Dr. Williams *Chiropractic Office*

CASE HISTORY

PLEASE PRINT

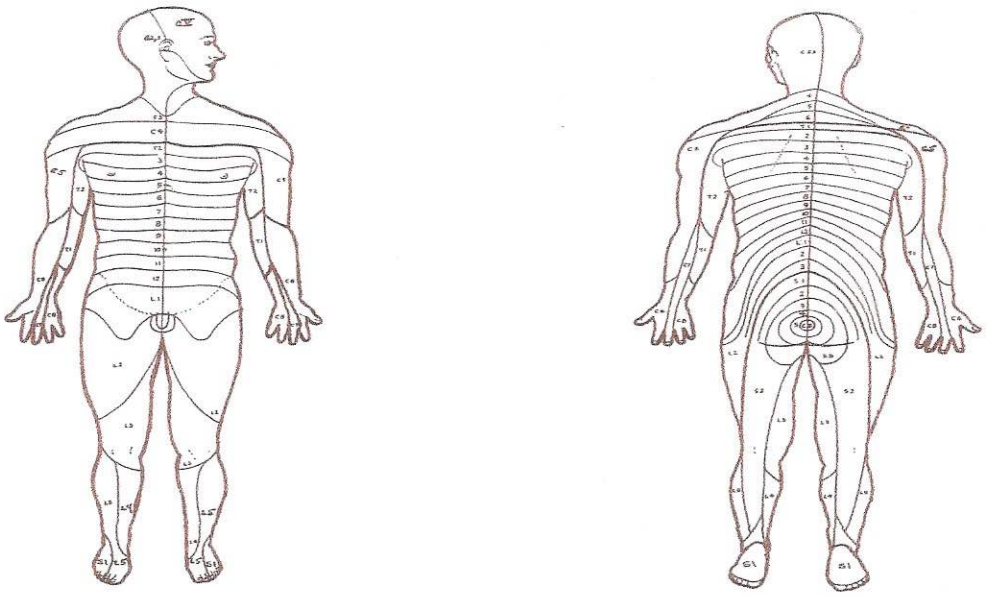
First Name **M.I.** **Last Name**

TYPE OF INJURY

Personal _____ **Sports** _____ **Motor Vehicle** _____ **Work Related** _____

Please Mark Area(s) & Type of Pain On The Drawings Using The Codes Listed Below

A-Ache **N-Numbness** **P-Pain** **S-Soreness** **ST–Stiffness** **T-Tingling**



PLEASE LIST THE REASON(S) YOU WOULD LIKE TO BE TREATED BY THIS OFFICE

1) _____

How Long Have You Had This Condition? **Day(s)** **Week(s)** **Month(s)** **Year(s)**

2) _____

How Long Have You Had This Condition? **Day(s)** **Week(s)** **Month(s)** **Year(s)**

Have You Had Any Spinal Surgical Procedures Such As Disc And/Or Vertebrae Fusions? Yes _____ **No** _____
If Yes When, Where, And Why? _____

_____

Have You Had Any Surgical Procedures On Your Shoulder(s), Arms, Forearms, Wrist, Hands, Hip(s), Thighs, Legs And/Or Feet? Yes _____ No_____ If Yes When, Where, And Why? _____

_____

Have You Had Any Surgical Procedures Such As Brain, Heart, Liver, Lungs...etc? Yes _____ No _____ If Yes When, Where, And Why? _____

_____

PLEASE LIST THE REASON(S) YOU WOULD LIKE TO BE TREATED BY THIS OFFICE

1) _____

How Long Have You Had This Condition? Day(s) Week(s) Month(s) Year(s)

2) _____

How Long Have You Had This Condition? Day(s) Week(s) Month(s) Year(s)

3) _____

How Long Have You Had This Condition? Day(s) Week(s) Month(s) Year(s)

Have You Had Any Spinal Surgical Procedures Such As Disc And/Or Vertebrae Fusions? Yes _____ No_____ If Yes When, Where, And Why? _____

_____

_____

Have You Had Any Surgical Procedures On Your Shoulder(s), Arms, Forearms, Wrist, Hands, Hip(s), Thighs, Legs And/Or Feet? Yes _____ No_____ If Yes When, Where, And Why? _____

_____

_____

Have You Had Any Surgical Procedures Such As Brain, Heart, Liver, Lungs...etc? Yes _____ No _____ If Yes When, Where, And Why? _____

_____

_____

In order for this office to properly serve you and help your condition, we need to know which of the following chiropractic treatment plans do you desire.

Acute Care aka Aspirin Care _____

I just want the pain to go away.

Rehabilitative Care aka Current Condition Care _____

I want the pain to go away and to correct the problem.

Preventative Care aka Wellness Care _____

I want to have regular chiropractic and spinal care.

Dr. Williams *Chiropractic Office* Financial Policy

I, the patient – guardian, understand Dr. Williams *Chiropractic Office* does not have a contract with my insurance company for chiropractic service(s) rendered therefore I, the patient - guardian, am financially responsible for all x-ray's, braces, orthopedic supports, supplements, vitamins as well as chiropractic service(s) rendered to and payment is due when chiropractic service(s) are rendered!

Date ____/____/____ ***Patient's – Guardian's Signature*** _____

DR. WILLIAMS CHIROPRACTIC OFFICE CONSULTATION NOTE(S):

Dr. Williams *Chiropractic Office*
(909) 592-2823

PAIN QUESTIONNAIRE

DATE: _____/_____/_____ **NAME:** _____

AREA(S) OF PAIN: _____

1. **Please Indicate Your Usual Level Of Pain During The Past Week!**

   No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst Pain Possible

2. **Does Pain, Numbness, Tingling Or Weakness Extend Into Your Back- Arm(s) – Legs?**

   No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst Pain Possible

3. **How Would You Rate Your General Health?**

   Good = 0 1 2 3 4 5 6 7 8 9 10 = Not Good At All

4. **If You Had To Spend The Rest Of Your Life With Your Condition As It Is Right Now – How Would You Feel About It?**

   Very Happy = 0 1 2 3 4 5 6 7 8 9 10 = Not Very Happy

5. **How Anxious – Tense – Uptight – Irritable – Fearful – Difficult In Concentrating – Relaxing – Have You Been Feeling During The Past Week?**

   No Tension = 0 1 2 3 4 5 6 7 8 9 10 = Very Tense

6. **How Much Have You Been Able To Control - Reduce – Help – Your Pain – On Your Own During The Past Week?**

   Very Controlled = 0 1 2 3 4 5 6 7 8 9 10 = No Control

7. **Please Indicate How Depressed – Down in The Dumps – Sad – Downhearted – In Low Spirits – Pessimistic Feelings I Have Been Feeling In The Past Week?**

   No Depression = 0 1 2 3 4 5 6 7 8 9 10 = Very Depressed

8. **How Certain Are You That You Will Be Doing Normal Activities Or Working Without Pain In Six (6) Months?**

   Very Certain = 0 1 2 3 4 5 6 7 8 9 10 = Not Certain

9. **Can You State "I Can Do Light Work For An Hour"**

   I Can = 0 1 2 3 4 5 6 7 8 9 10 = No I Cannot

10. **Can You State I Can Sleep At Night."**

    I Sleep All Night = 0 1 2 3 4 5 6 7 8 9 10 = I Cannot Sleep At Night

11. **An Increase In Pain Is An Indication That I Should Stop What I Am Doing Until The Pain Decreases Or Goes Away!**

    No Increase In Pain = 0 1 2 3 4 5 6 7 8 9 10 = I Have A Increase In Pain

12. **Physical Activity Makes My Pain Worse!**

    No = 0 1 2 3 4 5 6 7 8 9 10 = Yes Physical Activity Makes My Pain Worse

13. **I Should Not Do My Normal Activities Including Work With My Present Pain!**

    Able To Do My Normal Activities = 0 1 2 3 4 5 6 7 8 9 10 = Not Able To Do My Normal Activities

Dr. Williams *Chiropractic Office*

PLEASE CHECK ALL PRESENT SYMPTOMS

DATE ____/____/_____ **NAME** _____
PRINT FIRST PRINT MIDDLE PRINT LAST

PLEASE CIRCLE RIGHT OR LEFT

HEAD

- ____ HEADACHES
- ____ SINUS
- ____ MIGRAINE HEADACHE
- ____ HEADACHE ON TOP OF HEAD
- ____ HEADACHE ON BACK OF HEAD
- ____ HEADACHE ON FOREHEAD
- ____ HEADACHE ON SIDE OF HEAD
- ____ HEAD FEELS HEAVY
- ____ LIGHT HEADEDNESS
- ____ DIZZINESS
- ____ RINGING IN EARS

NECK

- ____ PAIN IN NECK
- ____ NECK PAIN WITH MOVEMENT
- ____ MUSCLE SPASMS

SHOULDERS

- ____ PAIN IN RIGHT SHOULDER
- ____ PAIN IN LEFT SHOULDER
- ____ PAIN ACROSS SHOULDERS
- ____ UNABLE TO MOVE SHOULDER
- ____ MUSCLE SPASMS IN SHOULDER

ARMS & HANDS

- ____ PAIN IN UPPER RIGHT OR LEFT ARM
- ____ PAIN IN RIGHT OR LEFT ELBOW
- ____ PAIN IN RIGHT OR LEFT FOREARM
- ____ PAIN IN RIGHT OR LEFT HAND
- ____ NUMBNESS IN RIGHT OR LEFT EXTREMITY

MID - BACK

- ____ MID BACK PAIN
- ____ DULL PAIN
- ____ SHARP PAIN

ABDOMEN

- ____ STOMACH PAIN
- ____ GAS
- ____ CONSTIPATION
- ____ DIARRHEA
- ____ NAUSEA
- ____ HEMORRHOIDS

LOWER BACK

- ____ LOW BACK PAIN
- ____ LOW BACK PAIN UPON MOVEMENT
- ____ MUSCLE SPASMS

CHEST

- ____ CHEST PAIN
- ____ RADIATING CHEST PAIN
- ____ SHORTNESS OF BREATH
- ____ BREAST PAIN RIGHT OR LEFT

LEGS & FEET

- ____ PAIN IN UPPER RIGHT OR LEFT LEG
- ____ PAIN IN RIGHT OR LEFT KNEE
- ____ PAIN IN RIGHT OR LEFT LEG
- ____ PAIN IN RIGHT OR LEFT ANKLE
- ____ PAIN IN RIGHT OR LEFT FOOT

NOTES

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