PRIOUX CHIROPRACTIC

7650 ANCHOR DRIVE, PORT ARTHUR, TX 77642

WELCOME TO OUR OFFICE! PLEASE TELL US A LITTLE ABOUT YOURSELF.

Name: _____ DOB: _____ Date: _____

Mailing Address:

_____

_____

_____

- Phone Number:

Home: ( ) _____-_____

Work: ( ) _____-_____

Cell: ( ) _____-_____

-Insurance provider
(Please present your new card to the front desk)

Who is/was your last chiropractor?

Dr: _____

Address: _____

_____

Phone: ( ) _____

When was your last visit? _____

What is your complaint and cause? _____

_____

Please rate your complaint. _____/10 (0 being no pain, 10 being the worst pain)

How long have you endured this complaint? _____

FUNCTIONAL RATING INDEX

Patient name_____Date_____

This questionnaire will give your provider information about how your condition affects your everyday life. Please answer every section by marking the one statement that most 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

(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain comes and goes and is moderate.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is worst imaginable at the moment.

SLEEPING

(0) I have no trouble sleeping
(1) My sleep is slightly disturbed (less than one hour sleepless).
(2) My sleep is mildly disturbed (1-2 hours sleepless).
(3) My sleep is moderately disturbed (2-3 hours sleepless).
(4) My sleep is greatly disturbed (3-5 hours sleepless).
(5) My sleep is completely disturbed (5-7 hours sleepless).

READING

(0) I can read as much as I want with no pain.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I cannot read as much as I want because of severe neck pain
(4) I can hardly read at all because of sever neck pain.
(5) I cannot read at all because of neck pain.

CONCENTRATION

(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have a great deal of difficulty concentrating when I want.
(5) I cannot concentrate at all.

WORK

(0) I can do as much work as I want
(1) I can only do my usual work but no more.
(2) I can only do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any work at all. I cannot do any work.
(5) I cannot do any work at all.

PERSONAL CARE

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

LIFTING

(0) I can lift heavy weight without extra pain.
(1) I can lift heavy, but it causes extra pain.
(2) Pain prevents me lifting heavy weight off the floor, but I manage if they are conveniently positioned (e.g. on a table)
(3) Pain prevents me from lifting heavy weight if they are conveniently position.
(4) I can only lift very light weight.
(5) I cannot lift or carry anything at all.

DRIVING

(0) I can drive my car without any pain.
(1) I can drive my car as long as I want with slight pain.
(2) I can drive my car as long as I want with moderate pain.
(3) I cannot drive my car as long as I want because of moderate pain.
(4) I can hardly drive at all because of severe pain.
(5) I cannot drive my car at all because of severe pain.

SOCIAL LIFE

(0) I can engage in all my recreation activities without pain.
(1) I can engage in all my usual activities with some pain.
(2) I am only able to engage in most but not all my usual activities because of pain.
(3) I can hardly do any recreation activities because of pain.
(4) I cannot do any recreation activities at all.

HEADACHE

(0) I have no headache at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come frequently
(5) I have headaches almost all the time.

SITTING

(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting longer than ½ hour.
(4) Pain prevents me from sitting longer than 10 minutes.
(5) I avoid sitting because it increases pain immediately.

WALKING

(0) I have no pain while walking.
(1) I have some pain while walking but it doesn't increase with distance.
(2) I cannot walk more than 1 mile without increasing pain.
(3) I cannot walk more than ½ mile without increasing pain.
(4) I cannot walk more than ¼ mile without increasing pain.
(5) I cannot walk at all without increasing pain.

ENERGY

(0) I have an abundance of energy
(1) I have more energy than tiredness.
(2) I am just as tired as I have energy.
(3) I am more tired than I have energy.
(4) I completely exhausted.

TOTAL: _____

STANDING

(0) I can stand as long as I want without pain.
(1) I have some pain while standing but it does not increase with time.
(2) I cannot stand for longer than 1 hour without increasing pain.
(3) I cannot stand for longer than ½ hour without increasing pain.
(4) I cannot stand for longer than 10 minutes without increasing pain.
(5) I avoid standing because pain immediately.

DIGESTION

(0) I have good digestion and do not have to limit foods.
(1) I have good digestion, only if I avoid certain foods.
(2) I need over-the-counter medicine to good digestion.
(3) I take prescription drugs to have good digestion.
(4) I have poor digestion, and nothing helps.

CHANGING DEGREE OF PAIN

(0) My pain is rapidly getting better.
(1) My pain fluctuates but overall is definitely getting better.
(2) My pain seems to be getting better but improvement is slow.
(3) My pain is neither getting better or worse.
(4) My pain is gradually worsening.
(5) My pain is rapidly worsening.

PRIOUX
CHIROPRACTIC
DR. DAVID PRIOUX JR. | DR. LUCIE LOK
7650 ANCHOR DR. PORT ARTHUR, TX
409.729.6003

DIAGNOSTIC RADIOGRAPH (X-RAY) WAIVER FORM

This is to acknowledge that:

The Doctors at Prioux Chiropractic has recommended that x-rays be taken so that a complete study and analysis may be made of my present condition (or subluxation).

I do not feel that my present condition (or subluxation) is serious enough to warrant the use of x-rays, so that a complete study and analysis may be made by the Doctors at Prioux Chiropractic. Therefor, you are hereby authorized and directed to provide Chiropractic Care to my present condition (or subluxation) to the best of your ability without a complete study analysis of said condition (or subluxation).

Should any untoward effects or any further illness or injury develop, directly or indirectly, as a result of such Care provided, I shall assume full responsibility. In consideration of your Chiropractic Care at my request without benefit of a complete study and analysis, I do hereby release you from all cause of action, damages and liabilities arising by reason of said Chiropractic Care, whether here-to-fore or here-after occluding, and whether known or unknown by the parties here-to.

Executed this _____ day of _____ 20_____

Patient's Signature: _____

Patient's Name (printed): _____