

NAME: _____ Mr Mrs Ms Miss Dr Rev
Last name First name Initial (please circle one of the above)

DATE OF BIRTH: Year _____ Month _____ Day _____ Ht _____ Wt. _____ Shoe Sz. _____

HOME ADDRESS: _____
Street City Province Postal Code

PHONE NUMBER: Home: _____ Cell: _____ Work: _____

EMAIL ADDRESS: _____

OCCUPATION: _____ **EMPLOYER:** _____

MEDICAL DOCTOR: _____ **HEALTH CARD#** _____

How did you hear about our office? _____

Who should we contact in case of emergency? _____ Phone # _____

What is your major complaint today? _____

How long have you had this condition? _____

Describe the onset of this condition? _____

Is the condition getting: (circle) Worse Same Better Consistent Recurring

How would you describe the pain? (circle) Aching Throbbing Tingling Numbness Burning
Shooting Intermittent Constant

Do you experience Numbness or Tingling to the arms or legs? YES NO

Is there a particular time of day when your complaint is worse? (circle)

Morning Afternoon Evening Night After activities

What activities are you unable to perform due to pain or functional impairment? (ie. golf)

Have you had this condition before? YES NO

Were XRAYs or other imaging performed? YES NO

What aggravates your condition? _____

What relieves your condition? _____

What types of treatment have you had for this condition? _____

Have you had previous chiropractic care? YES NO

If "yes" how long has it been since you were last treated? _____

DO YOU SUFFER –AT PRESENT- FROM ANY OF THE FOLLOWING

- () Fainting/ Spells/ Dizziness
- () Difficulty Sleeping
- () Pain that awakens you at night
- () General Tiredness/ Fatigue
- () Fever
- () Chills
- () Night sweats
- () Unexplained or unintentional Weight Loss

Current medications (including birth control)

List any surgeries/hospitalizations you've had & date

Supplements: _____

Have you suffered any fractures/dislocations?

HEALTH HABITS

Smoking: YES NO if "yes" how many years? _____ packs/day _____

Exercise: YES NO **Drinking Alcohol:** YES NO **Caffeine:** YES NO

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

Neuromusculoskeletal

- () Convulsions
- () Headaches
- () Backache
- () Stiff neck
- () Pain between shoulders
- () Spinal curvature
- () Swollen joints
- () Weakness
- () Twitching
- () Numbness
- () Tremors

Skin or Allergies

- () Allergy
- () Bruise Easily
- () Dryness
- () Eczema
- () Sensitive Skin
- () Shingles

Other

- () Diabetes
- () Cancer
- () Depression/Anxiety

Cardiovascular

- () Heart disease
 - () High blood pressure
 - () Low blood pressure
 - () Stroke
 - () Varicose Veins
 - () Irregular heart beat
- Gastrointestinal***
- () Poor digestion
 - () Nausea/Vomiting
 - () Belging/Bloating/Gas
 - () Irritable bowel
 - () Hemorrhoids

Ear/Nose/Throat

- () Earaches
- () Frequent colds
- () Sinusitis
- () Hayfever

- () Alcoholism
- () HIV positive
- () Thyroid trouble

Respiratory

- () Chest Pain
- () Chronic cough
- () Difficulty breathing
- () Wheezing

Genitourinary

- () Bed wetting
- () Frequent urination
- () Painful urination
- () Prostate trouble
- () Inability to control urine

Women Only

- () Pregnant
- () Cramping /backache
- () Miscarriage
- () Irregular Cycle
- () Hot flashes/menopausal

Mark the areas on your body where you feel the following sensations:

Ache

^^
^^
^^

Numbness

ooo
ooo
ooo

Pins &
Needles

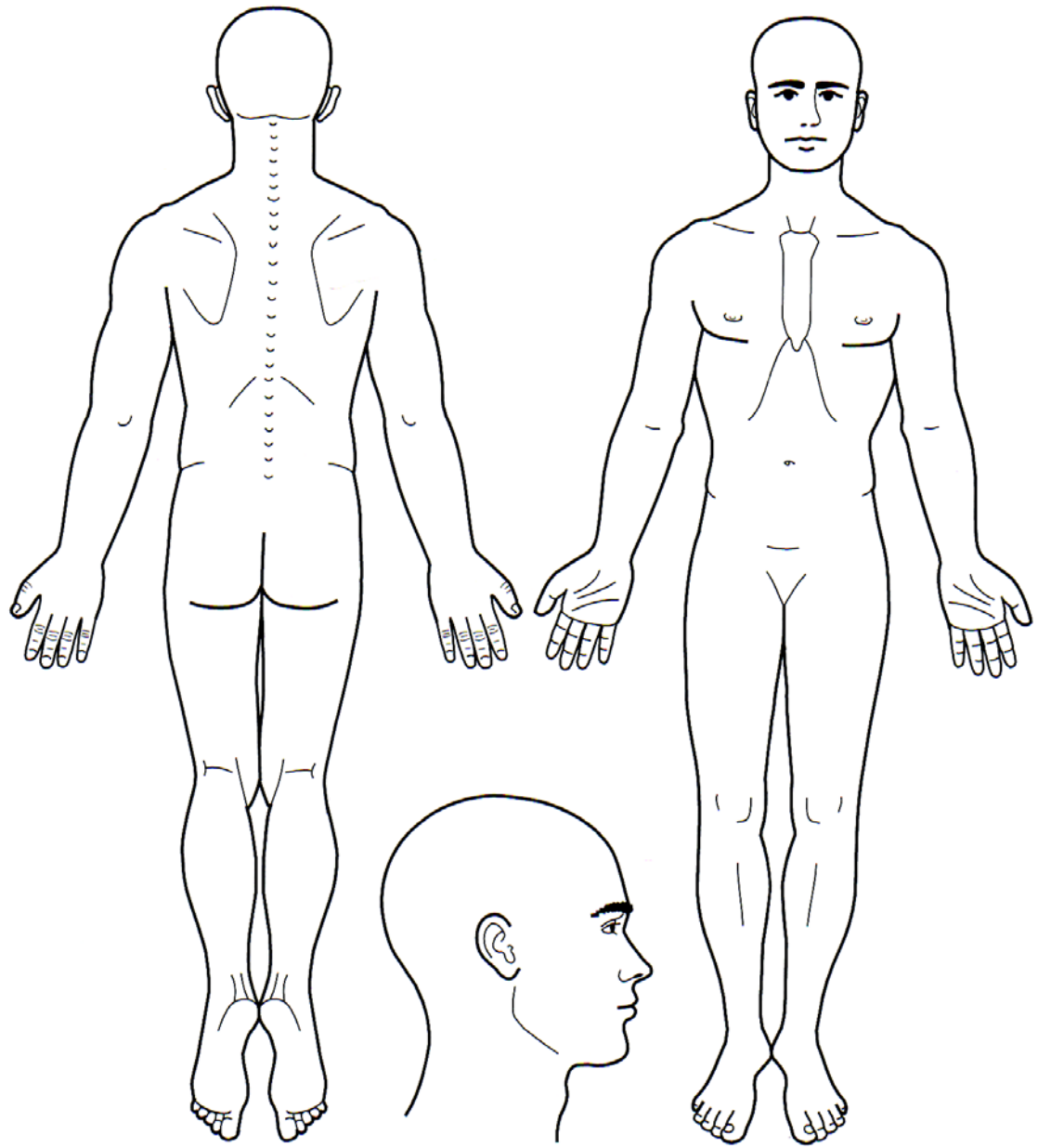
...
...
...

Burning

xxx
xxx
xxx

Stabbing

///
///
///



NAME _____

DATE _____

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU.

ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself, and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self -care.
- I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- I can lift heavy weights without causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – WORK

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

SECTION 5 – HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

SECTION 7 – SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- I can drive my car without neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.

SECTION 9 – READING

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

SECTION 10 – RECREATION

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

PATIENT NAME _____

DATE _____

SCORE _____ [50]

BENCHMARK -5 = _____

KINETESIS SPORTS INJURY & PERFORMANCE CLINIC
FEE SCHEDULE

Chiropractic Services

Initial Consultation	\$100.00
Gait / Orthotic Assessment	\$75.00
Regular Office Visit	\$60.00

We direct bill Blue Cross for chiropractic services. All fees are due at the time services are rendered.