SLOAN FAMILY CHIROPRACTIC, P.S.
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Present Health History

*Name:*_____ *Date:*____/____/_____

Current Function/Health

On the line below, please indicate your **current overall health** by placing a mark on the line which bests describes your present **whole body health.** This includes head, trunk, extremities, organs and systems.

Lowest Highest
0%_____ / _____ / _____ / _____100%
Function/Health 25% 50% 75%
Comments:_____
_____
_____

Please indicate **how** your body is not working right- this does not necessarily mean pain, rather, a lowering or change in your health and performance (example: strength, endurance, flexibility, sleep changes, frequency of pain, digestive complaints, leg, arm, neck, back, heart, lung, etc). If more than one complaint is being experienced, please list numerically and define them as:

Constant: 75%- 100% **Intermittent:** 30%-74% **Occasional:** 1%-29%

Parts **Malfunctioning:**

	Constant	Intermittent	Occasional
1._____	□	□	□
2._____	□	□	□
3._____	□	□	□
4._____	□	□	□
5._____	□	□	□
6._____	□	□	□
7._____	□	□	□
8._____	□	□	□

Activities of Daily Living

Please list how this has affected your life style and/or activities- example: cannot do sports, yard work, changes in work, relationships, etc.

_____
_____
_____
_____

Please place a mark on the line below which bests indicates your current activity level

Current Activity Level

0%_____ / _____ / _____ / _____100%
Can not do any activity 25% 50% 75% Can do all activity

Oswestry Disability Index- **NECK pain**

This questionnaire has been designed to give your physician information as to how your neck pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box which most closely describes your current condition.**

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 (Washing, Dressing, etc.)
- □ 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 can 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 extra pain.
- □ I can lift heavy weights but it gives extra pain.
- □ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table.
- □ Pain prevents me from lifting heavy weights 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.

Section 4: Reading
- □ I can read as much as I want to with no pain in my neck.
- □ I can read as much as I want to with slight pain in my neck.
- □ I can read as much as I want with moderate pain in my neck.
- □ I can't read as much as I want because of moderate pain in my neck.
- □ I can hardly read at all because of severe pain in my neck.
- □ I cannot read at all.

Section 5: 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.

Section 6: Concentration
- □ I can concentrate fully when I want to with no difficulty.
- □ I can concentrate fully when I want to with slight difficulty.
- □ I have a fair degree of difficulty in concentrating when I want to.
- □ I have a lot of difficulty in concentrating when I want to.
- □ I have a great deal of difficulty in concentrating when I want to.
- □ I cannot concentrate at all.

Section 7: Work
- □ I can do as much work as I want to.
- □ I can only do my usual work, but no more.
- □ I can do most of my usual work, but no more.
- □ I cannot do my usual work.
- □ I can hardly do any work at all.
- □ I can't do any work at all.

Section 8: Driving
- □ I can drive my car without any neck pain.
- □ I can drive my car as long as I want with slight pain in my neck.
- □ I can drive my car as long as I want with moderate pain in my neck.
- □ I can't drive my car as long as I want because of moderate pain in my neck.
- □ I can hardly drive at all because of severe pain in my neck.
- □ I can't drive my car at all.

Section 9: Sleeping
- □ I have no trouble sleeping.
- □ My sleep is slightly disturbed (less than 1 hr sleepless).
- □ My sleep is mildly disturbed (1-2 hrs sleepless).
- □ My sleep is moderately disturbed (2-3 hrs sleepless).
- □ My sleep is greatly disturbed (3-5 hrs sleepless).
- □ My sleep is completely disturbed (5-7 hrs sleepless).

Section 10: Recreation
- □ I am able to engage in all my recreational activities with no neck pain at all.
- □ I am able to engage in all my recreational activities, with some pain in my neck.
- □ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- □ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- □ I can not do any recreational activities.

*Signature:*_____ *Date:*____/____/_____
*Name:*_____

Oswestry Disability Index- **BACK Pain**

This questionnaire has been designed to give your physician information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box which most closely describes your current condition.**

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 (Washing, Dressing, etc.)
- □ I can look after myself normally without causing increased pain.
- □ I can look after myself normally it increases my 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 my personal care.
- □ I need help every day in most aspects of self-care.
- □ I do not get dressed, wash with difficulty, and stay in bed.

Section 3: Lifting
- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives extra pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

Section 4: Walking
- □ Pain does not prevent me walking any distance.
- □ Pain prevents me walking more than 1 mile.
- □ Pain prevents me walking more than ¼ of a mile.
- □ Pain prevents me walking more than 100 yards.
- □ I can only walk using a stick or crutches.
- □ I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting
- □ I can sit in any chair as long as I like.
- □ I can sit in my favorite chair as long as I like.
- □ Pain prevents me from sitting for more than 1 hour.
- □ Pain prevents me from sitting for more than ½ hour.
- □ Pain prevents me from sitting for more than 10 minutes.
- □ Pain prevents me from sitting at all.

Section 6: Standing
- □ I can stand as long as I want without extra pain.
- □ I can stand as long as I want but it gives me extra pain.
- □ Pain prevents me from standing more than 1 hour.
- □ Pain prevents me from standing for more than ½ an hour.
- □ Pain prevents me from standing for more than 10 minutes.
- □ Pain prevents me from standing at all.

Section 7: Sleeping
- □ My sleep is never disturbed by pain.
- □ My sleep is occasionally disturbed by pain.
- □ Because of pain, I have less than 6 hours sleep.
- □ Because of pain, I have less than 4 hours sleep.
- □ Because of pain, I have less than 2 hours sleep.
- □ Pain prevents me from sleeping at all.

Section 8: Social Life
- □ My social life is normal and causes no extra pain.
- □ My social life is normal but causes some extra pain.
- □ My social life is nearly normal but is very painful.
- □ My social life is severely restricted by pain.
- □ My social life is nearly absent because of pain.
- □ Pain prevents any social life at all.

Section 9: Employment/Homemaking
- □ My normal homemaking/job activities do not cause extra pain.
- □ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- □ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming)
- □ Pain prevents me from doing anything but light duties
- □ Pain prevents me from doing even light duties
- □ Pain prevents me from performing any job or homemaking chores.

Section 10: Traveling
- □ I can travel anywhere without pain.
- □ I can travel anywhere but it gives extra pain.
- □ Pain is bad but I manage journeys of over two hours.
- □ Pain restricts me to short necessary journeys under 30 minutes.
- □ Pain prevents me from traveling except to receive treatment.

*Signature:*_____ *Date:*____/____/_____
*Name:*_____

VISUAL ANALOGUE SCALE

Please make an "X" along the line to show how far from normal toward the worst possible situation your pain problem has taken you.

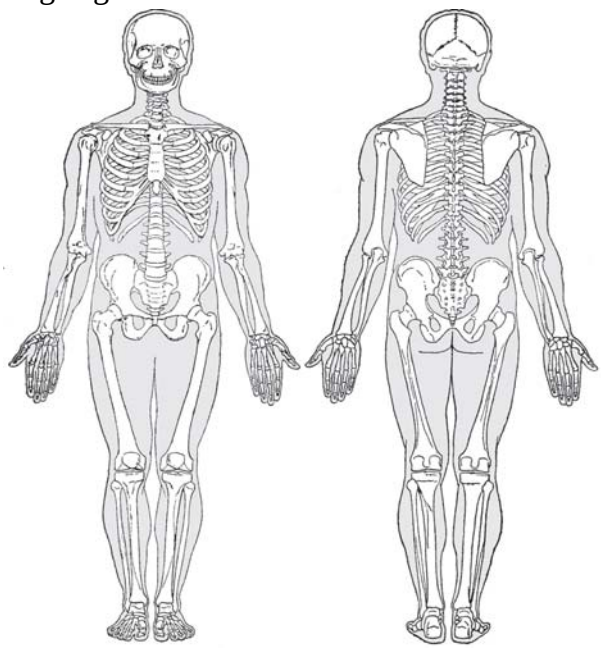
1. How bad is your pain?
   0%_____ / _____ / _____ / _____100%
   No Pain 25% 50% 75% Worst Possible Pain
2. How bad is the pain at night?
   0%_____ / _____ / _____ / _____100%
   No Pain 25% 50% 75% Worst Possible Pain
3. Does the pain interfere with your lifestyle?
   0%_____ / _____ / _____ / _____100%
   No Problem 25% 50% 75%Total Change in Lifestyle
4. How good are pain killers for your pain?
   0%_____ / _____ / _____ / _____100%
   Complete Relief 25% 50% 75% No Relief
5. How stiff is your back?
   0%_____ / _____ / _____ / _____100%
   No Stiffness 25% 50% 75% Worst Possible Stiffness
6. Does your pain interfere with walking?
   0%_____ / _____ / _____ / _____100%
   No Problem 25% 50% 75% Can Not Walk
7. Do you hurt when walking?
   0%_____ / _____ / _____ / _____100%
   No Pain 25% 50% 75% Worst Possible Pain
8. Does your pain keep you from standing still?
   0%_____ / _____ / _____ / _____100%
   Can stand still 25% 50% 75% Can Not Stand at All
9. Does your pain keep you from twisting?
   0%_____ / _____ / _____ / _____100%
   No Problem 25% 50% 75% Can Not Twist
10. Does your pain allow you to sit in an upright hard chair?
    0%_____ / _____ / _____ / _____100%
    Can Sit as long as I like 50% 75% Can Not Sit in a Chair
11. Does your pain allow you to sit in a soft arm chair?
    0%_____ / _____ / _____ / _____100%
    Can Sit as long as I like 50% 75% Can Not Sit in a Chair
12. Do you have back pain when lying in bed?
    0%_____ / _____ / _____ / _____100%
    No Pain 25% 50% 75% No Relief at All
13. How much does your pain limit your normal lifestyle?
    0%_____ / _____ / _____ / _____100%
    No Limit 25% 50% 75% Can Not Do Anything
14. Does your pain interfere with your work?
    0%_____ / _____ / _____ / _____100%
    No Problem 25% 50% 75% Can Not Work at All
15. How much have you had to change your at work place because of back pain?
    0%_____ / _____ / _____ / _____100%
    No Change 25% 50% 75% I Can Not Keep a Job

*Signature:*_____ *Date:*____/____/_____
*Name:*_____

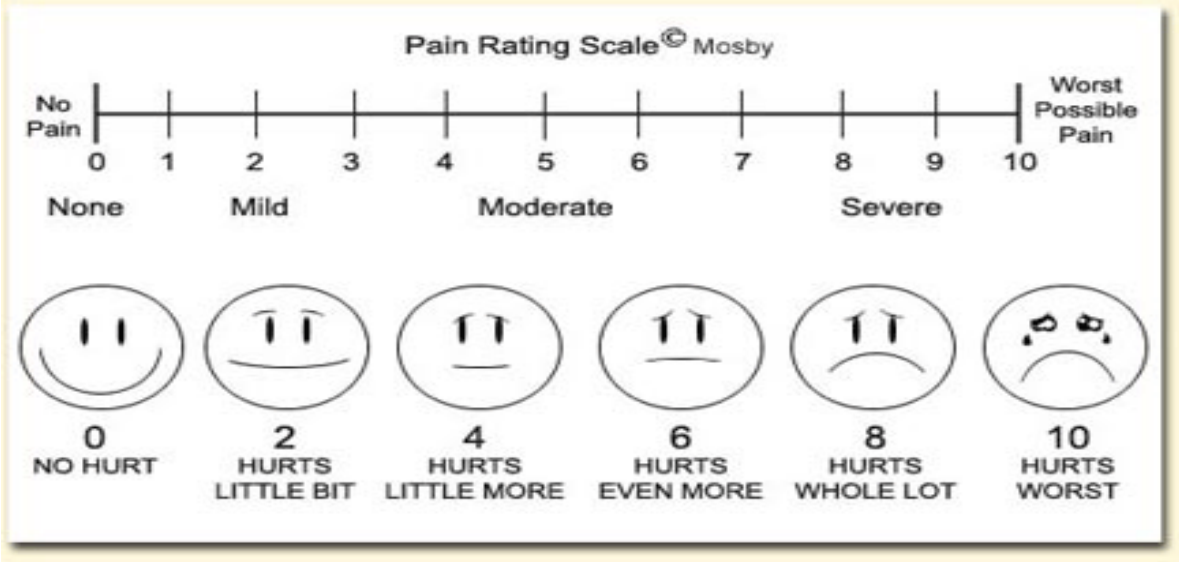
PAIN SCALE

If you are experiencing pain (sharp, dull, burning, stinging) or abnormal feelings (numbness, tingling, stiffness, abnormal sensation), please mark the area on the diagram below and label accordingly.

SP= Sharp Pain	DP= Dull Pain	B= Burning	S= Stinging
N= Numbness	T= Tingling	ST= Stiffness	A= Abnormal Sensation



Pain Scale: Please circle the number below that best describes your current pain and draw a line (or number that region) to the diagram above.



Patient's Signature_____ Date___/___/___
Print Name_____