FISK CHIROPRACTIC
ESTABLISHED 2019 & SPORTS CARE

NEW PATIENT INTAKE QUESTIONNAIRE

Please complete this form as thoroughly as possible. Your answers help us understand your concerns, health history, function, and goals for care.

1 PATIENT INFORMATION

Legal Name: _____ **DOB:** _____
Preferred Name: _____ **Date:** _____
Address: _____ **City/State/ZIP:** _____
Phone: _____ **Email:** _____
Emergency Contact: _____ **Phone:** _____

Primary Care Provider / Clinic: _____ **Phone:** _____

How did you hear about us? ■ Family/Friend ■ Google/Web ■ Social Media ■ Community/Event ■ Other: _____

2 REASON FOR TODAY'S VISIT

Primary concern: _____

Region/location: _____ **Side:** ■ Right ■ Left ■ Both ■ Midline ■ N/A

When did it begin? _____ **Specific injury/event?** ■ Yes ■ No **If yes:** _____

Onset: ■ Sudden ■ Gradual ■ Unsure **Since onset:** ■ Improving ■ Worsening ■ Same ■ Varies

Have you had this problem before? ■ No ■ Yes - when? _____

Does it travel/radiate? ■ No ■ Yes - where? _____

Frequency: ■ Constant ■ Frequent ■ Occasional ■ Intermittent

Description: ■ Aching ■ Sharp ■ Burning ■ Tight/Stiff ■ Throbbing ■ Numbness/Tingling ■ Weakness ■ Other: _____

Current symptom intensity (0 = none, 10 = worst imaginable): 0 1 2 3 4 5 6 7 8 9 10

Worst intensity in past 7 days: 0 1 2 3 4 5 6 7 8 9 10

Worse with: _____

Better with: _____

3 SYMPTOM LOCATION

3 SYMPTOM LOCATION

A full-size four-view anatomical body diagram is provided on the next page.

PLEASE COMPLETE THE BODY DIAGRAM

Mark pain, numbness/tingling, stiffness, radiating symptoms, weakness, or other concerns.

The larger diagram gives you room to identify the exact location and pattern of your symptoms.

4 FUNCTION & GOALS

Activities affected: ■ Sitting ■ Standing ■ Walking ■ Bending ■ Lifting ■ Sleeping ■ Work ■ Exercise/Sports ■ Other: _____

What would you like to be able to do that you currently cannot do comfortably?

_____

Main goal: ■ Reduce symptoms ■ Improve movement ■ Return to work ■ Return to exercise/sport ■ Maintain function ■ Other: _____

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BODY DIAGRAM - MARK YOUR SYMPTOMS

Mark every area where you are experiencing symptoms. Use the key below or add your own notes.

Patient Name: _____ DOB: _____

SYMPTOM KEY

X	Pain
///	Numbness / Tingling
O	Stiffness / Tightness
->	Radiating / Traveling
^	Weakness
*****	Other

FRONT (ANTERIOR)



BACK (POSTERIOR)



LEFT LATERAL



RIGHT LATERAL



Describe your symptoms, including where they begin, where they travel, and what they feel like:

5 CURRENT SYMPTOMS & SCREENING

Check any that apply currently or recently in connection with this concern.

- ■ Numbness/tingling
- ■ Balance difficulty
- ■ Headaches
- ■ Difficulty speaking/swallowing
- ■ Unexplained weight loss
- ■ Pain waking you at night
- ■ Bowel/bladder changes
- ■ Chest pain/shortness of breath
- ■ Muscle weakness
- ■ Dizziness/fainting
- ■ Vision changes
- ■ Fever/chills
- ■ Night sweats
- ■ Recent significant trauma
- ■ Groin/saddle numbness
- ■ None of the above

Explain checked items: _____

6 PERSONAL HEALTH HISTORY

- ■ High blood pressure
- ■ Stroke/TIA
- ■ Cancer
- ■ Arthritis
- ■ Seizure disorder
- ■ Kidney disease
- ■ Fracture/dislocation
- ■ None
- ■ Heart disease
- ■ Diabetes
- ■ Osteoporosis/osteopenia
- ■ Autoimmune disease
- ■ Blood/clotting disorder
- ■ Lung disease
- ■ Significant head injury
- ■ Other: _____

Current medications and supplements: _____

_____

_____

Blood thinner / anticoagulant? ■ No ■ Yes - name: _____

Medication or other allergies: _____

Previous surgeries / hospitalizations (include approximate dates):

_____

_____

Major injuries, fractures, motor vehicle accidents, or work injuries:

_____

_____

Pregnant or possibility of pregnancy? ■ Yes ■ No ■ N/A **Tobacco/nicotine:** ■ No ■ Current ■ Former

7 FAMILY HEALTH HISTORY

Check each family member known to have had the condition.

Condition	Mother	Father	Sibling(s)	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Heart disease / heart attack	■	■	■	■	■	■	■
High blood pressure	■	■	■	■	■	■	■
Stroke / TIA	■	■	■	■	■	■	■
Diabetes	■	■	■	■	■	■	■
Cancer	■	■	■	■	■	■	■
Osteoporosis / osteopenia	■	■	■	■	■	■	■
Arthritis	■	■	■	■	■	■	■
Autoimmune disease	■	■	■	■	■	■	■
Neurological disorder	■	■	■	■	■	■	■
Seizure disorder	■	■	■	■	■	■	■
Blood / clotting disorder	■	■	■	■	■	■	■
Other significant condition	■	■	■	■	■	■	■

Overall family history: ■ Known/completed above ■ Not sure/Unknown

Other family history/details: _____

8 PREVIOUS CARE & TESTING

Care for this problem? ■ No ■ Yes: ■ Chiropractic ■ PT ■ Medical ■ Massage ■ Injection ■ Surgery ■ Other: _____

Imaging/testing? ■ No ■ X-ray ■ MRI ■ CT ■ Ultrasound ■ EMG/NCS ■ Other: _____

Approximate date/location: _____

Results discussed with you? ■ No ■ Yes **What were you told?** _____

_____

_____

Previous chiropractic care? ■ Never ■ Within last year ■ More than one year ago ■ Currently elsewhere

9 RECORDS & CARE COORDINATION

If clinically relevant, may our office request pertinent records or imaging from another provider? ■ Yes ■ No

This records your preference only. A separate authorization/release may be required before records are requested or disclosed.

Provider/facility with relevant records: _____

10 LIFESTYLE, WORK & ACTIVITY

Occupation: _____ **Work demands:** ■ Sitting ■ Standing ■ Physical/manual ■ Mixed

Do symptoms affect work? ■ No ■ Yes - explain: _____

Exercise / recreational activities: _____

Physically active: ■ 0 days/wk ■ 1-2 ■ 3-4 ■ 5+ **Sleep:** ■ <5 hrs ■ 5-6 ■ 7-8 ■ 9+ **Sleep affected?** ■ No ■ Yes

Important work, lifestyle, training, or daily-routine information:

_____

_____

11 YOUR EXPECTATIONS

What would a successful outcome from care look like to you?

_____

_____

_____

_____

Specific event, competition, trip, work requirement, or deadline? ■ No ■ Yes **Date:** _____

If yes, describe: _____

Anything else you would like the doctor to know before your examination?

_____

_____

_____

_____

12 PATIENT ACKNOWLEDGMENT

I certify that the information provided on this questionnaire is complete and accurate to the best of my knowledge. I understand that this questionnaire assists with my history and examination and does not replace discussion with the provider. I agree to inform the office of significant changes to my health history, medications, or symptoms.

Patient/Guardian Signature: _____ Date: _____

If signed by guardian, printed name and relationship: _____

FOR OFFICE USE

Primary complaint/region: _____

Intake reviewed by: _____ Date: _____

Follow-up information needed: _____

_____

Administrative note: This intake questionnaire is intended to collect history and clinical information. Informed consent, privacy acknowledgments, financial policies, and formal records authorizations should be maintained as separate documents when applicable.

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: _____ File #_____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE

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

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ 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 at the most.

SECTION 4-WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5-SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

SECTION 6-STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

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

SECTION 9-TRAVELLING

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Instructions:

1. This is a self-report questionnaire: the patient is instructed to fill it out.

2. The patient follows the general instructions given at the top of the questionnaire.

3. Each section must be completed. If the patient leaves one blank, instruct them to complete the form. It must be completed in one sitting.

4. Each section has 6 possible answers. Statement 1 is graded as 0 points; statement 6 is graded as 5 points. A total score of 50 is thus possible and would indicate 100% disability. So, for example, a total score of 10 of a possible 50 would constitute a 20% disability.

5. The following interpretation of disability scores is excerpted from the developers of the Oswestry system (457):

0%-20%: Minimal disability

This group can cope with most living activities. Usually no treatment is indicated, apart from advice on lifting, sitting posture, physical fitness, and diet. In this group some patients have particular difficulty with sitting, and this may be important if their occupation is sedentary, e.g., a typist or lorry [truck] driver.

20%-40% Moderate disability

This group experiences more pain and problems with sitting, lifting, and standing. Travel and social life are more difficult and they may well be off work. Personal care, sexual activity*, and sleeping are not grossly affected, and the back condition can usually be managed by conservative means.

40%-60%: Severe disability

Pain remains the main problem in this group of patients, but travel, personal care, social life, sexual activity*, and sleep are also affected. These patients require detailed investigation.

60%-80%: Crippled

Back pain impinges on all aspects of these patients' lives—both at home and at work—and positive intervention is required.

80%-100%

These patients are either bed-bound or exaggerating their symptoms. This can be evaluated by careful observation of the patient during medical examination.

6. It is recommended that clinicians focus their discussions of the results with patients in positive terms, rather than reporting disability scores. For example, point out the 10% improvement on a subsequent test.

* Note: in the revised Oswestry, sex life questions were replaced with recreation questions.

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ*: This questionnaire is 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 ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity	***SECTION 6 - Concentration***
A I have no pain at the moment. **B The pain is very mild at the moment.** **C The pain is moderate at the moment.** **D The pain is fairly severe at the moment.** **E The pain is very severe at the moment.** **F The pain is the worst imaginable at the moment.**	**A I can concentrate fully when I want to with no difficulty.** **B I can concentrate fully when I want to with slight difficulty.** **C I have a fair degree of difficulty in concentrating when I want to.** **D I have a lot of difficulty in concentrating when I want to.** **E I have a great deal of difficulty in concentrating when I want to.** **F I cannot concentrate at all.**
SECTION 2 -Personal Care (Washing, Dressing, etc.)	***SECTION 7 - Work***
A I can look after myself normally without causing extra pain. **B I can look after myself normally, but it causes extra pain.** **C It is painful to look after myself and I am slow and careful.** **D I need some help, but manage most of my personal care.** **E I need help every day in most aspects of self care.** **F I do not get dressed, I wash with difficulty and stay in bed.**	**A I can do as much work as I want to.** **B I can only do my usual work, but no more.** **C I can do most of my usual work, but no more.** **D I cannot do my usual work.** **E I can hardly do any work at all.** **F I cannot do any work at all.**
SECTION 3 - Lifting	***SECTION 8 - Driving***
A I can lift heavy weights without extra pain. **B I can lift heavy weights, but it gives extra pain.** **C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.** **D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **E I can lift very light weights.** **F I cannot lift or carry anything at all.**	**A I can drive my car without any neck pain.** **B I can drive my car as long as I want with slight pain in my neck.** **C I can drive my car as long as I want with moderate pain in my neck.** **D I cannot drive my car as long as I want because of moderate pain in my neck.** **E I can hardly drive at all because of severe pain in my neck.** **F I cannot drive my car at all.**
SECTION 4 - Reading	***SECTION 9 - Sleeping***
A I can read as much as I want to with no pain in my neck. **B I can read as much as I want to with slight pain in my neck.** **C I can read as much as I want to with moderate pain in my neck.** **D I cannot read as much as I want because of moderate pain in my neck.** **E I cannot read as much as I want because of severe pain in my neck.** **F I cannot read at all.**	**A I have no trouble sleeping.** **B My sleep is slightly disturbed (less than 1 hour sleepless).** **C My sleep is mildly disturbed (1-2 hours sleepless).** **D My sleep is moderately disturbed (2-3 hours sleepless).** **E My sleep is greatly disturbed (3-5 hours sleepless).** **F My sleep is completely disturbed (5-7 hours)**
SECTION 5 - Headaches	***SECTION 10 - Recreation***
A I have no headaches at all. **B I have slight headaches which come infrequently.** **C I have moderate headaches which come infrequently.** **D I have moderate headaches which come frequently.** **E I have severe headaches which come frequently.** **F I have headaches almost all the time.**	**A I am able to engage in all of my recreational activities with no neck pain at all.** **B I am able to engage in all of my recreational activities with some pain in my neck.** **C I am able to engage in most, but not all of my recreational activities because of pain in my neck.** **D I am able to engage in a few of my recreational activities because of pain in my neck.** **E I can hardly do any recreational activities because of pain in my neck.** **F I cannot do any recreational activities at all.**

COMMENTS:_____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

SCORING TECHNIQUE FOR NECK DISABILITY INDEX

1. Each of the 10 sections is scored separately (0 to 5 points each) and then added up (max. total = 50).

***EXAMPLE*:**

Section 1. Pain Intensity	**Point Value**
A. _____ I have no pain at the moment	**0**
B. _____ The pain is very mild at the moment	**1**
C. _____ The pain is moderate at the moment	**2**
D. _____ The pain is fairly severe at the moment	**3**
E. _____ The pain is very severe at the moment	**4**
F. _____ The pain is the worst imaginable	**5**

2. If all 10 sections are completed, simply double the patients score.

3. If a section is omitted, divide the patient's total score by the number of sections completed times 5.

***FORMULA*:** $\frac{\text{PATIENT'S SCORE}}{\text{\# OF SECTIONS COMPLETED X 5}}$ **X 100 = _____ % DISABILITY**

***EXAMPLE*:**

If 9 of 10 sections are completed, divide the patient's score by 9 X 5 = 45; if……..

Patient's Score: 22

Number of sections completed: 9 (9 X 5 = 45)

22/45 X 100 = 48 % disability

Reference: Fairbanks CT, Couper C, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. Physio Ther 1980;66:271-273.