WELCOME to Wickiser Physical Medicine

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone # (H)_____ (W)_____ (C) _____

Your preferred type of communication: (circle one) Phone/ Mail/ Email

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. : _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Patient History

Name:_____ **DOB:**_____ **Date:**_____

1. When did your symptoms start? _____

Describe your symptoms and how they started: _____

_____

2. How do your symptoms affect your ability to perform daily activities?
(1-being no affect/ 10 - being severe) : circle one - 1 2 3 4 5 6 7 8 9 10

3. What activities make your symptoms worse? _____

4.What activities make your symptoms better? _____

5. What describes the nature of your symptoms? Sharp Shooting Dull Ache Numb Tingling Burning
Other _____

6. Who have you seen for your symptoms: No One Medical Doctor Other Chiropractor
Physical Therapist Other _____

A. When and what treatment? _____

B. What tests have you had for your symptoms and when were they performed?
X-rays Date:_____ CT Scan Date:_____ MRI Date:_____
Other Date: _____

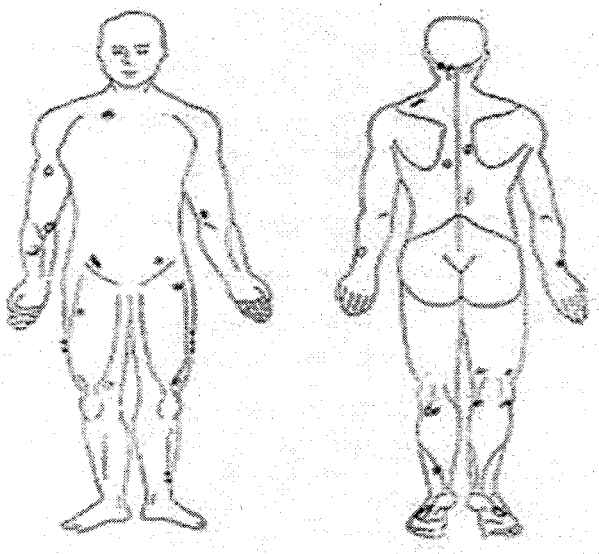
7. How often do you experience your symptoms?(Circle One)

Constantly (76-100% of the day)
Frequently (51-75% of the day)
Occasionally (26-50% of the day)
Intermittently (0-25% of the day)

8. How are your symptoms changing?

Getting Better
Not Changing
Getting Worse

9. Circle where your pain/symptoms is on the figures below:



10. How bad are your symptoms at their:
Worse: 0 1 2 3 4 5 6 7 8 9 10
Best: 0 1 2 3 4 5 6 7 8 9 10

Patient History

List any medications you are currently taking: (dosage and how often)

- _____
- _____
- _____
- _____

List any allergies you have: (Reaction and onset date)

- _____
- _____
- _____
- _____

History of Present Injury/Illness: (Check the ones that apply to you)

__Headaches
__Loss of Memory
__Hands Cold
__Numbness Arms/Hands
__Cold Sweats
__Irritability
__Loss of Strength – Arms
__Dizziness
__Clumsiness
__Sleeping Problems
__Buzzing in Ears
__Tension
__Loss of Smell
__Burning Muscle Pain
__Light Bothers Eyes
__Feet Cold
__Tingling in Legs/Feet
__Constipation
__Shortness of Breath
__Chest Pain/Rib Pain
__Loss of Strength/Legs
__Diarrhea
__Neck Stiff
__Face Flushed
__Nervousness
__Fainting
__Pain in Arms/Hands
__Difficulty Swallowing
__Head Seems to Heavy
__Tingling Arms/Hands
__Nausea
__Numbness Legs/Feet
__Fever
__Pain in Legs/Feet
__Sharp/Shooting Pain
__Neck Pain
__Ears Ring
__Back Pain/Stiffness
__Loss of Balance
__Fatigue
__Jaw Pain
__Pins/Needles in Arms
__Blurred Vision
__Sudden Weight Loss
__Depression
__Leg/Knee Pain
__Stomach Problems
__Night Pain
__Changes to Eye Sight
__Changes to Hearing
__Changes of Smell
__Change of Taste
__Bladder Change
__Bowel Change
__Changes in Sleep
__Changes in Emotion
__Change in Appetite

Have you missed work or school as a result of your injuries?_____

Do you smoke?_____ **Number of Packs:**_____

Do you drink alcohol?_____ **Number of drinks:**_____

Medical History: (Check the ones that apply to you)

__Heart Disease
__Tuberculosis
__Prostate Disorder
__Cancer
__Kidney Problems
__Stroke
__Asthma
__High Blood Pressure
__Ulcers
__Thyroid Problems
__Seizure Disorder
__High Cholesterol
__Pace Maker
__Pinched Nerve
__Herniated Disc
__Migraines
__Arthritis
__Liver Disease
__Kidney Disease
__Osteoporosis
__Bleeding Disorder
__Rheumatoid Arthritis
__Fibromyalgia

_____ **I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____

Date: _____

Reviewed By:_____

Date:_____

Neck Disability Index

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR **NECK PAIN** AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU.
ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ❑ I have no neck 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

- ❑ I can look after myself normally without causing extra neck pain.
- ❑ I can look after myself normally, but it causes extra neck 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 self -care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra neck pain.
- ❑ I can lift heavy weights, but it gives me extra neck pain.
- ❑ Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – READING

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 5 – HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't 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 neck pain.
- ❑ I can drive my car with only slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

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 neck pain.
- ❑ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ❑ I am able to engage in a few of my recreational activities because of neck pain.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50]

The Primary Care Low Back Disability Questionnaire (PCLBDQ)

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) _____/_____/_____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Instructions: This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please circle the choice which most closely describes your problem.

SECTION 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is very severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

A. I can lift heavy weight without pain
B. I can lift heavy weight, but it gives me pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned- e.g., on a table
E. Pain prevents me from lifting heavy weights, but can manage light-medium weights if they are conveniently positioned.

SECTION 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1 hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain on standing but it doesn't increase with pain.
C. I cannot stand for longer than 1 hour without increasing pain
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed but it doesn't prevent me from sleeping well.
C. Because of my pain, my normal night's sleep is reduced by < ¼
D. Because of my pain, my normal night's sleep is reduced by < ½
E. Because of my pain, my normal night's sleep is reduced by < ¾
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted by social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling, which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain restricts all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Office Use Only PCLBDQ Score:_____

I understand that information I have provided is current and correct to the best of my knowledge.

Signature _____ Date_____

The Roland Morris Low Back Pain and Disability Questionnaire

Patient Name: _____ **Date:** _____

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

☐ I stay at home most of the time because of my back.

☐ I change position frequently to try to get my back comfortable.

☐ I walk more slowly than usual because of my back.

☐ Because of my back, I am not doing any jobs that I usually do around the house.

☐ Because of my back, I use a handrail to get upstairs

☐ Because of my back, I lie down to rest more often.

☐ Because of my back, I must hold on to something to get out of an easy chair.

☐ Because of my back, I try to get other people to do things for me.

☐ I get dressed more slowly than usual because of my back

☐ I only stand up for short periods of time because of my back

☐ Because of my back, I try not to bend or kneel.

☐ I find it difficult to get out of a chair because of my back.

☐ My back pain is painful almost all the time.

☐ I find it difficult to turn over in bed because of my back.

☐ My appetite is not very good because of my back

☐ I have trouble putting on my sock (or stockings) because of the pain in my back.

☐ I can only walk short distances because of the pain in my back.

☐ I sleep less well because of my back.

☐ Because of my back pain, I get dressed with the help of someone else.

☐ I sit down for most of the day because of my back.

☐ I avoid heavy jobs around the house because of my back.

☐ Because of back pain, I am more irritable and bad tempered with people than usual.

☐ Because of my back, I go upstairs more slowly than usual.

☐ I stay in bed most of the time because of my back.

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? NO YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Comment: _____
10. Do you suffer from cold hands or feet? NO YES
    Comment: _____
11. Do have frequent falls or find that you trip over your feet while walking? NO YES
    Comment: _____
12. Do you suffer from frequent headaches? If yes, how often? NO YES
    _____
13. Have you ever been diagnosed by any physician with having peripheral neuropathy? NO YES
    If yes, when and what treatment has been tried?
    _____
14. Have you tried any medications for your pain such as anti-inflammatory? NO YES
    If yes, what kind of medication (Aleve, Motrin, Tylenol, steroids, flexeril)?
    _____
15. Have you tried any Physical Therapy or Chiropractic treatments before? NO YES
    If yes: When? For how long? What kind?
    _____
16. Have you had an MRI? NO YES
    If yes: When? Who ordered it? What was it ordered for?
    _____
17. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who ordered it?
    _____