Backstrom Chiropractic Clinic
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Glen Ellyn · IL 60137
Phone 630·790·2440 · Fax 630·790·4202

Confidential Patient Health Records

PATIENT INFORMATION **Patient #: _____ Date: _____**

Name: _____ Name of Spouse: _____

Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____ Age: _____

Sex: ____ Female ____ Male Race: Caucasian ___ Hispanic ___ Other: _____

Last 4 digits of your Social Security #: ___ ___ ___ ___ (required for Electronic Health Record creation and patient access)

Family Status: ___Single ___Married ___Divorced ___Widowed # of children ____

Referred to this office by: _____

E-mail: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

Please provide your cell phone carrier to receive appointment reminders by text

EMPLOYMENT INFORMATION

Employment Status: ___ Employed ___ Part-time Student ___ Full-Time Student Other_____

Occupation: _____ Employed by: _____

INSURANCE INFORMATION

Primary Health Insurance Carrier: _____ ID#: _____ Group #_____

Insured's Name: _____ Insured's Date of Birth: _____

Secondary Health Insurance Carrier: _____ ID#:_____ Group #_____

Insured's Name: _____ Insured's Date of Birth: _____

Who is responsible for your bill? ___ Self-Pay ___ Spouse ____ Parent (Guardian)

___ Auto Insurance ___Worker's Comp

___ This is **NOT** a Work-Related or Worker's Compensation injury

___ This is **NOT** an Auto Accident related injury

___ This is **NOT** a Personal Injury case currently under litigation

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Patient Name: _____ Patient #: _____ Date: _____

INITIAL EVALUATION
CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

Chief Complaint
My present symptoms are (list in order of importance):
Location: _____ Symptom: _____
Location: _____ Symptom: _____
Location: _____ Symptom: _____
Location: _____ Symptom: _____

Associated Symptoms
Are there any other conditions or symptoms that may be related to your major complaint?
❑No ❑Yes If yes, please explain _____
Are there any other unrelated health problems or symptoms?
❑No ❑Yes If yes, please explain _____

Quality
Pain Quality
Pain Characterized As (check all that apply):
❑none ❑aching ❑burning ❑constant ❑cramping ❑deep ❑Discomfort vague ❑dull
❑heavy ❑intermittent ❑localized ❑mild ❑moderate ❑non-radiating ❑painful to touch
❑persistent ❑piercing ❑radiating ❑severe ❑sharp ❑shooting ❑stabbing ❑throbbing
❑well localized pain ❑other _____
Does the pain travel or radiate? ❑Into arm R or L ❑Into leg R or L ❑Other _____
Pain Scale:
Rate the level of your pain/symptoms from 0, no pain/no symptoms, to 10, unbearable pain/symptoms:
Circle one: 0 1 2 3 4 5 6 7 8 9 10

Severity
How frequent is this condition? Severity is… (check all that apply):
❑acute ❑chronic ❑diminished ❑diminishing ❑improved ❑improving ❑increased ❑increasing
❑infrequent ❑irregular ❑occasional ❑persistent ❑progressing ❑recurrent ❑seasonal
❑other _____
Condition interferes:
❑with Appetite/Eating ❑ Household Activities ❑Normal Lifestyle ❑Routine Daily Activities ❑School
❑Sleeping ❑Work ❑other _____

Duration
Date the symptom(s) first appeared: _____
Are your symptoms a result of an injury or accident? ❑Yes ❑No
Date of the accident/injury, if applicable: _____
How long have your current symptoms been present? _____

Timing

Pain Timing (check all that apply):

My pain started: ❑After an accident ❑after a minor injury ❑physical activities ❑sitting ❑twisting ❑other: _____

My pain is worse with or when (check all that apply):

❑bending or stooping ❑coughing ❑driving ❑joint use ❑lifting ❑movement ❑on extremes of motion ❑on feet ❑physical activity ❑pressure any type ❑respiration ❑resting ❑with shoes ❑without shoes ❑sitting ❑sneeze ❑standing ❑straining ❑twisting ❑walking ❑walking up stairs ❑weight bearing

Other: _____

My pain improves with (check all that apply):

❑bending or stooping ❑getting off feet ❑heat ❑ice ❑manipulation of joint ❑manipulation of spine ❑massage ❑movement ❑OTC medications ❑standing ❑support brace ❑walking ❑physical activity ❑pressure ❑rest ❑with shoes ❑without shoes ❑sitting ❑soaking

Other: _____

My pain is worse (check all that apply):

❑at end of day ❑at night ❑in morning ❑later in the day ❑various times ❑other: _____

Symptoms Onset(check all that apply):

❑Abrupt ❑Gradual Onset ❑Recent Onset ❑Sudden Onset

Context

Mechanism of injury (check all that apply):

❑Blow ❑Fall or Slip ❑Near Fall ❑Lifting ❑Twisting

Other: _____

What activity were you doing when your symptoms began? _____

Where were you when your symptoms began? _____

Modifying Factors:

General:

❑None ❑Difficulty recovering

Previous Treatment:

❑No previous treatment ❑Previously Treated ❑Treated by another chiropractor ❑Treated by another physician

PAIN DRAWING

Name: _____ Date: _____

Date symptoms began and/or date of injury: _____

1. Please mark **area(s)** of injury or discomfort using the following symbols:

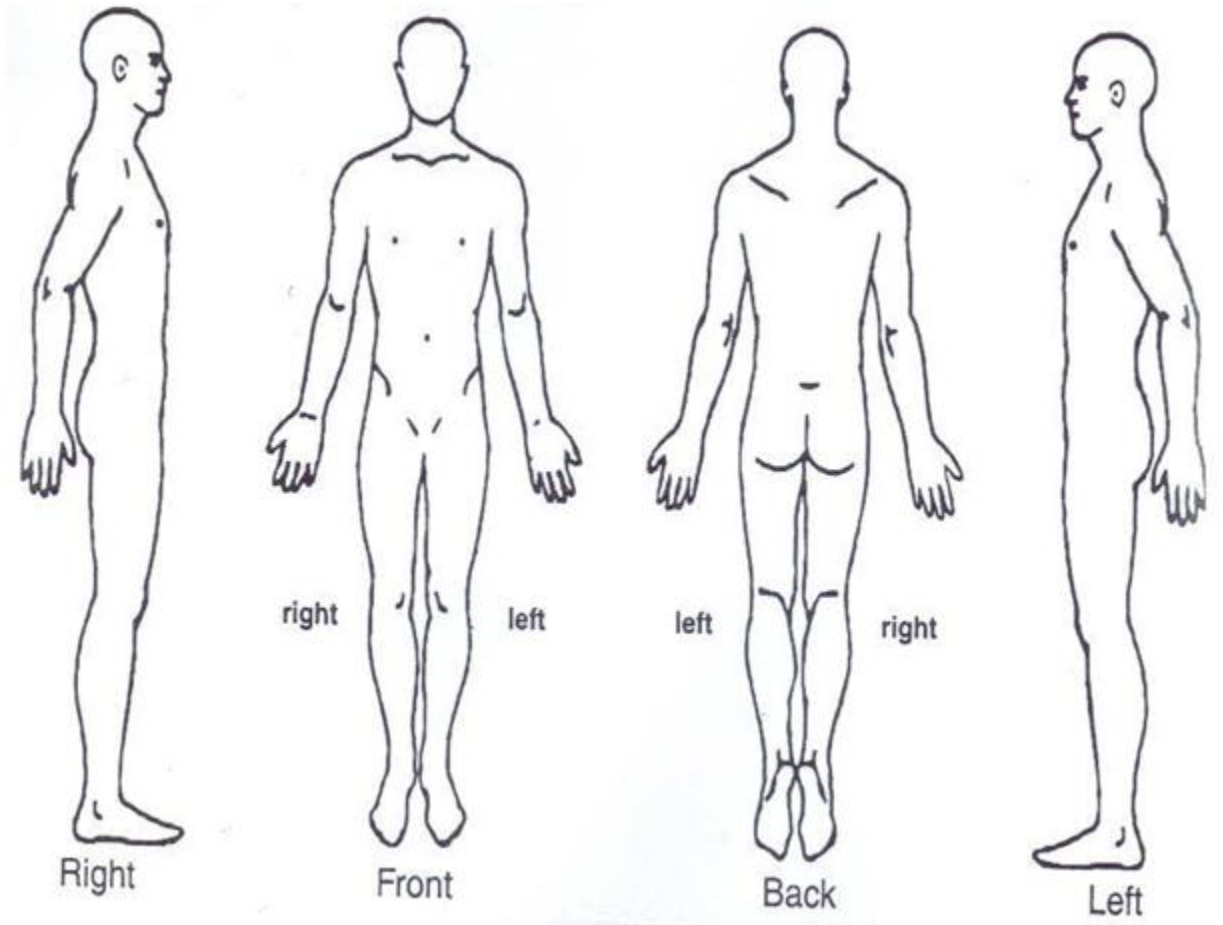
Type of pain:

Ache	Dull	Stiffness	Sharp	Stabbing	Shooting	Swelling	Cramping
A	D	S	SH	ST	SS	SW	C

Burning	Throbbing	Numbness	Tingling	Other _____
B	TH	N	T	

2. Indicate all scars from surgery or injury using the following symbol: ‡

3. Circle any area of pain not represented by a symbol.



On a scale of 0-10, please circle the level that most accurately represents your pain.
0 = No pain 10 = Unbearable Pain

Right Now	0	1	2	3	4	5	6	7	8	9	10
Average Pain	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10

Patient Name: _____ Patient #: _____ Date: _____

PAST HEALTH HISTORY

Past Medical History/Illnesses

____ NONE	____ CRPS (RSD)	____ Heart Disease	____ Pacemaker
____ Anemia	____ Depression	____ Hepatitis	____ Psychiatric Problems
____ Arthritis	____ Diabetes (insulin dep.)	____ Hypertension	____ Seizures
____ Asthma	____ Diabetes (noninsulin)	____ Kidney Disease	____ STD's
____ Cancer	____ Eye Problems	____ Liver Disease	____ Stroke (CVA)
____ Chicken Pox	____ Heart Attack	____ Lung Disease	____ Thyroid Problems

Other: _____

Past Surgeries

____ NONE	____ Cardiac Catheterization	____ Gall Bladder	____ Laminectomy
____ Angioplasty	____ Carpal Tunnel Repair	____ Hernia Repair	____ Pacemaker Insertion
____ Appendectomy	____ Coronary Bypass	____ Hysterectomy	____ Spinal Infusion
____ Caesarean Section	____ Cosmetic	____ Joint Replacement	

Other _____

Past Treatments

Description:	Date(s):	Description:	Date(s):
____ Chemotherapy	_____	____ Physical Therapy	_____
____ Chiropractic	_____	____ Psychiatric	_____
____ Non-surgical treatment	_____	____ Other	_____

Other: _____

Immunizations

All patients (65 years and older): Have you ever received a pneumonia vaccination? Y N

Auto Accident

My symptoms are a result of an auto accident: ____ No ____ Yes

OB/GYN History

Women (40-69 years): Date of last mammogram: _____

Are you pregnant? ____ No ____ Yes Due Date _____

Smoking Status

____ Never

____ Smoker ____ Lives with smoker Since age: ____

Current every day: ____ Current some day: ____

Former Smoker: ____ Date Quit: _____

____ Cigarettes ____ Cigar ____ Pipe ____ Chews ____ Dips

PRESCRIPTION MEDICATIONS

Current Medications	Dosage in mg.	Times per day
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Allergies Please indicate any allergies you have to any Medications (Prescription Drugs):

Medication:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Medical Symptoms Questionnaire

Patient Name: _____ Patient #: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point scale
0 – *Never or almost never* have the symptoms
1 – *Occasionally* have it, effect is *not severe*
2 – *Occasionally* have it, effect is *severe*
3 – *Frequently* have it, effect is *not severe*
4 – *Frequently* have it, effect is *severe*

Head
_____Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ **Total**

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened, or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(does not include near- or far-sightedness)
_____ **Total**

Ears
_____ Itchy Ears
_____ Earaches, ear infection
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ **Total**

Nose
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ **Total**

Mouth/ Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores
_____ **Total**

Skin
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ **Total**

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ **Total**

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ **Total**

Digestive Tract
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ **Total**

Joints/Muscle
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ **Total**

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ **Total**

Energy/Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ **Total**

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ **Total**

Emotions
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ **Total**

Other
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ **Total**

_____ **GRAND TOTAL**

Patient Name:_____ Patient #:_____Date:_____

Revised Oswestry Back Pain Disability Questionnaire

This questionnaire was designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by **circling the corresponding number** for the description that most applies to you. You may feel that more than one statement may relate to you, but **please, just circle one choice which most closely describes your problem right now.**

PAIN INTENSITY

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is severe.
5 The pain is severe and does not vary much.

PERSONAL CARE

0 I would not have to change my way of washing or dressing in order to avoid pain.
1 I would not normally change my way of washing or dressing even though it causes pain.
2 Washing and dressing increases the pain, but I manage not to change my way of doing it.
3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4 Because of the pain, I am unable to do some washing and dressing without help.
5 Because of the pain, I am unable to do any washing or dressing without help.

LIFTING

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights, but it causes extra pain.
2 Pain prevents me from lifting heavy weights off the floor
3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned, e.g., on a table.
4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift very light weights, at the most.

WALKING

0 Pain does not prevent me from walking any distance.
1 Pain prevents me from walking more than one mile.
2 Pain prevents me from walking more than ½ mile.
3 Pain prevents me from walking more than ¼ mile.
4 I can only walk while using a cane or on crutches.
5 I am in bed most of the time and have to crawl to the toilet.

SITTING

0 I can sit in any chair as long as I like without pain.
1 I can only sit in my favorite chair as long as I like.
2 Pain prevents me from sitting more than one hour.
3 Pain prevents me from sitting more than ½ hour.
4 Pain prevents me from sitting more than 10 minutes.
5 Pain prevents me from sitting at all.

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 one 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 it increases the pain straight away.

SLEEPING

0 I get no pain in bed.
1 I get pain in bed, but it does not prevent me from sleeping well.
2 Because of pain, my normal night's sleep is reduced by less than one-quarter.
3 Because of the pain, my normal night's sleep is reduced by less than one-half.
4 Because of the pain, my normal night's sleep is reduced by less than three-quarters.
5 Pain prevents me from sleeping at all.

SOCIAL LIFE

0 My social life is normal and gives me no pain.
1 My social life is normal, but increases the degree of my pain.
2 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3 Pain has restricted my social life and I do not go out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of the pain.

TRAVELING

0 I get no pain while traveling.
1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
2 I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3 I get extra pain from traveling which compels me to seek a alternative forms of travel.
4 Pain restricts all forms of travel.
5 Pain prevents all forms of travel except that done lying down.

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 at present.
3 My pain is neither better or worse.
4 My pain is gradually worsening
5 My pain is rapidly worsening.

Patient Name: _____Patient #: _____ Date: _____

Vernon-Mior Neck Pain Disability Questionnaire

This questionnaire was designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by **circling the corresponding number** for the description that most applies to you. You may feel that more than one statement may relate to you, but **please, just circle one choice which most closely describes your problem right now.**

PAIN INTENSITY

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

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 manage most of my personal care.
4 I need help every day in most aspects of self care.
5 I do not get dressed, I wash with difficulty and stay in bed.

LIFTING

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

READING

0 I can read as much as I want to with no pain in my neck.
1 I can read as much as I want to with slight pain in my neck.
2 I can read as much as I want to moderate pain in my neck.
3 I cannot read as much as I want because of moderate pain in my neck.
4 I cannot read as much as I want because of severe pain in my neck.
5 I cannot read at all.

HEADACHES

0 I have no headaches at all.
1 I have slight headaches that come infrequently.
2 I have moderate headaches that come infrequently.
3 I have moderate headaches that come frequently.
4 I have severe headaches that come frequently.
5 I have headaches almost all of the time.

CONCENTRATION

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

DRIVING

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

SLEEPING

0 I have no trouble sleeping.
1 My sleep is slightly disturbed (less than 1 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).

RECREATION

0 I am able to engage in all of my recreation activities, with no neck pain at all.
1 I am able to engage in all of my recreational activities, with some pain in my neck.
2 I am able to engage in most, but not all of my usual recreational activities because of my neck pain.
3 I am able to engage in a few of my usual recreational activities because of my neck pain.
4 I can hardly do any recreational activities because of pain in my neck.
5 I cannot do any recreational activities at all.