CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license.
All Information you supply is confidential. We comply with all federal privacy standards. Please **print** clearly

Chris Thompson, DC
10 Penny Lane
Weaverville NC 28787
828-777-6115
weavervillechiropractor.com

_____
Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
☐ No ☐ Yes **When?** _____

_____
Whom may we thank for referring you?

_____
If so, whom?

_____
Your Last Name

Gender
☐ Male ☐ Female

_____
Your Social Security Number

_____
Your First Name

_____
Your Middle Name (or Initial)

_____
Birth Date (MM/DD/YYYY)

_____
Address

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

_____ _____ _____
City **State** **Zip/PostalCode**

_____
E-mail Address

_____
Your Cell Phone

_____ _____ _____
Emergency Contact **Home Phone** **Spouse's Name**

_____
Your Occupation

_____
Your Employer

May we contact you at work?
☐ Yes ☐ No

_____
Address

Preferred method of contact?
☐ Home Phone ☐ Cell Phone
☐ WorkPhone ☐ Email

_____ _____ _____ _____
City **State** **Zip/Postal Code** **Work Phone**

_____ _____
Primary Care Provider's Name **City and State**

Your Height _____.____ **Your Weight:** _____ **Lbs**

CONFIDENTIAL HEALTH INFORMATION

Patient Name

1. The symptom that prompted me to seek care today Include: _____

_____

2. And are the result of (darken square) ☐ an accident or injury

☐ Work ☐ Auto ☐ Other _____

☐ A worsening long term problem

☐ An interest in: ☐ Wellness ☐ Other _____

3. Onset (When did you first notice your current symptoms)

_____

4. Intensity (How extreme are your current symptoms?) 0-10

0 ☐-☐-☐-☐-☐-☐-☐-☐-☐-☐-☐10

Absent Uncomfortable [6] Agonizing

5. Duration and Timing (When did it start and how often do you feel it ?)

☐ Constant ☐ Comes and goes How often?_____

_____

6. Quality of the symptoms (what does it feel like)

☐ Aching

☐ Dull

☐ Burning Sensation

☐ Cramps

☐ Tingling

☐ Numbness

☐ Stiffness

☐ Sharp

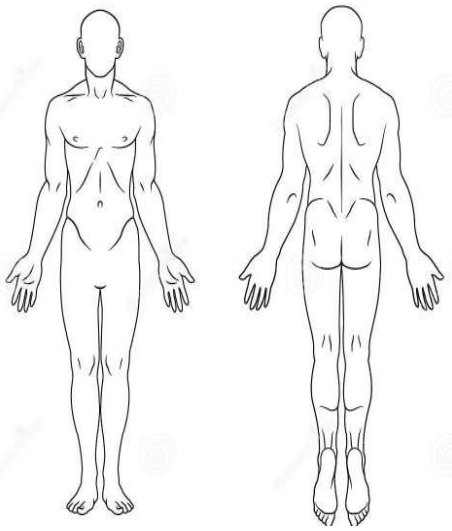
☐ Throbbing

☐ Shooting with motion

☐ Stabbing with motion

☐ Other _____

7. Location (Where does it hurt?) mark the areas on the illustration)



8. Radiation (How does it affect other areas of your body? To what area does the pain radiate, shoot, or travel.)

_____

9. Aggravting or Relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.

What tends to worsen the problem _____

What tends to lessen the problem _____

Is it worse getting in or out of a car ☐Yes ☐No

10. Prior Interventions (What have you done to relieve the Symptoms?)

☐ Prescription Medicine ☐ OTC's: Alieve, Ibuprofen, Motrin, Tylenol

☐ Physical therapy ☐ Acupuncture ☐ Surgery ☐ Ice

☐ Heat ☐ Stretching ☐ Massage ☐ Chiropractic

☐ Other _____

11. What else should Dr. Chris Thompson know about your current condition? _____

_____

12. How does your current condition interfere with your work? **(Circle)** None Mildly Moderately Substantially

12b. How has this current condition affected your social life? **(Circle)** None Mildly Moderately Substantially

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body.

Please darken the square besides and each condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck pain	☐	☐	Back problems	☐	☐	Hip disorders
☐	☐	Knee injuries	☐	☐	Foot/ankle pain	☐	☐	Shoulder Problem	☐	☐	Elbow/wrist pain	☐	☐	TMJ issues	☐	☐	Poor posture

NONE ☐ Initials _____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins & Needles	☐	☐	Numbness

NONE ☐ Initials _____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High blood Pressure	☐	☐	Low blood Pressure	☐	☐	High Cholesterol	☐	☐	Poor Circulation	☐	☐	Angina	☐	☐	Excessive bruising

NONE ☐ Initials _____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay fever	☐	☐	Shortness of breath	☐	☐	Pneumonia

NONE ☐ Initials _____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anorexia / Bulimia	☐	☐	Ulcer	☐	☐	Food sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea

NONE ☐ Initials _____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Blurred Vision	☐	☐	Ringing in ears	☐	☐	Hearing Loss	☐	☐	Chronic ear Infection	☐	☐	Loss of smell	☐	☐	Loss of taste

NONE ☐ Initials _____

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Skin cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair loss	☐	☐	Rash

NONE ☐ Initials _____

Doctor's Initials
Chris Thompson, D.C.

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ☐
☐	☐	Thyroid issues	☐	☐	Immune disorders	☐	☐	Hypoglycemia	☐	☐	frequent Infection	☐	☐	Swollen Glands	☐	☐	Low Energy	Initials _____

I. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ☐
☐	☐	Kidney stones	☐	☐	Infertility	☐	☐	Bedwetting	☐	☐	Prostate Issues	☐	☐	Erectile dysfunction	☐	☐	PMS symptoms	Initials _____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ☐
☐	☐	Fainting	☐	☐	Low Libido	☐	☐	Poor appetite	☐	☐	Fatigue	☐	☐	Sudden weight gain / loss (pick one)	☐	☐	Weakness	Initials _____

All other Systems Negative ☐

Past Personal , Family and Social History

Please identify your past health history including accidents, injuries illnesses and traumas. Please complete each section fully.

14. Illnesses

Check the illness you have **Had** and the past or **Have** now

Had	Have	
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Atherosclerosis
☐	☐	Cancer
☐	☐	Chicken Pox
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Glaucoma
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart disease
☐	☐	Hepatitis
☐	☐	HIV positive
☐	☐	Malaria
☐	☐	Multiple Sclerosis
☐	☐	Mumps
☐	☐	Polio
☐	☐	Scarlet fever
☐	☐	Sexually transmitted dx
☐	☐	Stroke

17. Injuries you have had

Have you ever . . .

☐ Had spinal of nerve disorder

☐ Been knocked unconscious _____

_____

☐ Been injuried in any auto accident

_____

_____

_____

_____

☐ Had a fracture or a broken bone

_____

_____

_____

Had	Have	
☐	☐	Typhoid fever
☐	☐	Tuberculosis
☐	☐	Ulcer

15. Operations

Surgical interventions which may or may not have included hospitalization.

☐ Appendix removal

☐ Heart Bypass Surgery

☐ Cancer

☐ Cosmetic Surgery

☐ Elective Surgery _____

_____

☐ Eye surgery

☐ Hysterectomy

☐ Pacemaker

☐ Spine_____

_____

_____

☐ Tonsillectomy

☐ Vasectomy

☐ Other_____

_____

_____

☐ Used a crutch or other support

☐ Used a Neck or Back Brace

☐ Received a Tattoo

☐ Had a body Piercing

16. Treatments

Check the one you've received in the Past or are receiving currently.

Past	Currently	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth control pills
☐	☐	Chemotherapy
☐	☐	Chiropractic care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone replacement
☐	☐	Inhaler
☐	☐	Massage therapy
☐	☐	Physical therapy
☐	☐	Nutritional supplements

_____

_____

_____

☐ ☐ Medications your taking now

(prescriptions and over the counter)

_____

_____

_____

18. Family History

Some health issues are hereditary. Tell Dr. Thompson about the health of your immediate family members.

Relative (Age if living)	State of health Good	Poor	Illness	Age at death	Cause of death Natural	Illness
Mother _____	☐	☐	_____	_____	☐	☐
Father _____	☐	☐	_____	_____	☐	☐
Brother 1 _____	☐	☐	_____	_____	☐	☐
Brother 2 _____	☐	☐	_____	_____	☐	☐
Sister 1 _____	☐	☐	_____	_____	☐	☐
Sister 2 _____	☐	☐	_____	_____	☐	☐

19. Are there any other Hereditary Issues the you know about? _____

_____

20. Social History

Tell Dr. Thompson about your health habits and stress levels.

Alcohol use	☐ Daily ☐ Weekly	How much? _____	Prayer or meditation? ☐ Yes ☐ No
Coffee use	☐ Daily ☐ Weekly	How much? _____	Job pressure/stress? ☐ Yes ☐ No
Tobacco use	☐ Daily ☐ Weekly	How much? _____	Financial peace? ☐ Yes ☐ No
Exercising	☐ Daily ☐ Weekly	How much? _____	Vaccinated - Covid 19 ☐ Yes ☐ No
Pain relievers	☐ Daily ☐ Weekly	How much? _____	Mercury fillings? ☐ Yes ☐ No
Soft drinks	☐ Daily ☐ Weekly	How much? _____	Recreational drugs? ☐ Yes ☐ No
Water intake	☐ Daily ☐ Weekly	How much? _____	

Hobbies _____

Doctors Initials
Chris Thompson,D. C.

21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

Patient name

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying down	☐	☐	☐	☐
Bending over	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in /out car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing self	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐

22. What is the major stressor in your life? _____ **23. How much sleep do you average per night?** _____ **Hours.**

24. What is the type and approximate age of your mattress and pillow?_____ **25. What is your preferred sleeping position?** _____

26. Describe your typical eating habits: ☐ **Skip breakfast** ☐ **Two meals a day** ☐ **Three meals a day** ☐ **Snack between meals**

27. What would be the most significant thing that you could do to improve your health? _____

_____

Acknowledgements

To set clear expectations, improve communications and get the best results in the shortest amount of time.

Please read each statement and initial your agreement.

Initials _____ **I instruct the chiropractor to deliver the the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropratic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-ray examination maybe hazardous to an unborn child and I certify that to best of my knowledge i am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, text, emails or heath information to me as an extension of my care in this office.**

Initials _____ **I acknowlage that any insurance agreement is between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **To the best of my ability the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Initials _____ **I agree to accept marketing emails and text from the office for educational and scheduling purposes .**

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date (MM/DD/YYY)

Doctor's Initials
Chris Thompson, D.C.

Neck Pain and Disability

Patient Name: _____ File # _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating Pain

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but can manage if they are conveniently positioned, for example 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 very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4—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 can't do any work at all.

Neck Pain

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Raw Score _____ _____% Disability

Section 6 – 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.

Section 7 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 8 – Driving

- ☐ I drive my car without any 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 can't 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 can't drive my car at all.

Section 9 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my Neck.
- ☐ I can't do any recreation activities at all.

Revised Oswestry Low Back Disability

Patient Name: _____ File # _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1- 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 very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2- 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 and dressing without help.

SECTION 3- 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, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ 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.

SECTION 4- WALKING
- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5- 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 more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

Low Back Pain

SECTION 6- STANDING
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on 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 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7- SLEEPING
- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well. (less than 1 hr. sleepless)
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4. (1-2 hrs. sleepless).
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2. (2-3 hrs. sleepless).
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4. (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 8- SOCIAL LIFE
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, 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.

SECTION 9- TRAVELING
- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, 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.

SECTION 10- CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively 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.

No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating Pain

Raw Score _____ _____% Disability