

Backstrom Chiropractic Clinic
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Confidential Patient Health Records / Re-Evaluation

In accordance with the compliance regulations, it is necessary to update your patient information every 90 days. Please complete the following with as much detail as possible. Thank you.

Date: _____

Please complete the following so we can make sure our records are up-to-date:

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____

Family Status: Single ___ Married ___ Divorced ___ Widowed ___

Last 4 digits of your Social Security #: _____ (for Electronic Health records)

E-mail: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

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

Patient Name: _____ Patient #: _____ Date: _____
Incident: _____ [office use only]

RE-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

General

Condition Overall Status: constant decreasing increasing increases with exertion
 intermittent no change rapidly changing slowly changing new symptoms intermittent
 localized mild moderate non-radiating painful to touch

Improvement: none improving improved then deterioration not adequate

Symptom Quality

Symptoms 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/Symptom 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...

acute chronic diminished diminishing improved improving increased increasing
 infrequent irregular w/movement never occasional persistent progressing
 recurrent regular seasonal stable gradually progressing
 sub-acute

Condition interferes:

with Appetite/Eating Household Activities Normal Lifestyle Routine Daily Activities School
 Sleeping Work

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/Symptom Timing

My pain/symptoms started: After an accident after a minor injury physical activities sitting
twisting

other: _____

Exacerbated by:

My pain/symptom is worse with or when: 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: _____

Improves:

My pain/symptom improves with: 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: _____

Worse:

My pain is worse: at end of day at night in morning later in the day various times
other: _____

Symptoms Onset:

Descriptors: Abrupt Gradual Onset Recent Onset Sudden Onset

Context

Mechanism of injury:

Blow Fall or Slip 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:

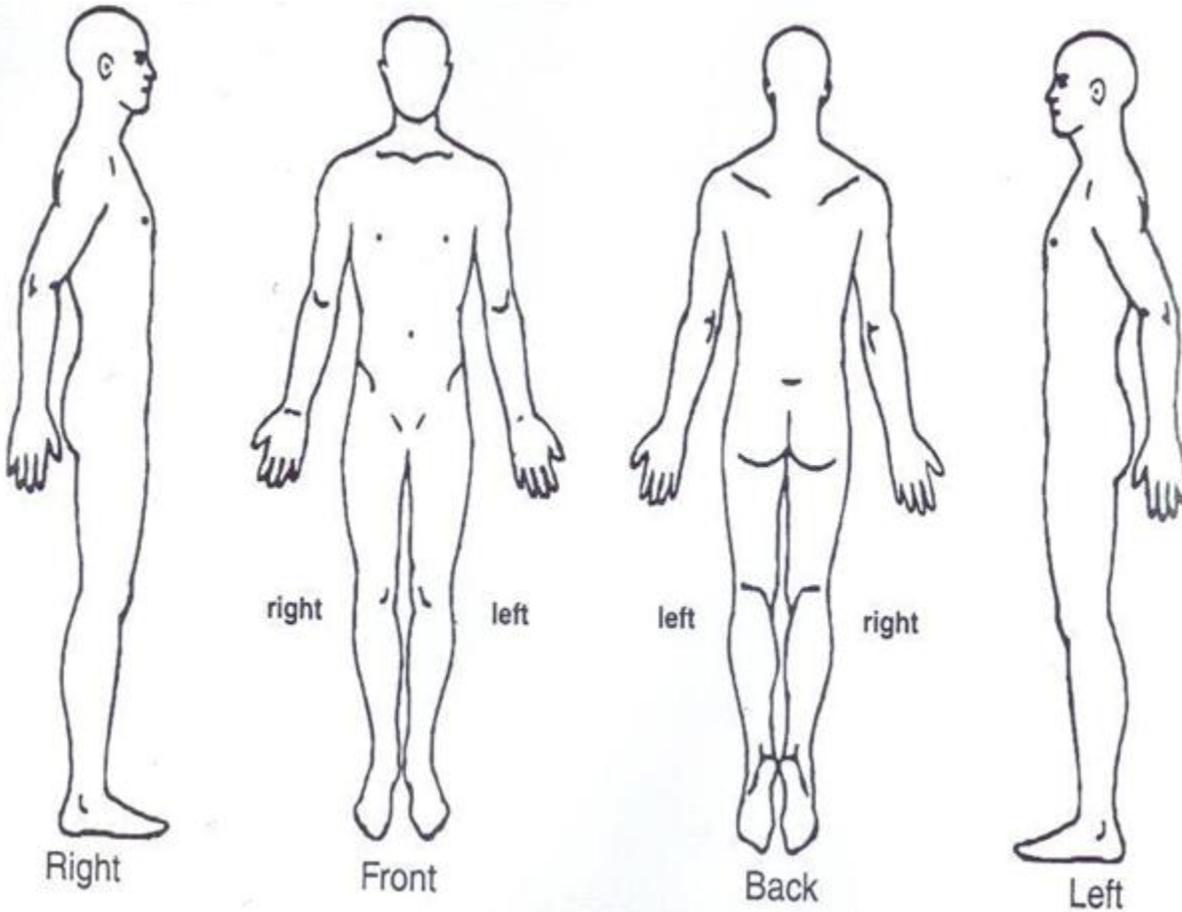
Type of pain:

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: _____

Medical History/Illnesses (Since your last visit)

- | | | | |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> CRPS (RSD) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes (insulin dep.) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes (noninsulin) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Problems |

Other: _____

Surgeries/Indicate Type and Date of Surgery (Since your last visit)

Treatments (Since your last visit)

- | | | | |
|---|----------|---|----------|
| Description: | Date(s): | Description: | Date(s): |
| <input type="checkbox"/> Chemotherapy | _____ | <input type="checkbox"/> Physical Therapy | _____ |
| <input type="checkbox"/> Chiropractic | _____ | <input type="checkbox"/> Psychiatric | _____ |
| <input type="checkbox"/> Non-surgical treatment | _____ | <input type="checkbox"/> Other | _____ |

Immunizations (Since your last visit)

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

Injuries/Accidents (Since your last visit)

Description: _____ Date: _____

OB/GYN History (Since your last visit)

Women (40-69 years): Date of last mammogram: _____
Are you pregnant? No Yes Due Date _____

Smoking Status Check here if same as previous _____

- Never
 Smoker Lives with smoker Since age: _____
Current every day: _____ Current some day: _____
Former Smoker: _____ Date Quit: _____
 Cigarettes Cigar Pipe Chews Dips

PRESCRIPTION MEDICATIONS Check here if same as previous _____

<u>Current Medications</u>	<u>Dosage in mg.</u>	<u>Times per day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Check here if same as previous _____

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
 _____ Bloating 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 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 nor 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 cannot 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.