McNamara Chiropractic Center

3320 North Federal Highway, Lighthouse Point, FL 33064
(954)943-1100

Barcode/Z#:

Patient Information Form

Name: _____ **Today's Date:**_____ Account Number

Please complete the Patient Information Form and the Patient Intake Questionnaire. Thank You.

Patient Information:

Full Name: _____ Date of Birth: _____/_____/_____
Address: _____ Social Sec #: _____-_____-_____
City: _____ Home Phone: _____
State: _____ Zip: _____ Cel Phone: _____
Email Address: _____
Employer: _____ Work Phone: _____
Emergency Contact: _____ Phone #: _____

Spouse / Parent / Guardian Information:

Full Name: _____ Date of Birth: _____/_____/_____
Address: _____ Social Sec #: _____-_____-_____
City: _____ Home Phone: _____
State: _____ Zip: _____ Cel Phone: _____
Email Address: _____
Employer: _____ Work Phone: _____

Insurance and Primary Care Physician Information:

Company: _____ Member/Acct#: _____
Employer: _____ Group #:_____
Member / Policyholder's Name: _____

PCP Name: _____ Phone #: _____
City: _____ State: _____

Please sign this form, and move on to the Patient Intake Questionnaire.

_____
(Patient Signature) (Date)

Patient Intake Questionnaire

Barcode/Z #:

Account Number

Name: _____ **Today's Date:** _____

Reason for Visit:

❑ Pain Symptoms ❑ Wellness Visit ❑ Auto Accident
❑ Work Related Injury ❑ Sports Injury ❑ Other Injury

Date of Injury: _____

❑ **Auto Accident:**

❑ Driver ❑ Passenger, Front ❑ Passenger, Rear ❑ Pedestrian

Were You Wearing Seat Belt? ❑Yes ❑No Did You Receive Aid at Scene? ❑Yes ❑No
Is there a Police Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Type of Car? _____Year? _____ Was the Car Driveable? ❑Yes ❑No

Did You Hit? ❑ Air Bag ❑ Steering Wheel ❑ Side Door ❑ Dashboard ❑ Windshield

Describe the Accident: _____

_____

_____

❑ **Work Related Injury:**

Job Title: _____ Company: _____ How long? _____

Describe Your Normal Work Activities: _____

Did You File a Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Explain in Detail What Caused the Injury: _____

_____

_____

❑ **Sports or Other Injury:**

Explain in Detail What Caused the Injury: _____

_____

_____

Where Did the Injury Occur? _____

Did You File a Report? ❑Yes ❑No Were You Taken to Hospital? ❑Yes ❑No
Did You See Your PCP? ❑Yes ❑No

Primary Symptoms: (Check all that apply)

☐ Headache ☐ Migraines ☐ Neck Pain ☐ Neck Stiffness ☐ Shoulder Pain
☐ Arm Pain ☐ Low Back Pain ☐ Hip Pain ☐ Leg Pain ☐ Back Pain
☐ Soreness ☐ Discomfort ☐ Numbness ☐ Tingling ☐ Dizziness
☐ Fatigue ☐ Weakness ☐ Memory Loss ☐ Hearing Loss ☐ Depressed
☐ Elbow Pain ☐ Knee Pain ☐ Fever ☐ Sweating ☐ Sleep Problems
Other: _____

Additional Symptoms: _____

_____

Where Specifically Does it Hurt? (Check all that apply)

☐ Neck ☐ Upper Back ☐ Mid Back ☐ Lower Back ☐ Left Hip ☐ Right Hip
☐ Left Shoulder ☐ Right Shoulder ☐ Left Arm ☐ Right Arm ☐ Left Elbow ☐ Right Elbow
☐ Left Leg ☐ Right Leg ☐ Left Knee ☐ Right Knee ☐ Left Ankle ☐ Right Ankle
☐ Head ☐ Eyes ☐ Ears ☐ Chest ☐ Abdomen ☐ Buttocks
☐ Other: _____

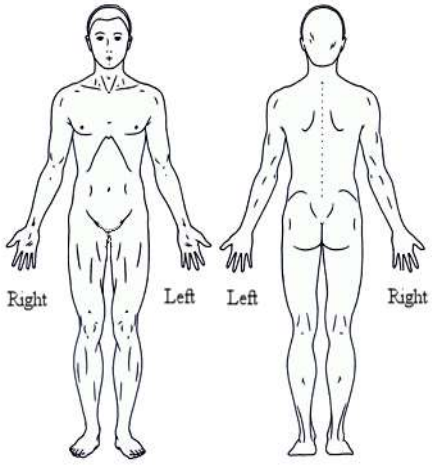
Please Describe the Pain and Place an "X" on the Picture:

Severity:
☐ Mild ☐ Mild-to-Mod ☐ Moderate ☐ Mod-to-Severe ☐ Severe

Frequency:
☐ Once ☐ Intermittent ☐ Occasional ☐ Frequent ☐ Constant

Quality:
☐ Dull ☐ Medium ☐ Sharp ☐ Stabbing ☐ Burning

The Pain is worse: (Check all that apply)
☐ Morning ☐ Midday ☐ After Work ☐ Evening ☐ Nighttime



Describe on a Scale of 1 (mild) to 10 (severe) How You Feel:

Circle One: 1 2 3 4 5 6 7 8 9 10

Have you Been Treated for this Current Condition in the Past?

❑ Yes ❑ No When? _____ By Whom? _____

What Activities of Daily Living are you unable to perform due to your pain?

☐ Sleeping ☐ Walking ☐ Standing ☐ Sitting ☐ Running ☐ Climbing
☐ Bathing ☐ Showering ☐ Dressing ☐ Shoes ☐ Toileting ☐ Cleaning
☐ Self Care ☐ Family Care ☐ Child Care ☐ Home Care ☐ Driving ☐ Gardening
☐ Working ☐ Lifting ☐ Desk Work ☐ Traveling ☐ School ☐ Concentrate

Describe how the pain affects these Activities of Daily Living:

_____

Check the box that describes the pain and Activities of Daily Living (ADL):

1 – No Pain	2 – Slight Discomfort	3 – Pain with No Effect on ADL's	4 – Pain with a Little Effect on ADL's	5 – Pain Prevents Any ADL's	6 – Pain Limits Work and Prevents Any ADL's	7 – Pain Prevents Both Work and ADL's	8 – Pain Prevents Working, ADL's and Activity	9 – Pain Keeps Me in Bed or Sitting at All Times	10 – Pain is Horrible, Cannot Tolerate Movement

ADDITIONAL COMPLAINTS: _____

_____

PAST HISTORY:

What other conditions have you been treated for? (Explain in detail)

_____

_____

What Surgeries or Procedures have you had? (Explain in detail)

_____

Medical History – (Check all that apply)

You:

☐ Diabetes	☐ Arthritis	☐ AIDS	☐ Sciatica	☐ Bursitis	☐ Osteoporosis
☐ Alzheimer	☐ Kidney Dis.	☐ Gout	☐ Amputation	☐ Ulcers	☐ High Blood Pressure
☐ Cancer	☐ Heart Attack	☐ Stroke	☐ COPD	☐ Scoliosis	☐ Low Blood Pressure
☐ Ulcers	☐ Deafness	☐ Blindness	☐ Migraines	☐ Disc Disorder	☐ Neuralgia
☐ Constipation	☐ Diarrhea	☐ Nausea	☐ Vomiting	☐ Varicose Vein	☐ Convulsions
☐ Fainting	☐ Sweats	☐ Chills	☐ Nervousness	☐ Eczema	☐ Prostrate Trouble
☐ Bleeding	☐ Tonsilitis	☐ Earache	☐ Hemorrhoids	☐ Pregnancy	☐ Neuro-Muscular Disease

☐ Other: (Be specific) _____

Your Family:

_____

List any Current Allergies: (Be specific)

_____

Current Medications you are Taking: (Be specific)

_____

_____

Social Activities:

☐ Smoke Cigarettes ____ # packs per day ☐ Smoke Cigars ☐ I don't smoke
☐ Drink Alcohol Beverages ___ # per day, or ___ # per week ☐ I don't drink alcohol.
☐ Beer ☐ Wine ☐ Mixed Drinks
☐ I admit to history of Recreational Drug Use. ☐ I deny history of Recreational Drug Use.
☐ I am currently Pregnant. Due Date: _____

Comments: _____

Please sign this form and thank you for visiting our office!

_____ _____

(Your Signature) (Date) Carol McNamara Krauss, D.C. (Date)

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QUADRUPLE VISUAL ANALOG SCALE

Name:_____ Date:_____

Where is your Pain?_____
INSTRUCTIONS: Please circle the number that best describes the question being asked.

EXAMPLE:
No Pain_____Worst Pain
0 1 2 3 4 5 6 (7) 8 9 10

1. What is your pain RIGHT NOW?

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

2. What is your TYPICAL or AVERAGE pain?

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

3. What is your pain lever AT IT'S BEST (How close to "0" does your pain get)?

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

4. What is your pain lever AT IT'S WORST (How close to "10" does your pain get)?

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

Comments: _____

_____

_____ _____
Patient Signature Date Carol McNamara Krauss, D.C. Date

For Office Use Only:
The scores from items 1, 2 and 4 above are averaged and then multiplied by 10 to yield a score from zero to 100.
The final score is then categorized as "low-intensity" (pain < 50) or "high-intensity" (pain > 50).

Score: _____ Improvement: _____ % Intensity: _____

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Activities of Daily Living Assessment Questionnaire

Patient Name _____ **Date** _____

Please rate your current difficulties, resulting from your current symptoms, with regard to the various Activities of Daily Living listed below. Only answer items that specifically apply to you.

PART ONE:
Use the following 1-5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty:

1= "I can do it without any difficulty"
2= "I can do it without much difficulty, despite some pain"
3= "I manage to do it by myself, despite marked pain"
4= "I manage to do it, despite the pain, but only if I have help"
5= "I cannot do it at all, because of the pain"

Difficulties with Self Care and Personal Hygiene Activities:

__ Bathing	__ Drying Hair	__ Brushing Teeth
__ Putting on Shoes	__ Showering	__ Combing Hair
__ Tying Shoes	__ Eating	__ Doing Laundry
__ Washing Hair	__ Washing Face	__ Putting on Pants
__ Cooking Meals	__ Doing Dishes	__ Going to Bathroom
__ Family Care	__ Child Care	__ Sleeping

Difficulties with Physical Activities:

__ Standing	__ Standing Long Time	__ Walking
__ Walking Distances	__ Bending Back	__ Bending Forward
__ Twisting Left	__ Twisting Right	__ Sitting
__ Kneeling Down	__ Reaching	__ Climbing

Difficulties with Functional Activities:

__ Carrying Small Items	__ Carrying Large Items	__ Exercising
__ Climbing Stairs	__ Lifting off Table	__ Lifting off Floor
__ Carrying Briefcase	__ Carrying Purse	__ Work Related Functions

Difficulties with Social and Recreational Activities:

__ Bowling	__ Jogging	__ Swimming
__ Skating	__ Competitive Sports	__ Riding Bike
__ Golfing	__ Dancing	__ Skiing
__ Hobbies	__ Dining Out	__ Dating/Marriage

Difficulties with Traveling:

__ Driving a Car	__ Riding in a Car
__ Riding a Train	__ Driving for Long Periods
__ Riding on an Airplane	__ Riding a Motorcycle

Patient Initials: _____