches	
Right hip pain		Upper back pain	
Left hip pain		Upper back spasm/stiffness	
Right sided groin pain		Mid back pain	
Left sided groin pain		Mid back spasm/stiffness	
Right sided gluteal/buttocks pain		Right shoulder pain	
Left sided gluteal/buttocks pain		Left shoulder pain	
Right leg pain		Right arm pain	
Left leg pain		Left arm pain	
Right knee pain		Right elbow pain	
Left knee pain		Left elbow pain	
Right ankle pain		Right wrist pain	
Left ankle pain		Left wrist pain	
Right foot/toe pain		Right hand/finger pain	
Left foot/toe pain		Left hand/finger pain	
Other:			

CHIEF COMPLAINT PAIN TYPE AND FREQUENCY:

Please mark an "X" on all that apply:			
Constant		Achy	
Frequent		Burning	
Intermittent		Dull	
Occasional		Sharp	
Mild		Shooting / Radiating	
Moderate		Throbbing	
Severe			
Other:			

CHIEF COMPLAINT AGGRAVATORS:

Please mark an "X" on all that apply:			
Any type of exertion		Prolonged standing	
Bending		Sleeping or waking up	
Moving from seated to standing		Twisting	
Prolonged sitting		Walking/Running	
Other:			

Has your complaints decreased or prevented your ability to exercise: YES or NO

REVIEW OF SYMPTOMS / MEDICAL HISTORY:

Please mark an "X" on any that apply:			
I am in good health		Kidney disease	
Arthritis		Liver problems	
Asthma		Lung disease	
Cancer		Muscle tension and/or pain	
Diabetes		Osteoporosis	
Fibromyalgia		Stomach problems	
Heart problems		Thyroid problems	
High Cholesterol		Vertebra fracture	
Joint problems			
Other:			

PAST SURGERIES:

Please mark an "X" on all that apply:			
Appendectomy		Lumbar Spine Surgery	
Cervical Spine Surgery		Mastectomy	
Heart Surgery		Thoracic Spine Surgery	
Hysterectomy		Gall Bladder Removal/Surgery	
Other:			

FAMILY HISTORY:

Please mark an "X" on all that apply:			
Arthritis		Headaches / Migraines	
Cancer		Heart disease	
Chronic pain		High blood pressure	
Diabetes		High cholesterol	
Fibromyalgia		Osteoporosis	
Other:			

Please select the most appropriate answer for each of the questions below:

Low Back, Hip & Leg:

1. Over the past week, on average, how would you rate your back pain?

0 = No pain — 10 = Worst pain possible

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

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

0 = No interference — 10 = Unable to carry out activity

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

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

0 = No interference — 10 = Unable to carry out activity

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

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

0 = Not at all anxious — 10 = Extremely anxious

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

5. 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

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

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

0 = Has made it no worse — 10 = Has made it much worse

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

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

0 = Completely control it — 10 = No control whatsoever

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

Neck, Upper Back, Shoulder & Arm:

1. Over the past week, on average, how would you rate your neck pain?

0 = No pain — 10 = Worst pain possible

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

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

0 = No interference — 10 = Unable to carry out activity

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

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

0 = No interference — 10 = Unable to carry out activity

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

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

0 = Not at all anxious — 10 = Extremely anxious

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

5. 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

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

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

0 = Has made it no worse — 10 = Has made it much worse

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

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

0 = Completely control it — 10 = No control whatsoever

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