Heritage Chiropractic Clinic – Geoffrey A. Sandels, D.C.
2407 Lenora Church Road / Snellville, Georgia 30078-6916 / 770-979-2731

Welcome to our office!

Today's Date: ____/____/____

Your Name:_____ [ ] Male [ ] Female

What do you prefer to be called/Nickname:_____

Date of Birth:____/____/____ Age: _____

Social Security Number: _____-____-_____

Home Address: _____

City: _____ State:_____ Zip_____

Home Phone: (_____)_____ Work Phone: (____)_____

Mobile Phone: (_____)_____ Email: _____

Employer:_____

Address:_____

City: _____ State: _____ Zip:_____

Occupation:_____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Seperated

Number of Children_____

Spouse's Name_____ Spouse Employer_____

Spouse's Phone:_____

Emergency Contact:_____ Phone (____)_____

Payment By: _____Cash _____Check _____Credit Card _____Insurance

Insurance Company_____Relation to Insured_____

Who can we thank for referring you?_____

Patient's Signature_____ Guardian, if Minor_____

Date: _____

Notice: Full Payment for services rendered is due at the end of each visit. If for any reason the request cannot be met, arrangements must be made in advance before seeing the doctor.

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PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

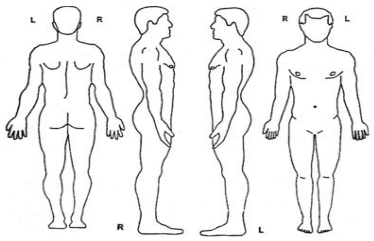
2. Indicate on the drawings below where you have pain/symptoms

a. _____

b. _____

c. _____

d. _____



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight**_____ **Age**_____

Occupation_____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco
□	□ Low Back Pain	□	□ Angina	□	□ Drug/AlcoholDependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	For Females Only	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

- **List all prescription medications you are currently taking:**

_____

- **List all of the over-the-counter medications you are currently taking:**

_____

- **List all surgical procedures you have had:**

_____

What activities do you do at work?

Sit:	□ Most of the day	□ Half the day	□ A little of the day
Stand:	□ Most of the day	□ Half the day	□ A little of the day
Computer work:	□ Most of the day	□ Half the day	□ A little of the day
On the phone:	□ Most of the day	□ Half of the day	□ A little of the day

What activities do you do outside of work?

_____

Have you ever been hospitalized? □ No □ Yes
if yes, why _____

Have you had significant past trauma? □ No □ Yes

Anything else pertinent to your visit today? _____

Patient Signature_____ Date:_____

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NECK PAIN QUESTIONNAIRE

Patient Name: _____ Date: _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your neck pain had affected your ability to manage your everyday activities. Please answer each section by checking or circling the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

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

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LOW BACK PAIN QUESTIONAIRE

Patient Name: _____ Date: _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your back pain had affected your ability to manage your everyday activities. Please answer each section by checking or circling the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

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 severe.
- The pain is severe and does not vary much.

Standing

- I can stand as long as I want without pain.
- I have some pain while 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 ten minute without increasing pain.
- I avoid standing, because it increases the pain straight away.

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 or dressing without help.

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 one than one quarter.
- Because of pain, my normal night's sleep is reduced by less than one-half.
- Because of pain, my normal night's sleep is reduced by less than three-quarters.
- Pain prevents me from sleeping at all.

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.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- 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.

Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, My 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.

Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one 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 while using a cane or on crutches.
- I am in bed most of the time and have to crawl to the toilet.

Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling 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.

Sitting

- I can sit in any chair as long as I like without pain.
- 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 than ten minutes.
- Pain prevents me from sitting at all.

Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely 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.