PRIOUX CHIROPRACTIC

7650 ANCHOR DRIVE, PORT ARTHUR, TX 77642

PAST PATIENT PAPER WORK

WELCOME BACK!

NAME:_____ **DOB:**_____ **DATE:**_____

IF ANY INFORMATION HAS CHANGED, PLEASE UPDATE BELOW.

-MAILING ADDRESS

_____

_____

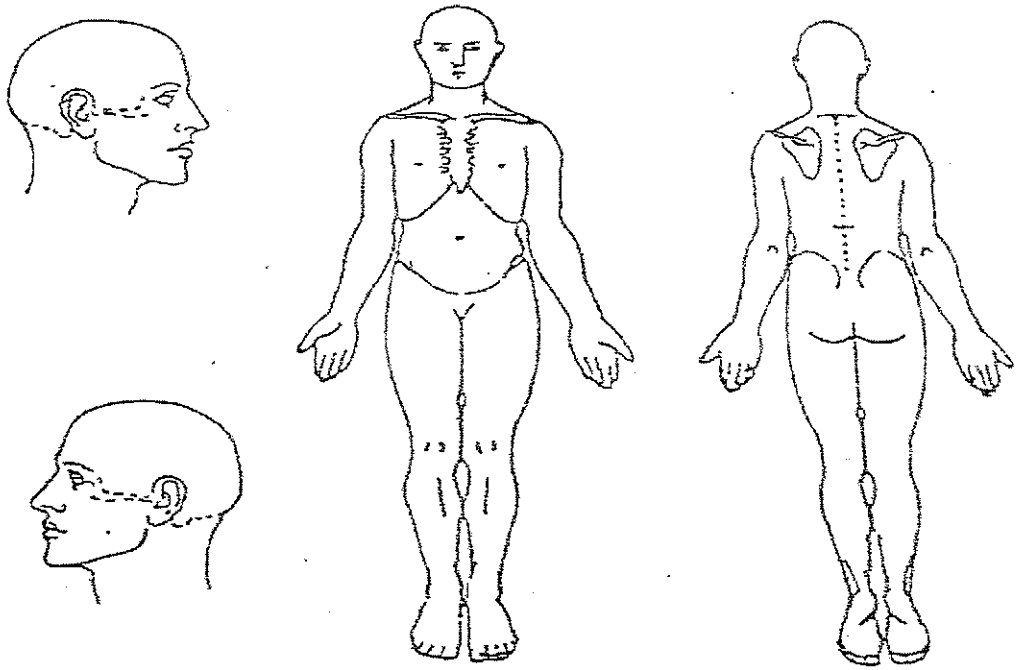
-PHONE NUMBER

( )_____/_____

( )_____/_____

-IF ANY INSURANCE CHANGES HAVE BEEN MADE, PLEASE INFORM THE FRONT DESK.

WHERE IS THE PAIN/PROBLEM LOCATED? Please mark on pictures below



Symptom Survey

List problems from most sever to least sever. Please be as specific as possible.

Problem #1._____

Location of pain:_____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) **Pain is**? Mild Moderate Severe

Progression (circle): same, better, worse. **How often is the pain present?** Constant, 50-75%, 25-50%, less than 25%

When did you notice the problem? _____ **What happened**_____

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____

Worse with (circle): sitting standing walking bending twisting lifting movement other_____

Quality of pain(circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes or No / where?_____

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

Other _____ **did it help**? Yes or No

Problem #2._____

Location of pain:_____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) **Pain is**? Mild Moderate Severe

Progression (circle): same, better, worse. **How often is the pain present?** Constant, 50-75%, 25-50%, less than 25%

When did you notice the problem? _____ **What happened**_____

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____

Worse with (circle): sitting standing walking bending twisting lifting movement other_____

Quality of pain(circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes or No / where?_____

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

Other _____ **did it help**? Yes or No

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: 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 BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

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DIAGNOSTIC RADIOGRAPH (X-RAY) WAIVER FORM

This is to acknowledge that:

The Doctors at Prioux Chiropractic have recommended that X-rays be taken so that a complete study and analysis may be made of my present condition.

I do not feel that my present condition (or subluxation) is serious enough to warrant the use of X-rays. Therefore, you are hereby authorized to provide Chiropractic care for my present condition to the best of your ability without X-rays.

Should any effects, further illness or injury develop, directly or indirectly, as a result of such care provided, I shall assume full responsibility. I do hereby release my treating doctor from all cause of action, damages and liabilities.

Executed this: _____ day of _____ 20_____

Patient's Signature: _____

Patient's Name (printed):_____