

# WELCOME

## SHAW CHIROPRACTIC CENTER

### NEW PATIENT DATA SHEET

PATIENT NAME \_\_\_\_\_ Date \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX M/F SOCIAL SECURITY# \_\_\_\_\_ PHONE# \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ # OF CHILDREN/ AGES \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ HEALTH PLAN \_\_\_\_\_  
SUBSCRIBER ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ SPOUSE NAME \_\_\_\_\_  
SPOUSE EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

1. DESCRIBE YOUR SYMPTOMS \_\_\_\_\_

2. WHEN DID THEY START \_\_\_\_\_

3. HOW DID THEY START \_\_\_\_\_

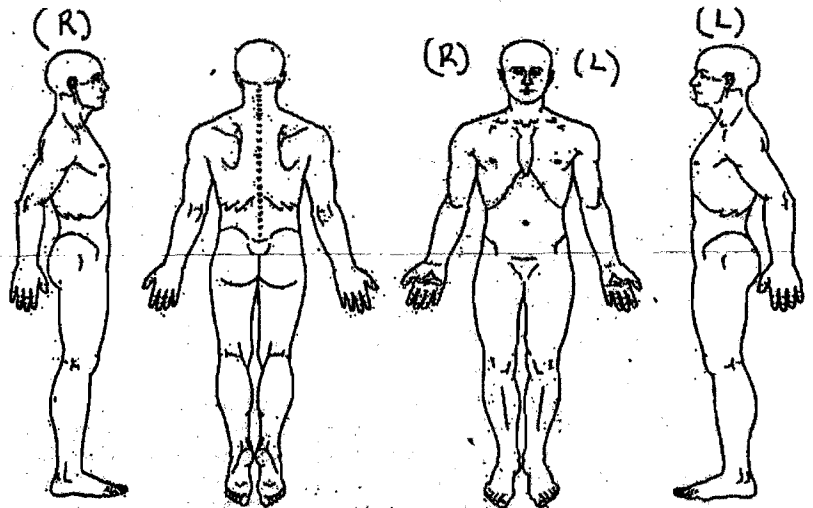
4. How often do you experience your symptoms?

- a. Constantly (76-100% of the day)
- b. Frequently (51-75% of the day)
- c. Occasionally (26-50% of the day)
- d. Intermittently (0-25% of the day)

*Indicate where you have pain or other symptoms*

4. What describes the nature of your symptoms?

- a. Sharp
- b. Shooting
- c. Dull Ache
- c. Burning
- d. Numb
- e. Tingling



5. How are your symptoms changing?

- a. Getting Better
- b. Not Changing
- c. Getting Worse

6. During the past 4 weeks:

a. Indicate the average intensity of your symptoms: 0 \_\_\_\_\_ (none) \_\_\_\_\_ (unbearable) 10

b. How much has pain interfered with your normal work (including both outside the home and housework)  
\_\_\_ Not at all \_\_\_ A little Bit \_\_\_ Moderately \_\_\_ Quite a Bit \_\_\_ Extremely

7. During the past 4 weeks how much of the time has your condition interfered with your social activities?

All of the time  Most of the time  Some of the time  A little of the time  None of the time

8. In general would you say your overall health right now is...

Excellent  Very Good  Good  Fair  Poor

9. Who have you seen for your symptoms?

No one  Medical Doctor  Other Chiropractor  Physical Therapist  Other

a. What treatment did you receive and when? \_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

X-rays date \_\_\_\_\_  MRI date \_\_\_\_\_  CT Scan date \_\_\_\_\_  Other date \_\_\_\_\_

10. Have you had similar symptoms in the past?  Yes  No

a. If you have received treatment in the past for the same or similar symptoms, whom did you see?

This Office  Medical Doctor  Other Chiropractor  Physical Therapist  Other

11. Is there a chance you are pregnant?  Yes  No

12. Do you wear a heel lift?  Yes  No

Please check all of the following that apply to you:  None Apply

- | No                       | Yes                      | Condition                   |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | History of Recent Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Fever                |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use          |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills         |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date) _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/Fainting          |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in Groin/Buttocks  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Retention           |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Tumor                |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Trauma               |

- | No                       | Yes                      | Condition  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems  |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # of births _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain, <input type="checkbox"/> Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/Seizures  |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Low/Mid Back Pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Neck Pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis  |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Alcohol Use   |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Tobacco Use   |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgeries/Medications: _____   |
|                          |                          | _____  |
|                          |                          | _____  |
|                          |                          | _____  |

Family History:  Cancer  Diabetes  High Blood Pressure  Cardiovascular Problems/Stroke

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Shaw Chiropractic Center will ASSIST me in making collection from the insurance company and that any amount authorized to be paid directly to the Shaw Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that I am personally responsible for payment of all present and future services rendered, including any charges my insurance company or Medicare denies or does not cover. Should Shaw Chiropractic Center elect to place my account in collections I shall become liable for all costs of collection including but not limited to collection agency or attorney fees as well as the total account balance due.*

*I understand that Shaw Chiropractic Center and its employees do not diagnose, treat, or claim to cure medical conditions and are not responsible for the diagnosis of any medical conditions. I understand that the practice of Chiropractic is based solely on the presence, analysis and correction of vertebral subluxations and other skeletal misalignments and I hereby authorize Dr. Shaw to provide Chiropractic Care for me.*

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian's

Consent to Treat a Minor: \_\_\_\_\_ Date: \_\_\_\_\_

# 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

- Ⓐ I have no pain at the moment.
- Ⓛ The pain is very mild at the moment.
- Ⓜ The pain comes and goes and is moderate.
- Ⓝ 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.

## Sleeping

- Ⓐ I have no trouble sleeping.
- Ⓛ My sleep is slightly disturbed (less than 1 hour sleepless).
- Ⓜ My sleep is mildly disturbed (1-2 hours sleepless).
- Ⓝ My sleep is moderately disturbed (2-3 hours sleepless).
- Ⓞ My sleep is greatly disturbed (3-5 hours sleepless).
- Ⓟ My sleep is completely disturbed (5-7 hours sleepless).

## 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 cannot read as much as I want because of moderate neck pain.
- Ⓞ I can hardly read at all because of severe neck pain.
- Ⓟ I cannot read at all because of neck pain.

## Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- Ⓛ I can concentrate fully when I want with slight difficulty.
- Ⓜ I have a fair degree of difficulty concentrating when I want.
- Ⓝ I have a lot of difficulty concentrating when I want.
- Ⓞ I have a great deal of difficulty concentrating when I want.
- Ⓟ I cannot concentrate at all.

## Work

- Ⓐ I can do as much work as I want.
- Ⓛ I can only do my usual work but no more.
- Ⓜ I can only do most of my usual work but no more.
- Ⓝ I cannot do my usual work.
- Ⓞ I can hardly do any work at all.
- Ⓟ I cannot do any work at all.

## 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 I 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.

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓝ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓞ I can only lift very light weights.
- Ⓟ I cannot lift or carry anything at all.

## Driving

- Ⓐ I can drive my car without any neck pain.
- Ⓛ I can drive my car as long as I want with slight neck pain.
- Ⓜ I can drive my car as long as I want with moderate neck pain.
- Ⓝ I cannot drive my car as long as I want because of moderate neck pain.
- Ⓞ I can hardly drive at all because of severe neck pain.
- Ⓟ I cannot drive my car at all because of neck pain.

## Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- Ⓛ I am able to engage in all my usual recreation activities with some neck pain.
- Ⓜ I am able to engage in most but not all my usual recreation activities because of neck pain.
- Ⓝ I am only able to engage in a few of my usual recreation activities because of neck pain.
- Ⓞ I can hardly do any recreation activities because of neck pain.
- Ⓟ I cannot do any recreation activities at all.

## Headaches

- Ⓐ I have no headaches at all.
- Ⓛ I have slight headaches which come infrequently.
- Ⓜ I have moderate headaches which come infrequently.
- Ⓝ I have moderate headaches which come frequently.
- Ⓞ I have severe headaches which come frequently.
- Ⓟ 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

# 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

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓟ The pain comes and goes and is very severe.
- Ⓡ The pain is very severe and does not vary much.

## Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓡ Pain prevents me from sleeping at all.

## Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓡ I avoid sitting because it increases pain immediately.

## Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓡ I avoid standing because it increases pain immediately.

## Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓡ I cannot walk at all without increasing pain.

## Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓟ Because of the pain I am unable to do some washing and dressing without help.
- Ⓡ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓟ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓡ I can only lift very light weights.

## Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓡ Pain restricts all forms of travel.

## Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓡ I have hardly any social life because of the pain.

## Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓡ My pain is rapidly worsening.

Back  
Index  
Score