Active Spine and Sports

*Please complete the editable PDF form below. When you are done please click on the "Print Form" button at the end of the document*

# Personal History

Date _____

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name _____

Address _____

City _____

State/ Province _____ Zip/ Postal Code _____

Home phone _____

Business phone _____

Cell phone _____

e-mail address _____

Gender ☐ Male ☐ Female

Birth Date _____ Age _____

Employer _____

Address _____

City _____

State/ Province _____ ZIP/ Postal Code _____

Occupation _____

emergency contact - Name _____

emergency contact - Phone _____

Social Security Number _____

Have you ever been treated by a chiropractor before?

☐ YES ☐ NO

How would you describe your chief complaint at this time?

When did it start? _____

What makes the pain better? _____

How would you describe your pain? _____

At what time of the day or week is your pain worse? _____

The pain is ☐ Intermittent ☐ Constant

Have you had this problem in the past? ☐ YES ☐ NO If so, how often? _____

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise you heart rate?

How would you describe your chief complaint at this time?

When you engage in the physical activity noted above, what is the average duration of activity?

☐ Less than 10 minss ☐ 10 – 20 mins ☐ 20 – 30 mins ☐ 30 – 60 mins ☐ ver 60 mins

When you engage in the physical activity noted above, what do you feel the level of effort is? _____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?

Is your pain the result of a motor vehicle accident? ☐ YES ☐ NO

Have you filed a legal suit? ☐ YES ☐ NO

Is your pain the result of a work related injury? ☐ YES ☐ NO

If so, have you filed a worker's compensation claim? ☐ YES ☐ NO

Please list accidents, injuries, surgeries, and hospitalizations you have had ... (a brief discription, if possible Date or Age)

When you engage in the physical activity noted above, what is the average duration of activity?

| | | |
|---|---|---|
| Arthritis | ☐ Self | Family member _____ |
| Asthma | ☐ Self | Family member _____ |
| Cancer | ☐ Self | Family member _____ |
| Diabetes | ☐ Self | Family member _____ |
| Heart Disease | ☐ Self | Family member _____ |
| Hypertension | ☐ Self | Family member _____ |
| Hypoglycemia | ☐ Self | Family member _____ |
| Kidney Disease | ☐ Self | Family member _____ |
| Depression | ☐ Self | Family member _____ |
| Mental Illness | ☐ Self | Family member _____ |

Do you drink coffee or black tea? ☐ YES ☐ NO If so, how much per day? _____

Do you smoke tobacco? ☐ YES ☐ NO If so, how much per day? _____

Do you drink alcohol? ☐ YES ☐ NO If so, how often? _____

What medications, vitamins, supplements, herbs do you take?

| | | | |
|---|---|---|---|
| Name | | Reason | |
| Name | | Reason | |
| Name | | Reason | |
| Name | | Reason | |
| Name | | Reason | |

Please list any allergies that you have...

# QUADRUPLE VISUAL ANALOGUE SCALE

**INSTRUCTIONS: Please mark the appropriate fields that best describes the question being asked.**

*Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

Please rate your pain level with each of the following statements.

0 = no pain
5 = medium pain
10 = worst possible pain

**Complaint:** ☐ Headache ☐ Neck ☐ low back

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. What is your pain level RIGHT NOW? | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| 2. What is your level of AVERAGE pain? | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| 3. What is your pain level when it gets better? | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| 4. What is your pain level at awake hours? | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| 5. What is your pain level AT ITS WORST? | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Name _____ Date _____

Age _____

**SCORE** _____

# CORE Y F

**Complaint:** ☐ Low back ☐ Leg OR Neck ☐ Arm

1. Please indicate your usual level of pain during the past week

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| no pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible pain |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

2. Does pain, numbness, tingling or weakness extend into your leg (from the low back) and/or arm (from the neck)?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| None of the time | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | All of the time |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

3. How would you rate your general health?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Excellent | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Poor |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Delighted | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Poor |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

5. How anxious (e.g. tense, uptight, irritable, fearful, difficulty in concentrating / relaxing) you have been feeling during the past week?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Extremely anxious |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

6. How much you have been able to control (i.e., reduce/help) your pain/complaint on your own during the past week?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| can reduce | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | can't reduce at all |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

7. Please indicate how depressed you have been feeling in the past week?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Not depressed | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Extremely depressed |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

8. On a scale of 0 to 10, how certain are you that you will be doing normal activities or working in six months?

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Not certain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very certain |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

9. I can do light work for an hour.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| agree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | disagree |
| | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | |

10. I can sleep well at night.

| agree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | disagree |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | |

11. An increase in pain is an indication that I should stop what I am doing until the pain decreases.

| agree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | disagree |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | |

12. Physical activity makes my pain worse.

| agree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | disagree |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | |

13. I should not do my normal activities including work with my present pain.

| agree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | disagree |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | |

Name _____ Date _____

Please sign your name _____

***Please bring this printed form with you when you come to visit us for the first time.***

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