Cornerstone **CHIROPRACTIC**
804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

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

Confidential Patient Case History: Neck Primary

Please complete this questionnaire as thoroughly as possible so we can learn about your health and better help you.

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ **Gender**: □ Male □ Female

Preference for Appointment Reminders & Other General Contact: □Phone □Email □Text (Cell Company:_____)

Preferred Language: □ English □ Spanish □ Other: _____

Race & Ethnicity: □ White □ Hispanic or Latino □ Black or African American □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Pacific Islander □ Other or Decline to answer

Social Security Number _____ Employer/Occupation _____
Marital Status □ M □ S □ D □ W Spouse's Name _____
Children's Names & Ages _____
Who referred you to us? _____
How else did you hear about us? _____

Health History Questionnaire

1. What brings you into this office (e.g. want to be healthier, backache, heartburn, etc.)?
   _____
2. If you are experiencing a symptom:
   a. When did it begin? _____
   b. How did it happen? _____
   c. How often does it affect you? □constant □intermittent
   d. Symptom is currently: □increasing □decreasing □not changing
   e. Symptom is worse in the: □morning □afternoon □night □same all day
   f. If there is pain, is it: □sharp □dull □ache □shooting □tingling □radiating □stabbing □other_____

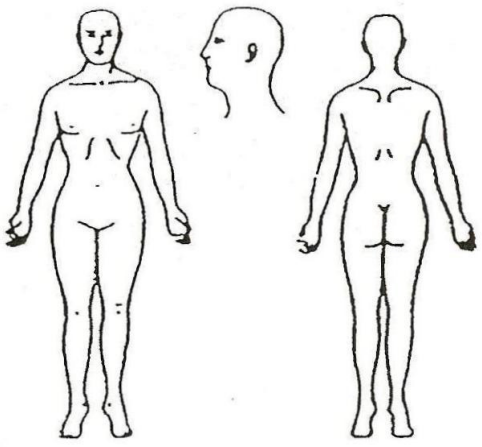
***PAIN LEVEL**: On a scale of 0 - 10, with 0 being pain free and can function quite well, and 10 being excruciating pain all the time, where would you rate the intensity of your pain?*

0	1	2	3	4	5	6	7	8	9	10
No Pain		Low Pain		Moderate Pain			Intense Pain			Excruciating Pain

   g. What makes the symptom better? □nothing □sitting □lying down □walking □moving □bending/twisting □other_____
   h. What makes the symptom worse? □nothing □sitting □lying down □walking □moving □bending/twisting □other_____
   i. How have you treated the symptom? □ice □heat □medication □other_____
   j. Have you seen another provider for this complaint? □yes □no
      If so, who: □Chiropractor □MD □Osteopath □Specialist □other_____
      When and what was their treatment_____
   k. Has this condition affected your: □sleep □work □chores □family/social life □leisure □other_____
   l. Have you had this or similar conditions in the past? _____
3. What do you hope to gain from this office?
   □improved general health □symptom relief □increased productivity □positively change my life □other_____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles •••• Stabbing ////



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

4. Have you suffered injuries in the past? □yes □no
   □car accident date_____ □falls date_____ □hospitalization date_____
   □fracture date_____ □sprain/strain date_____ □other_____
5. Do you have a family history of:
   □heart disease □cancer □arthritis □diabetes □lung conditions □high blood pressure
   □stroke/vascular problems □kidney or liver conditions □other_____
6. Do you have a family physician? Name: _____
7. **Please list any disease or condition with which you have been diagnosed:** _____
   _____ □ *No Diagnoses*
8. Please list any nutritional supplements that you are currently taking: _____
   _____ □ *No Supplements*
9. **Please list any medications that you are currently taking:** _____
   _____ □ *No Medications*
10. **Please list any medication allergies that you have:** _____
    _____ □ *No Known Med. Allergies*
11. Please list any surgical operations and dates _____
    _____ □ *No Surgeries*
12. **Current Height:** _____ **Current Weight:** _____
13. **Smoking status (age 13 & over)**: □ Never smoked □ Former smoker □ Current smoker

Neck Disability Questionnaire

Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity
- [ ] I have no pain at the moment.
- [ ] The pain is mild at the moment.
- [ ] The pain comes and goes and is moderate.
- [ ] The pain is moderate and does not vary much.
- [ ] The pain is severe but comes and goes.
- [ ] The pain is severe and does not vary much.

Personal Care (e.g., Washing, Dressing)
- [ ] I can look after myself normally without causing increased pain.
- [ ] I can look after myself normally, but it increases my pain.
- [ ] It is painful to take care of myself, and 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, I wash with difficulty, and stay in bed.

Work
- [ ] I can do as much work as I want to.
- [ ] I can only do my usual work, but no more.
- [ ] I can do most of my usual work, but no more.
- [ ] I cannot do my usual work.
- [ ] I can hardly do any work at all.
- [ ] I cannot do any work at all.

Headaches
- [ ] I have no headaches at all.
- [ ] I have slight headaches which come infrequently.
- [ ] I have moderate headaches which come infrequently.
- [ ] I have slight headaches which come frequently.
- [ ] I have moderate headaches which come frequently.
- [ ] I have headaches almost all the time.

Concentration
- [ ] I can concentrate fully when I want to with no difficulty.
- [ ] I can concentrate fully when I want to with slight difficulty.
- [ ] I have a fair degree of difficulty in concentrating when I want to.
- [ ] I have a lot of difficulty in concentrating when I want to.
- [ ] I have a great deal of difficulty in concentrating when I want to.
- [ ] I cannot concentrate at all.

Driving
- [ ] I can drive my car without neck pain.
- [ ] I can drive my car as long as I want with slight pain in my neck.
- [ ] I can drive my car as long as I want with moderate pain in my neck.
- [ ] I cannot drive my car as long as I want because of moderate pain in my neck.
- [ ] I can hardly drive my car at all because of severe pain in my neck.
- [ ] I cannot drive my car at all.

Sleeping
- [ ] I have no trouble sleeping.
- [ ] My sleep is slightly disturbed (less than 1 hour sleepless).
- [ ] My sleep is mildly disturbed (1-2 hours sleepless).
- [ ] My sleep is moderately disturbed (2-3 hours sleepless).
- [ ] My sleep is greatly disturbed (3-5 hours sleepless).
- [ ] My sleep is completely disturbed (5-7 hours sleepless).

Recreation
- [ ] I am able to engage in all recreational activities with no pain in my neck at all.
- [ ] I am able to engage in all recreational activities with some pain in my neck.
- [ ] I am able to engage in most, but not all recreational activities because of pain in my neck.
- [ ] I am able to engage in a few of my usual recreational activities because of pain in my neck.
- [ ] I can hardly do any recreational activities because of pain in my neck.
- [ ] I cannot do any recreational activities at all.

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Reading

[ ] I can read as much as I want to with no pain in my neck.
[ ] I can read as much as I want with slight pain in my neck.
[ ] I can read as much as I want with moderate pain in my neck.
[ ] I cannot read as much as I want because of moderate pain in my neck.
[ ] I cannot read as much as I want because of severe pain in my neck.
[ ] I cannot read at all.

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, but I can manage if the weights 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 lift only very light weights.
[ ] I cannot lift or carry anything at all.

Review of Systems

Past	Present		Past	Present	
☐	☐	Neck or back pain	☐	☐	Hemorrhoids
☐	☐	Headaches	☐	☐	Difficulty swallowing
☐	☐	Jaw pain	☐	☐	Heartburn or indigestion
☐	☐	Arm, shoulder, elbow, wrist or hand pain	☐	☐	Ulcer
☐	☐	Leg, hip, knee, ankle or foot pain	☐	☐	Aortic aneurysm
☐	☐	Swelling or stiffness of joints	☐	☐	High blood pressure
☐	☐	Numbness, loss of sensation, or tingling	☐	☐	Heart murmur
☐	☐	General fatigue	☐	☐	Heart palpitations
☐	☐	Depression	☐	☐	Chest pains or angina
☐	☐	Troubled sleep	☐	☐	Heart attack
☐	☐	Loss of memory	☐	☐	Stroke
☐	☐	Fainting	☐	☐	Asthma or Allergies
☐	☐	Seizures	☐	☐	Skin rashes
☐	☐	Visual disturbances	☐	☐	Cancer or non-cancerous tumor
☐	☐	Dizziness	☐	☐	Blood disorder
☐	☐	Ear noises or ringing	☐	☐	Emphysema
☐	☐	Hard of Hearing	☐	☐	Arthritis (or Rheumatoid arthritis)
☐	☐	Earache or Ear Fluid	☐	☐	Diabetes
☐	☐	Shortness of breath or wheezing	☐	☐	Hepatitis
☐	☐	Chronic cough or chronic sinusitis	☐	☐	Epilepsy
☐	☐	Runny nose or post nasal drip	☐	☐	Lupus
☐	☐	Throat soreness or hoarseness	☐	☐	HIV/AIDS
☐	☐	Chronic ear or throat infections	☐	☐	Other_____
☐	☐	Loss of taste or appetite	**Men Only**		
☐	☐	Abnormal weight gain or loss	☐	☐	Prostate problems
☐	☐	Excessive thirst	☐	☐	Erectile dysfunction
☐	☐	Heat or cold intolerance	☐	☐	Testicular pain
☐	☐	Loss of bladder control	**Women Only**		
☐	☐	Painful or frequent urination	☐	☐	Irregular menstrual flow
☐	☐	Bladder infection	☐	☐	Breast soreness or lumps
☐	☐	Kidney disorder or stones	☐	☐	Menstrual cramping
☐	☐	Abdominal pain	☐	☐	PMS
☐	☐	Constipation/irregular bowel habits	☐	☐	Endometriosis
☐	☐	Liver or gallbladder problems	☐	☐	Recurrent yeast or fungal infection
☐	☐	Hernia	☐	☐	Hot flashes
☐	☐	Irritable bowel or colitis	Duration of cycle _____ Duration of flow _____		
☐	☐	Nausea	Menstrual flow: ☐ Heavy ☐ Moderate ☐ Light		
☐	☐	Bloating or gas	Last period _____		
☐	☐	Diarrhea	No. Pregnancies _____ No. Births _____		
			Contraception Type _____		

Patient's signature: _____ Date: _____
Parent/ Guardian signature: _____ Date: _____