

# New Patient Information



Best Chiropractic:  
A Creating Wellness  
Center

Patient ID #: \_\_\_\_\_ (office use only)

Today's Date

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Date of Birth

Age \_\_\_\_\_

Gender (check one)

Male

Female

Social Security Number: \_\_\_\_\_

Employment Status (check one)

Employed

FT Student

PT Student

Other

Retired

Self Employed

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

Who can we thank for referring you: \_\_\_\_\_

Marital Status (check one)  Single  Married  Divorced  Widowed

**Please present CURRENT INSURANCE CARD(S) to front desk so a copy can be included in your file.**

**We also require the following information regarding the Policy Subscriber:**

## PRIMARY

Insurance Company \_\_\_\_\_

Relation to Policy Holder:  Self  Spouse  Dependent

If NOT "Self", please fill out the following:

Name of Policy Holder \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

## SECONDARY

Insurance Company \_\_\_\_\_

Relation to Policy Holder:  Self  Spouse  Dependent

If NOT "Self", please fill out the following:

Name of Policy Holder \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

Current medications: including dosage, times per day taken....

If there are no current medications, check here:

- 1) \_\_\_\_\_ 5) \_\_\_\_\_
- 2) \_\_\_\_\_ 6) \_\_\_\_\_
- 3) \_\_\_\_\_ 7) \_\_\_\_\_
- 4) \_\_\_\_\_ 8) \_\_\_\_\_

**Current Vitamins / Supplements**

- 1) \_\_\_\_\_ 4) \_\_\_\_\_
- 2) \_\_\_\_\_ 5) \_\_\_\_\_
- 3) \_\_\_\_\_ 6) \_\_\_\_\_

List any known allergies you have had to any medications. Include your reaction to the medication.

If no allergies are known, check here:

- 1) \_\_\_\_\_ 3) \_\_\_\_\_
- 2) \_\_\_\_\_ 4) \_\_\_\_\_

Briefly list your main health problems: (all health issues) \_\_\_\_\_  
\_\_\_\_\_

Has any doctor diagnosed you with Hypertension presently?  Yes  No If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

Has any doctor diagnosed you with Diabetes presently?  Yes  No If yes, what kind?  Type I  Type II  
*If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*  Yes  No  Not Sure  
*If yes, other comments regarding Diabetes:* \_\_\_\_\_

Have you had an X-Ray or CT scan or MRI of your low back spine in the past 28 days?  Yes  No

Patient (or Guardian) Signature: \_\_\_\_\_

# New Patient Questionnaire

Dr. Matthew Nelson    Dr. Joel Sengbusch  
Phone: (715) 386-9393    Fax: (715) 386-9885



Best Chiropractic:  
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## Medical Condition:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Psychiatric Illness
<input type="checkbox"/> Skin Disorder	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other _____

## Surgeries:

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Cervical Disc
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Laminectomies
<input type="checkbox"/> Other _____		

## Allergies:

<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish / Shellfish	<input type="checkbox"/> Milk / Lactose
<input type="checkbox"/> Peanut	<input type="checkbox"/> Soy	<input type="checkbox"/> Sulfites
<input type="checkbox"/> Wheat / Gluten	<input type="checkbox"/> Other _____	

## Social History:

Caffeine used	<input type="checkbox"/> not at all	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Chew tobacco	<input type="checkbox"/> not at all	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Drink alcohol	<input type="checkbox"/> not at all	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Exercise	<input type="checkbox"/> not at all	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Experience stress	<input type="checkbox"/> not at all	<input type="checkbox"/> occasionally	<input type="checkbox"/> often
Smoke per day	<input type="checkbox"/> not at all	<input type="checkbox"/> 1 pack or less	<input type="checkbox"/> 1 pack ++
Wear seatbelts	<input type="checkbox"/> not at all	<input type="checkbox"/> usually	<input type="checkbox"/> always

## Family History:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid

## Substance Use:

Alcohol	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Amphetamines	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Barbiturates	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Cocaine	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Crystal Meth	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Heroin	<input type="checkbox"/> Past	<input type="checkbox"/> Present
Marijuana	<input type="checkbox"/> Past	<input type="checkbox"/> Present

## Male Children:

<input type="checkbox"/> 0-6 years of age	<input type="checkbox"/> 7-10 years of age	<input type="checkbox"/> 11-18 years of age
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## Female Children:

<input type="checkbox"/> 0-6 years of age	<input type="checkbox"/> 7-10 years of age	<input type="checkbox"/> 11-18 years of age
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Occupational Activities:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Administration        | <input type="checkbox"/> Business Owner        | <input type="checkbox"/> Clerical / Secretarial |
| <input type="checkbox"/> Computers             | <input type="checkbox"/> Construction          | <input type="checkbox"/> Child Care             |
| <input type="checkbox"/> Executive / Legal     | <input type="checkbox"/> Food Service Industry | <input type="checkbox"/> Healthcare             |
| <input type="checkbox"/> Equipment Operator    | <input type="checkbox"/> Heavy Manual Labor    | <input type="checkbox"/> Home Services          |
| <input type="checkbox"/> Household             | <input type="checkbox"/> Light Manual Labor    | <input type="checkbox"/> Manufacturing          |
| <input type="checkbox"/> Military              | <input type="checkbox"/> Medium Manual Labor   | <input type="checkbox"/> Police / Fire          |
| <input type="checkbox"/> Professional Services | <input type="checkbox"/> Retail Worker         | <input type="checkbox"/> Teacher                |
| <input type="checkbox"/> Truck Driver          | <input type="checkbox"/> Other _____           |   |

Recreational Activities:

- |   |                                  |                                      |
|---|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Backpacking    | <input type="checkbox"/> Biking  | <input type="checkbox"/> Boating     |
| <input type="checkbox"/> Football       | <input type="checkbox"/> Golf    | <input type="checkbox"/> Racket Ball |
| <input type="checkbox"/> Running        | <input type="checkbox"/> Skiing  | <input type="checkbox"/> Soccer      |
| <input type="checkbox"/> Swimming       | <input type="checkbox"/> Tennis  | <input type="checkbox"/> Walking     |
| <input type="checkbox"/> Weight Lifting | <input type="checkbox"/> Bowling | <input type="checkbox"/> Other _____ |

**Have you had trouble with any of the following?**

Cardiovascular:

- |                     |                                  |                               |                             |
|---------------------|----------------------------------|-------------------------------|-----------------------------|
| Poor Circulation    | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Aortic Aneurism     | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Heart Disease       | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Vascular Disease    | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Heart Attack        | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Chest Pain          | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| High Cholesterol    | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Pace Maker          | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Jaw Pain            | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Irregular Heartbeat | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Swelling of Legs    | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |

Genitourinary:

- |                    |                                  |                               |                             |
|--------------------|----------------------------------|-------------------------------|-----------------------------|
| Kidney Disease     | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Lower Side Pain    | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Burning Urination  | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Frequent Urination | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Blood in Urine     | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Kidney Stone       | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |

Hematologic/Lymphatic:

- |                   |                                  |                               |                             |
|-------------------|----------------------------------|-------------------------------|-----------------------------|
| Hepatitis         | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Blood Clots       | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Cancer            | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Easy Bruising     | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Easy Bleeding     | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |
| Fever/Chill/Sweat | <input type="checkbox"/> Present | <input type="checkbox"/> Past | <input type="checkbox"/> No |

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **Pain Intensity**

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## **Sleeping**

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## **Sitting**

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## **Standing**

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## **Walking**

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## **Personal Care**

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## **Traveling**

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## **Social Life**

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## **Changing degree of pain**

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## **Pain Intensity**

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## **Sleeping**

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## **Reading**

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## **Concentration**

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

## **Work**

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## **Personal Care**

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

## **Lifting**

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## **Driving**

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## **Recreation**

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## **Headaches**

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score