Dearinger & Klindt CCC, PLLC
107 N. 5th Street
Bardstown, KY 40004
Phone: 502-348-3202 Fax: 502-348-0321

CONFIDENTIAL PATIENT INFORMATION

How did you hear about our office?_____

First Name: _____ MI: _____ Last Name: _____

Address: _____

/City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Employer: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: M - F Shoe size: _____

Preferred Language: _____ Ethnicity: _____ Race: _____

Marital Status: Married - Single - Widowed - Student

Name of Spouse: _____ Spouse's DOB: _____

Spouse's employer: _____ Spouse's SS number: _____

List any Allergies:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: _____

List any Surgeries:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other: _____

List ALL Past Medical History conditions:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression

☐ Diabetes ☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain

☐ Genetic Spinal Condition ☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure

☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain

☐ Minor Heart Problem ☐ Multiple Sclerosis ☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's

☐ Polio ☐ Prostate Problems ☐ Shoulder Pain ☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/Strain

☐ Stroke/Heart Attack ☐ Other: _____

List Type of Medications you are taking:

☐ Anxiety ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin ☐ Birth control ☐ Cardiovascular ☐ Allergy ☐ Seizure

☐ Other: _____

Medication Allergies: _____

List your Family History:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition

☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio

☐ Prostate Problems ☐ Stroke/Heart Attack ☐ Other: _____

Please list family member with this medical history (ex. mother, father etc.)

_____

_____

_____

OVER

Health Questionnaire

NAME:
LAST: _____ FIRST: _____ M.I. _____ DATE: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL

Occas.	Freq.		Occas.	Freq.		Occas.	Freq.	
____	____	Allergies (List below)	____	____	Convulsions	____	____	Dizziness or Fainting
____	____	Headache	____	____	Neuralgia	____	____	Numbness

GASTRO-INTESTINAL

____	____	Colon Trouble	____	____	Constipation	____	____	Diarrhea
____	____	Difficult Digestion	____	____	Distension of Abdomen	____	____	Gall Bladder Trouble
____	____	Hemorrhoids	____	____	Liver Trouble	____	____	Pain Over Stomach

MUSCLE & JOINT

____	____	Arthritis	____	____	Bursitis	____	____	Foot Trouble
____	____	Low Back Pain	____	____	Neck Pain or Stiffness	____	____	Pain Between Shoulders
____	____	Pain, Numbness or Cramps	____	____	Sciatica	____	____	Swollen Joints
____	____	Shoulders	____	____	Arms	____	____	Feet
____	____	Elbows	____	____	Hands	____	____	Hips
____	____	Legs	____	____	Knees			

RESPIRATORY

____	____	Chest Pain	____	____	Chronic Cough	____	____	Difficult Breathing
____	____	Spitting up Blood	____	____	Spitting up Phlegm	____	____	Wheezing

EYES, EARS NOSE & THROAT

____	____	Asthma	____	____	Colds	____	____	Deafness
____	____	Earache	____	____	Ear Discharge	____	____	Ear Noises
____	____	Eye Pain	____	____	Nasal Obstruction	____	____	Nosebleeds
____	____	Sinus Infections						

SKIN

____	____	Bruise Easily	____	____	Dryness	____	____	Varicose Veins
____	____	Skin Eruptions (Rash)						

GENITO-URINARY

____	____	Bed Wetting	____	____	Blood in Urine	____	____	Frequent Urination
____	____	Inability to Control Kidneys	____	____	Kidney Infection or Stones	____	____	Painful Urination
____	____	Prostate Trouble	____	____	Pus in Urine			

CARDIO-VASCULAR

____	____	Hardening of Arteries	____	____	High Blood Pressure	____	____	Low Blood Pressure
____	____	Pain Over Heart	____	____	Poor Circulation	____	____	Rapid Heart Beat
____	____	Slow Heart Beat	____	____	Swelling of Ankles			

FOR WOMEN ONLY

____	____	Cramps or Backache	____	____	Hot Flashes	____	____	Excessive Menstrual Flow
____	____	Irregular Cycle	____	____	Menopausal Symptoms	____	____	Painful Menstruation

PREGNANT: YES / NO **DATE OF LAST PERIOD** _____ **PREVIOUS MISCARRIAGES**: YES / NO

DATE OF LAST: (APPROX)

Physical Examination _____
Blood Test _____
Chest X-Ray _____
Spine X-Ray _____
Dental X-Ray _____
Urine Test _____

HABITS

____ Alcohol
____ Coffee
____ Tobacco
____ Drugs
____ _____(other)

YES / NO HAVE YOU EVER:

____ ____ Been knocked Unconscious?
____ ____ Used Crutches or other support?
____ ____ Been treated for spine or nerve disorders?
____ ____ Had a fractured bone?
____ ____ Been Hospitalized other than surgery?
____ ____ Had Surgery? (List below)

Please list any allergies, medications and past surgeries: _____

✓ **CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD**

o **CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS**

Have	Had		Have	Had		Have	Had		Have	Had		Have	Had		Have	Had	
___	___	Alcoholism	___	___	Diabetes	___	___	Gout	___	___	Multiple Sclerosis	___	___	Stroke	___	___	Anemia
___	___	Emphysema	___	___	Goiter	___	___	Heart Disease	___	___	Eczema	___	___	Polio	___	___	Tuberculosis
___	___	Appendicitis	___	___	Miscarriage	___	___	Rheumatic Fever	___	___	Ulcers	___	___	Cancer	___	___	Foot Problems

DOCTOR ALERT: _____

Have you had any auto or other accidents? □ No □Yes

Describe: _____

Date of last physical examination: _____ Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day? _____

Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

What is your major complaint? _____Date problem began? _____

Which side? Right Left Both

How did this problem begin (falling, lifting, etc.)? _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW

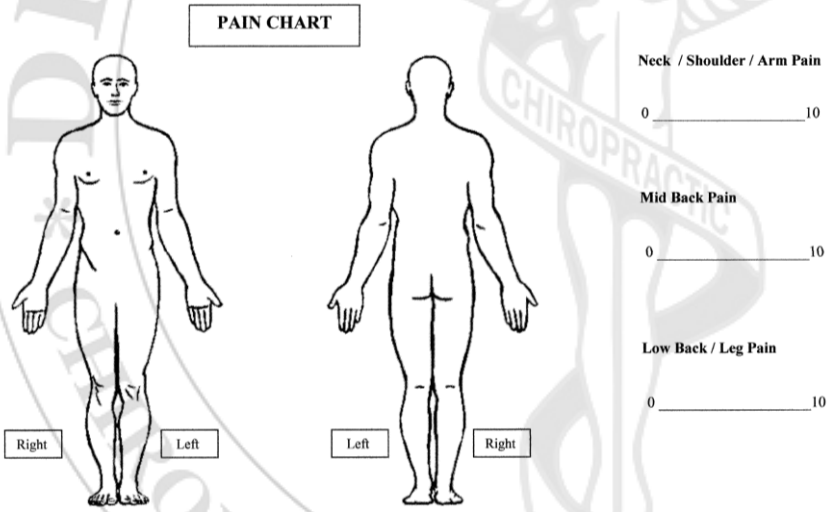
- Mark the areas on this body where you feel the pain or discomfort.
- Use the appropriate symbols below to describe your pain.
- Mark areas of radiation. (ex: down arm or leg)
- Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
.....	0 0 0 0 0 0 0 0	x x x x x	******	/ / / / / / / /
.....	0 0 0 0 0 0 0 0	x x x x x	******	/ / / / / / / /

Please indicate on the pain scale to the right of the diagram below the severity of your pain.
Using 0 for no pain and 10 being the worst pain you have felt with this condition.

Main reason for consulting the office:

□ Become pain free
□ Explanation of my condition
□ Learn how to care for my condition
□ Reduce symptoms
□ Resume normal activity level



How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your SECOND complaint? _____Date problem began? _____

Which Side? Right Left Both

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, **I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment**. I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interest on indebtedness together with such collection costs and reasonable attorney fees as may be require to effect collection.

Signature: _____ Date: _____

Oswestry Disability Questionnaire (Lower Back)

Name:_____ Date: _____

This questionnaire has been designed to give your therapist 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 conditions 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.**

Pain Intensity
__ I can tolerate the pain without having to use pain medication.
__ The pain is bad, but I can manage without having to pain medication.
__ Pain medication provides me complete relief from pain.
__ Pain medication provides me with moderate relief from pain.
__ Pain medication provides me with little relief from pain.
__ Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)
__ I can take care of myself normally without increased pain.
__ I can take care of myself normally but it increases pain.
__ It is painful to take care of myself, I am slow and careful.
__ I need help but I am able to manage most of my personal care.
__ I need help every day in most aspects of my care.
__ I do not get dressed, was with difficulty and stay in bed.

Lifting
__ I can lift heavy weights without increased pain.
__ I can lift heavy weights, but it causes increased pain.
__ Pain prevents me from lifting heavy weights off the floor, can manage if the weights are conveniently positioned (ex. on a table).
__ Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
__ I can lift only very light weights.
__ I can not lift or carry anything at all.

Walking
__ Pain does not prevent me from walking any distance.
__ Pain prevents me from walking more than 1 mile.
__ Pain prevents me from walking more than 1/2 mile.
__ Pain prevents me from walking more than 1/4 mile.
__ I can only walk with crutches or a cane.
__ I am in bed most of the time and have to crawl to the toilet.

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 for more than 1 hour.
__ Pain prevents me from sitting for more than 1/2 hour.
__ Pain prevents me from sitting for more than 10 minutes.
__ Pain prevents me from sitting at all.

Standing
__ I can stand as long as I want without increased pain.
__ I can stand as long as I want to but increases my pain.
__ Pain prevents me from standing more than 1 hour.
__ Pain prevents me from standing more than 1/2 hour.
__ Pain prevents me from standing more than 10 minutes.
__ Pain prevents me from standing at all.

Sleeping
__ Pain does not prevent me from sleeping well.
__ I can sleep well only by using pain medication.
__ Even when I take pain medication, I sleep less than 6 hours.
__ Even when I take pain medication, I sleep less than 4 hours.
__ Even when I take pain medication, I sleep less than 2 hours.
__ Pain prevents me from sleeping at all.

Social Life
__ My social life is normal and does not increase my pain.
__ My social life is normal, but it increases my level of pain.
__ Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
__ Pain prevents me from going out very often.
__ Pain has restricted my social life to my home.
__ I have hardly any social life because of my pain.

Traveling
__ I can travel anywhere without increased pain.
__ I can travel anywhere, but it increases my pain.
__ My pain restricts my travel over 2 hours.
__ My pain restricts my travel over 1 hour.
__ My pain restricts my travel to short trips under 1/2 hour.
__ My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking
__ My normal homemaking/job activities do not cause 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 doing 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.

Score: _____ (Doctor's use)

Neck Index

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
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.

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).

Reading

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

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
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 only 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.

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 I 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 if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything 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 neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

Neck Index Score