Case #:_____

# Confidential Patient Data

IF YOU NEED ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST.

## PATIENT INFORMATION

Name:_____ Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Email:_____ Home Phone:_____ Cell Phone:_____
Date of Birth:_____ Age:_____ ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other
Emergency Contact:_____Relationship:_____ Phone:_____
Referred to this office by:_____

Payment for Services will be: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance
☐ Automobile Insurance ☐ Worker's Compensation

Insurance Company:_____ Effective Date:_____
Insured's Employer:_____ Employer Phone:_____
Are you covered by more than one insurance company? ☐ Yes ☐ No If yes, _____
(Other Insurance Company Name)

## MEDICAL/FAMILY HISTORY S = SELF M = MOTHER F = FATHER

(Please indicate which conditions have been experienced by the above by marking the appropriate boxes).

| S | M | F | | S | M | F | | S | M | F | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | AIDS | ☐ | ☐ | ☐ | Dislocated Joints | ☐ | ☐ | ☐ | Neck Pain |
| ☐ | ☐ | ☐ | Anemia | ☐ | ☐ | ☐ | Epilepsy | ☐ | ☐ | ☐ | Nervousness |
| ☐ | ☐ | ☐ | Arthritis | ☐ | ☐ | ☐ | German Measles | ☐ | ☐ | ☐ | Numbness |
| ☐ | ☐ | ☐ | Asthma | ☐ | ☐ | ☐ | Headaches | ☐ | ☐ | ☐ | Polio |
| ☐ | ☐ | ☐ | Back Pain | ☐ | ☐ | ☐ | Heart Trouble | ☐ | ☐ | ☐ | Poor Circulation |
| ☐ | ☐ | ☐ | Bladder Trouble | ☐ | ☐ | ☐ | Reproductive Disorders | ☐ | ☐ | ☐ | Hepatitis |
| ☐ | ☐ | ☐ | Bone Fracture | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | ☐ | Cancer | ☐ | ☐ | ☐ | HIV/ARC | ☐ | ☐ | ☐ | Rheumatism |
| ☐ | ☐ | ☐ | Chest Pain | ☐ | ☐ | ☐ | Kidney Disorder | ☐ | ☐ | ☐ | Scarlet Fever |
| ☐ | ☐ | ☐ | Concussion | ☐ | ☐ | ☐ | Bowel Control Loss | ☐ | ☐ | ☐ | Serious Injury |
| ☐ | ☐ | ☐ | Convulsions | ☐ | ☐ | ☐ | Menstrual Cramps | ☐ | ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | ☐ | Diabetes | ☐ | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ | ☐ | Tuberculosis |
| ☐ | ☐ | ☐ | Indigestion | ☐ | ☐ | ☐ | Muscular Dystrophy | ☐ | ☐ | ☐ | Venereal Disease |

Have you been treated by a physician for any health conditions in the last year? ☐ Yes ☐ No If yes, describe condition:
_____

SURGICAL HISTORY:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had a metal implant? ☐ Yes ☐ No Gunshot Wound? ☐ Yes ☐ No

ACCIDENT HISTORY ☐ Job ☐ Auto ☐ Other _____ Date:_____
☐ Job ☐ Auto ☐ Other _____ Date:_____
☐ Job ☐ Auto ☐ Other _____ Date:_____

FAMILY DOCTOR:_____ CLINIC_____
Date of last physical exam: _____ Height:_____inches Weight:_____lbs
Are you pregnant? ☐Yes ☐No Date of last menstrual period?_____

## DESCRIBE PRESENT MAJOR COMPLAINTS:

Please rate your symptoms from (1) LEAST PAINFUL to (10) MOST PAINFUL

| | SCALE |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

SYMPTOMS DEVELOPED FROM: ☐Job Related Injury ☐Auto Accident ☐Other Accident
☐Illness ☐Gradual Onset ☐Unknown Cause
SYMPTOMS ARE WORSE IN THE: ☐Morning ☐Afternoon ☐Night
SYMPTOMS: ☐Come & Go ☐Constant
SYMPTOMS HAVE PERSISTED FOR:_____Hour(s) _____Day(s) _____Week(s) _____Month(s) _____Year(s)
HAVE YOU EVER HAD THIS BEFORE? ☐Yes ☐No If YES, when?_____
IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?_____
_____
NAME & LOCATION OF DOCTOR PREVIOUSLY SEEN FOR PRESENT CONDITION(S):
_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:

| | | | |
|---|---|---|---|
| ☐Bending | ☐Reaching | ☐Straining at Stool | ☐Coughing |
| ☐Sitting | ☐Turning Head | ☐Lifting | ☐Sneezing |
| ☐Walking | ☐Lying Down | ☐Standing | ☐Other_____ |

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:

| | | | |
|---|---|---|---|
| ☐Rest | ☐Sitting | ☐Icing | ☐Standing |
| ☐Lying Down | ☐Activity | ☐Heat | ☐Stretching |

INFORMED CONSENT: I understand and am informed that with Chiropractic care, as in the practice of medicine and all other health care modalities, results are not guaranteed and there is no promise of a cure. I further understand and am informed that while Chiropractic is remarkable safe and effective and provides many patients with benefits, including pain relief and enhanced health, there can be associated risks, just as in the practice of medicine. Potential risks include, but not limited to: soreness, fractures, physiotherapy burns and stroke. I have read, or have had read to me, the above consent. This consent is for Chiropractic care and procedures to be performed on me, or for the patient named below for whom I am legally responsible whether in my presence or absence.

Patient Name_____
Patient Signature_____ Date_____

*Eau Claire Chiropractic, S.C.*

# BOURNEMOUTH QUESTIONNAIRE

The following scales have been designed to find out about your neck/back pain and how it is affecting you. Please answer ALL questions on a scale from 1 to 10 that best describe how you feel.

| **NECK** Date | | | | | |
|---|---|---|---|---|---|
| Over the past week, on average, how would you rate your neck pain?<br>0 = no pain 10 = worst paint possible | | | | | |
| Over the past week, how much has your neck pain interfered with your daily activities? (i.e. housework, dressing, lifting, reading, driving)<br>0 = no interference 10 = unable to carry out activity | | | | | |
| Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social and family activities?<br>0 = no interference 10 = unable to carry out activity | | | | | |
| 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 | | | | | |
| 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 | | | | | |
| ***Discussed the depression score & offered referral for counseling.* | | | | | |
| Over the past week, how have you felt your work, either inside or outside of the home, has affected (or would affect) your neck pain?<br>0 = has made it no worse 10 = has made it much worse | | | | | |
| Over the past week, how much have you been able to control (reduce/help) your neck pain on your own? 0 = have complete control 10 = no control whatsoever | | | | | |
| Normal = 0% Score: Total Points/70 x 100 = Total % | | | | | |
| Bolton JE, Humphreys BK: the Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure II. Psychometric Properties in Neck Pain Patients JMPT 2002; 25 (3): 141-148 | | | | | |

| **BACK** Date | | | | | |
|---|---|---|---|---|---|
| Over the past week, on average, how would you rate your back pain?<br>0 = no pain 10 = worst paint possible | | | | | |
| Over the past week, how much has your back pain interfered with your daily activities? (i.e. housework, dressing, walking, climbing stairs, getting in and out of bed/chair)<br>0 = no interference 10 = unable to carry out activity | | | | | |
| Over the past week, how much has your back pain interfered with your ability to take part in recreational, social and family activities?<br>0 = no interference 10 = unable to carry out activity | | | | | |
| 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 | | | | | |
| 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 | | | | | |
| ***Discussed the depression score & offered referral for counseling.* | | | | | |
| Over the past week, how have you felt your work, either inside or outside of the home, has affected (or would affect) your back pain?<br>0 = has made it no worse 10 = has made it much worse | | | | | |
| Over the past week, how much have you been able to control (reduce/help) your back pain on your own? 0 = have complete control 10 = no control whatsoever | | | | | |
| Normal = 0% Score: Total Points/70 x 100 = Total % | | | | | |
| Bolton JE, Humphreys BK: the Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure II. Psychometric Properties in Neck Pain Patients JMPT 2002; 25 (3): 141-148 | | | | | |

Patient Name:_____ Patient Signature:_____