JENSEN CHIROPRACTIC CLINIC REGISTRATION & HISTORY

Patient Information

Date _____ Chart # _____

Patient Name

_____

Title Last First MI Suffix

_____ _____

Preferred Name Maiden Name

SS/HIC# _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

E-mail _____

Home Phone _____ Cell Phone_____

Preferred Method of contact: Phone- Cell/Home/Work or E-Mail

Patient Occupation _____

Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Emergency Contact Information

Name _____ Relationship _____

Home Phone _____ Cell phone _____

Work Phone _____

Marital Status ___ Married ___ Widowed ___ Separated
___ Divorced ___ Partnered ___Minor

IF YOU ARE HERE BECAUSE OF AN ACCIDENT AND HAVE NOT INFORMED US ALREADY, PLEASE DO SO RIGHT AWAY

Who is responsible for this account: _____

If not you, relationship to person responsible _____

Whom may we thank for referring you? _____

_____ _____

Signature **Date**

Health Habits

Caffeine (drinks/day) _____ Alcohol (drinks/week) _____

Street Drugs (kind/frequency) _____

Tobacco ___ Current smoker ____ pk/week
___ Former Smoker ____ pk/week
___ Never smoker

Federal Demographic Compliance

Preferred Language

__ English __ Spanish __ Other: _____

Race

__ I do not wish to provide this information
__ White
__ Black or African American
__ American Indian or Alaska Native
__ Asian
__ Native Hawaiian or Other Pacific Isandler
__ Other

Ethnicity

__ I do not wish to provide this information
__ Hispanic or Latino
__ Non-Hispanic or Non-Latino
__ Other

Activity

Exercise

__ None
__ Moderate - type _____
__ Daily - type _____
__ Aggressive - type _____

Work

__ Sitting __ Standing
__ Light Labor __ Heavy Labor
__ Stress __ Heavy Lifting
__ Hazardous Substances
__ Other _____

Medications/Supplements/Allergies

List of medications/dosage you are currently taking. (***We can copy your list if you have one***)

_____
_____
_____
_____
_____
_____

List of Supplements/dosage

_____
_____
_____
_____

Please List any allergies to medications/substances/foods

_____
_____
_____

Patient Condition

Reason for visit _____ Have you seen a Chiropractic Physician before? _____
When did your symptoms appear _____
What other treatment have you already received for your condition:
__Medications __ Injections __Surgery __ Physical Therapy __ Chiropractic __None __ Other_____
Date of Last:
Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
MRI _____ CT Scan _____ Bone Scan _____
Are you pregnant __Yes __ No Due Date _____

Family History

Relative	Alive	Deceased	Present Health or Cause of Death	Date/Age of Death
Father				
Mother				
Spouse				

Relative	No. Alive	Health	No. Deceased	Cause of Death
Brothers				
Sisters				
Children		**Age & Health**		**Age & Cause of Death**

Check which illnesses have occurred in any of your blood relatives: ___ Diabetes ___ Cancer __Bleeding tendency __Kidney disease
__Tuberculosis __ Heart disease __ Stroke __High blood pressure __Nervous illness __Other _____

Health History

Please list all Surgeries/Dates: _____
_____

Please check all conditions/symptoms you have or have had in the past (check box to left of condition/symptom)

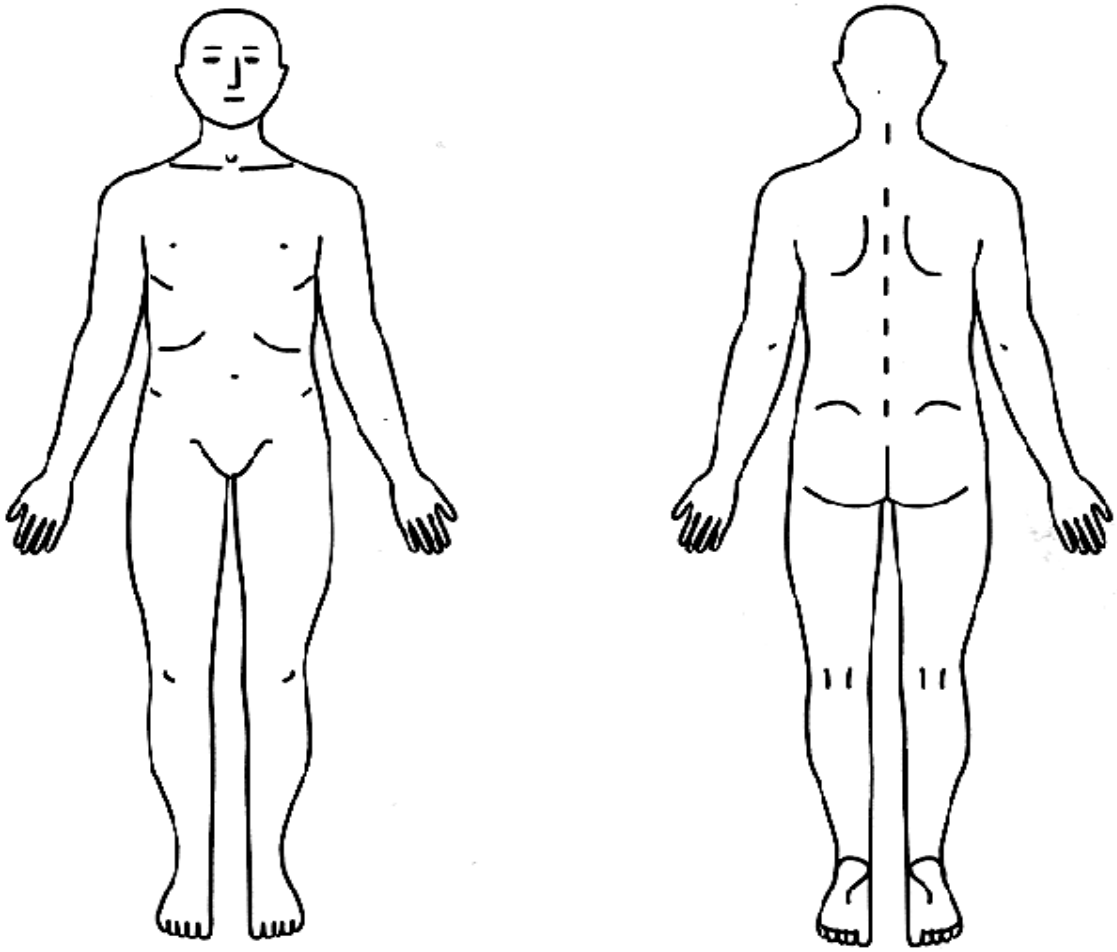
☐	AIDS/HIV	☐	Herpes	☐	Tuberculosis	☐	Excessive Thirst	☐	Itching/Rash
☐	Alcoholism	☐	High Blood Pressure	☐	Tumors, Growths	☐	Gas	☐	Change in Moles
☐	Allergy Shots	☐	High Cholesterol	☐	Typhoid Fever	☐	Hemorrhoids	☐	Scars
☐	Anemia	☐	Kidney Disease	☐	Ulcers	☐	Indigestion	☐	Sore that won't Heal
☐	Anorexia	☐	Liver Disease	☐	Whooping Cough	☐	Nausea	☐	
☐	Appendicitis	☐	Measles		GENERAL HEALTH	☐	Rectal Bleeding		MEN ONLY
☐	Arthritis	☐	Migraine Headaches	☐	Chills	☐	Stomach Pain	☐	Prostate Issues
☐	Asthma	☐	Miscarriage	☐	Depression/Nervous	☐	Vomiting	☐	Erection Difficulties
☐	Bleeding Disorders	☐	Mononucleosis	☐	Dizziness/Fainting	☐	Vomiting Blood	☐	Lump in Testicles
☐	Breast Lump	☐	Multiple Sclerosis	☐	Fever		EYE/EAR/NOSE/THROAT	☐	Penis Discharge
☐	Bronchitis	☐	Mumps	☐	Forgetfulness	☐	Bleeding Gums	☐	Sore on Penis
☐	Bulimia	☐	Osteoporosis	☐	Headache	☐	Blurred Vision	☐	
☐	Cancer	☐	Pacemaker	☐	Loss of Sleep	☐	Crossed Eyes		WOMEN ONLY
☐	Cataracts	☐	Parkinson's Disease	☐	Loss of Weight	☐	Difficulty Swallowing	☐	Abnormal Pap Smear
☐	Chemical Dependency	☐	Pinched Nerve	☐	Numbness	☐	Double Vision	☐	Bleeding Between Periods
☐	Chicken Pox	☐	Pneumonia	☐	Sweats	☐	Earache/Ear Discharge	☐	Breast Lump
☐	Diabetes	☐	Polio		GENITO-URINARY	☐	Hay Fever	☐	Extreme Menstrual Pain
☐	Emphysema	☐	Prosthesis	☐	Blood in Urine	☐	Hoarseness	☐	Hot Flashes
☐	Fractures	☐	Psychiatric Care	☐	Frequent Urination	☐	Loss of Hearing	☐	Nipple Discharge
☐	Glaucoma	☐	Rheumatoid Arthritis	☐	Bladder Control Issues	☐	Nosebleeds	☐	Painful Intercourse
☐	Goiter	☐	Rheumatoid Arthritis	☐	Painful Urination	☐	Persistent Cough	☐	Vaginal Discharge
☐	Gonorrhea	☐	Scarlet Fever		GASTROINTESTINAL	☐	Ringing in Ears	☐	Mammogram
☐	Gout	☐	STD	☐	Appetite Poor	☐	Sinus Problems	☐	
☐	Heart Disease	☐	Stroke	☐	Blurred Vision	☐	Vision- Flashes/Halos	☐	
☐	Hepatitis	☐	Suicide Attempt	☐	Bowel Changes	☐	SKIN	☐	
☐	Hernia	☐	Thyroid Problems	☐	Constipation	☐	Bruise Easily	☐	
☐	Herniated Disc	☐	Tonsillitis	☐	Diarrhea	☐	Hives	☐	

JENSEN CHIROPRACTIC CLINIC
PAIN CHART

Print Name _____ DOB _____ Chart # _____

Mark the areas of the body where your feel the described sensations.
Use the appropriate symbol.
Include **ALL** affected areas.

NUMBNESS	+++++	BURNING	XXXXX
PINS & NEEDLES	000000	SHARP	///////
DULL & ACHING	********	WEAK	^^^^^



No Pain | Slight Pain | Moderate Pain | Severe Pain | Unbearable Pain

Patient Signature _____ Date _____

JENSEN CHIROPRACTIC CLINIC LTD.
2002 East Fifth Street
Sterling, IL 61081
815-626-0270

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Chart # _____ **Total Score** _____
PRINTED

_____ _____
Signature **Date**

JENSEN CHIROPRACTIC CLINIC
NECK DISABILITY INDEX

Print Name _____DOB_____ Chart #_____

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, CIRCLE THE **ONE** CHOICE WHICH MOST CLOESLY DESCRIBES YOUR PROBLEM **RIGHT NOW**.

SECTION 1: PAIN INTENSITY
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

SECTION 2: PERSONAL CARE (WASHING, DRESSING, ETC.)
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 aspect of self-care
F I do not get dressed; I wash with difficulty and stay in bed

SECTION 3: LIFTING
A I can lift heavy weights without extra pain
B I can lift heavy weights, but it causes 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

SECTION 4: READING
A I can read as much as I want with no pain in my neck
B I can read as much as I want with slight pain in my neck
C I can read as much as I want with moderate pain in my neck
D I can't read as much as I want because of moderate pain in my neck
E I can't read at all

SECTION 5: HEADACHES
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 a headache almost all of the time

COMMENTS:

SECTION 6: CONCENTRATION
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 7: WORK
A I can do as much work as I want to
B I can 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 8: DRIVING
A I can drive my car without any neck pain
B I can drive my car as long as I want with slight neck pain
C I can drive my car as long as I want with moderate neck pain
D I can't drive my car as long as I want because of moderate neck pain
E I can hardly drive at all because of severe neck pain
F I cannot drive my car at all

SECTION 9: SLEEPING
A I have no trouble sleeping at all
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 sleepless)

SECTION 10: RECREATION
A I am able to engage in all of my recreation activities, with no neck pain at all
B I am able to engage in all of my recreation activities, with some neck pain
C I am able to engage in most, but not all of my usual recreation activities because of my neck pain
D I am able to engage in a few of my usual recreation activities because of my neck pain
E I can hardly do any recreation activities because my neck pain
F I cannot do any recreation activities at all due to my neck pain

Patient Signature _____

Date _____

JENSEN CHIROPRACTIC CLINIC

MODIFIED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

Print Name _____ Date ----------
DOB _____ Chart # _____Occupation_____

How long have you had back pain ____Years ____ Months ____Weeks

How long have you had leg pain ____Years ____Months ____ Weeks

This questionnaire had been designed to give us information as to how your back pain has affected your ability to manage in everyday activities. Please answer each section by placing a mark on the line that **BEST** describes your condition **TODAY**. We realize you may feel that two of the statements may describe your condition, but please, **mark only the line that most closely describes your current condition**.

PAIN INTENSITY

___ The pain is mild and comes and goes
___ The pain is mild and does not vary much
___ The pain is moderate and comes and goes
___ The pain is moderate and does not vary much
___ The pain is severe and comes and goes
___ The pain is severe and does not vary much

PERSONAL CARE (washing, dressing, etc.)

___ I do not have to change the way I wash and dress myself to avoid pain
___ I do not normally change the way I wash or dress myself even though it causes some pain
___ Washing and dressing increases my pain, but I can do it without changing my way of doing it
___ Washing and dressing increases my pain, and I find it necessary to change the way I do it
___ Because of my pain I am partially unable to wash and dress without help
___ Because of my pain I am completely unable to wash or dress myself

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 they are conveniently positioned
___ Pain prevents me from lifting heavy weights off the floor, 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

WALKING

___ I have no pain when walking
___ I have pain when walking, but I can still walk my required normal distances
___ Pain prevents me from walking long distances
___ Pain prevents me from walking intermediate distances
___ Pain prevents me from walking even short distances
___ Pain prevents me from walking at all

Continued on back side 

SITTING
___ Sitting does not cause me any pain
___ I can only sit as long as I like providing that I have my choice of seating surfaces
___ Pain prevents me from sitting for more than 1 hour
___ Pain prevents me from sitting for more than ½ 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 but my pain increases with time
___ Pain prevents me from standing more than 1 hour
___ Pain prevents me from standing more than ½ hour
___ Pain prevents me from standing more than 10 minutes
___ I avoid standing because it increased my pain right away

SLEEPING
___ I get no pain when I am in bed
___ I get pain in bed, but it does not prevent me from sleeping well
___ Because of my pain, my sleep is only ¾ of my normal amount
___ Because of my pain, my sleep is only ½ of my normal amount
___ Because of my pain, my sleep is only ¼ of my normal amount
___ 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 (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 get no increased pain when traveling
___ I get some pain while traveling, but none of my usual forms of travel make it any worse
___ I get increased pain while traveling, but it does not cause me to seek alternative forms of travel
___ I get increased pain while traveling which causes me to seek alternative forms of travel
___ My pain restricts all forms of travel except that which is done while I am lying down
___ My pain restricts all form of travel

EMPLOYMENT/HOMEMAKING
___ My normal job/homemaking activities do not cause pain
___ My normal job/homemaking activities increase my pain, but I can still perform all that is required of me
___ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (lifting, vacuuming, etc.)
___ Pain prevents me from doing anything but light duties
___ Pain prevents me from performing any job or homemaking chores

Printed Name _____ Date_____ Chart #_____

Signature _____

SCORE _____%