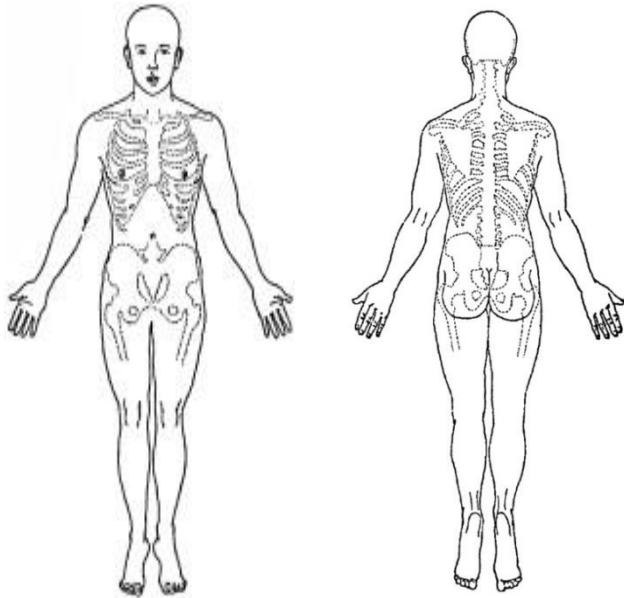


Name (Please Print) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**COMPLETE THESE DIAGRAMS  
MARKING AREAS OF PAIN**



Please list your areas of pain and then rate your pain.

Zero=No Pain 0 1 2 3 4 5 6 7 8 9 10 10=Unbearable

1. \_\_\_\_\_ Rate 0-10 \_\_\_\_

Onset Date/Describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_ Rate 0-10 \_\_\_\_

Onset Date/Describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_ Rate 0-10 \_\_\_\_

Onset Date/Describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. \_\_\_\_\_ Rate 0-10 \_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List anything that caused/contributed to your problem(s) \_\_\_\_\_

Is this new or Have you ever had these issues before? Yes \_\_\_\_ No \_\_\_\_ if yes, please explain

Have you been treated for this before by anyone:  NO  Yes Who? \_\_\_\_\_

Problem 1: \_\_\_\_\_

Please describe the character of your current discomfort (YOU MAY CHECK MORE THAN ONE RESPONSE):

- Sharp/Stabbing  Shooting  Ache  Dull  Soreness  Stiffness  Weakness  Throbbing/Gnawing  Numbness/tingling
- Burning  Gripping/Constricting Grabbing  Cramping/Spasm

**How often present?**  Constant ( 75% or more of the time),  Frequent (51-75%)  Occasional (26-50%)  Intermittent (25% or less)

Do you have to change what you do due to the pain?  No  A little  Moderate  A lot  Can't do some things at all

Problem 2: \_\_\_\_\_

- Sharp/Stabbing  Shooting  Ache  Dull  Soreness  Stiffness  Weakness  Throbbing/Gnawing  Numbness/tingling
- Burning  Gripping/Constricting Grabbing  Cramping/Spasm

**How often present?**  Constant (75% or more of the time),  Frequent (51-75%)  Occasional (26-50%)  Intermittent (25% or less)

Do you have to change what you do due to the pain?  No  A little  Moderate  A lot  Can't do some things at all

Problem 3: \_\_\_\_\_ Affect on your daily activity?  None  A little  Moderate  A lot  Can't do some

- Sharp/Stabbing  Shooting  Ache  Dull  Soreness  Stiffness  Weakness  Throbbing/Gnawing  Numbness/tingling
- Burning  Gripping/Constricting Grabbing  Cramping/Spasm

**How often present?**  Constant (75% or more of the time),  Frequent (51-75%)  Occasional (26-50%)  Intermittent (25% or less)

Please list your primary care doctor first, then other doctors and health conditions:

<b>Dr Name:</b>	<b>Specialty?</b>	<b>Dr Name:</b>	<b>Specialty?</b>
_____	_____	_____	_____
_____	_____	_____	_____

**\*\*IF YOU CARRY A LIST OF MEDICATIONS PLEASE PROVIDE A COPY AND DO NOT COMPLETE BELOW\*\***

<b>Medications you take:</b>	<b>For what condition?</b>	<b>Medications you take:</b>	<b>For what condition?</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Do you have any Medication Allergies? YES / NO (If yes please list below)**

<b>Medication Name:</b>	<b>Reaction?</b>	<b>Medication Name:</b>	<b>Reaction?</b>
_____	_____	_____	_____

Has any member of your family experienced back or neck pain/stiffness, or been treated for a similar condition?

Relationship to Patient		Describe Condition
1.		
2.		
Family History	Age	Health problems or cause of death
Mother		
Father		
Mother's mother		
Mother's father		
Father's mother		
Father's father		
Brothers		
Sisters		
Children		

Chronic Illnesses \_\_\_\_\_

Please describe and include dates of Surgery/ Hospitalization/ Operations: \_\_\_\_\_

Auto Accidents/Fractures/Injuries( Ever): \_\_\_\_\_

Any Falls in the Last Year: \_\_\_\_\_

Smoking Status (Circle one):  Never-Smoked  Everyday-Smoke  Occasional Smoke  Former-Smoker

HABITS: Sleep (# of hours): \_\_\_\_\_  Trouble falling asleep?  Pain wakes you  Trouble sleeping for other reasons  
 Do you feel stiff in the morning?  Yes I sleep on my  Back  Side  Stomach  use more than one pillow  
 How would you grade your general stress level?  No Stress  Minimal Stress  Moderate Stress  Greatly Stressed

Physical Activity Level at Work:  Sit 50% or more of the day  Light Manual labor  General labor  Heavy labor

General Physical Activity:  No Regular Exercise  Light Routine Exercise  Strenuous Routine Exercise

Hobbies – List \_\_\_\_\_

***I state that the information on all pages of this form is true and correct. I authorize Action Medical Center to examine, make x-rays, treat me and do whatever is deemed necessary in accordance with the state statutes, for the care and management of my condition.***

**Patient Signature**

**Date**

# Action Medical Center

# Patient Demographics

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_

Nick Name \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender (check one)  Male  Female  Unspecified Marital Status (check one)  Single  Married  Other

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Email: \_\_\_\_\_

For your convenience, we use Appointment TEXT REMINDERS. My cell carrier is:

- AT&T     Boost Mobile     Cricket     Metro PCS     Nextel  
 Sprint     T Mobile     US Cellular     Verizon

Employment Status (check one)  Employed  Retired  Self Employed  Other  FT Student  PT Student

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Their Phone \_\_\_\_\_

**If you are not the insured policy holder, please complete the information on the policy holder.**

Name of Insured/Policy Holder \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**If patient is a minor, please complete:**

Your Name \_\_\_\_\_ Relationship to minor \_\_\_\_\_

**How did you hear about our office?** You may check one or more, this information is important to us, thank you

- Internet Search     Online Ad     YouTube     Facebook     Newspaper     Sign/Banner  
 Friend/Co-worker     Insurance Company     Doctor Referred     Other \_\_\_\_\_

I state that the information on all pages of this form is true and correct. I authorize Action Medical Center to examine, x-ray, treat me and do whatever is deemed necessary in accordance with the state statutes, for the management of my condition.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**\*\*\*PLEASE READ and INITIAL EACH LINE BELOW\*\*\***

- \_\_\_\_\_ • I understand that Action Medical Center will prepare any necessary reports and forms to assist in collecting from the insurance company.
- \_\_\_\_\_ • I authorize Action Medical Center to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for payment of charges incurred by me as a result of professional services rendered. I hereby release Action Medical Center of any consequence thereof.
- \_\_\_\_\_ • Any amount paid by the insurance company directly to Action Medical Center will be credited to my account. However, I understand that all unpaid services rendered to me are charged directly to me and I am responsible for payment.
- \_\_\_\_\_ • I hereby authorize and direct payment of any medical expense benefits allowable to the doctor named above as payment toward the total charges for professional services rendered.
- \_\_\_\_\_ • We will attempt to collect from your insurance company until all of our efforts have been exhausted. If your insurance has not paid within 120 days, collection efforts will cease and you (the patient) will be billed for the amount the insurance has not paid.

***\*\*I agree that a Photostat copy of this agreement shall serve as the original\*\****

If you wish to allow our office to release information or records pertaining to your medical condition and care, please list the authorized parties below:

Name of Authorized Party	Relationship to Patient

If you would like a report sent to your primary care physician regarding your medical condition and care, please list the first and last name of your doctor and phone number if available. Please check **YES** or **NO**.

Name of Doctor	Phone Number

\_\_\_\_\_ **YES**, I would like a report sent to my doctor.

\_\_\_\_\_ **NO**, I would not like a report sent to my doctor.

**\*\*Patient Signature\*\***

**Witness**

**Date**

# NECK INDEX includes: UPPER BACK and ARMS

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 can't read as much as I'd like because of neck pain.
- (4) I can only read a little because of severe neck pain.
- (5) I can't read at all because of the neck pain.

## Concentration

- (0) I can concentrate fully when I want with no difficulty.
- (1) I can concentrate fully with slight difficulty.
- (2) I have a fairly difficult time concentrating.
- (3) I have a lot of difficulty concentrating.
- (4) I have great difficulty concentrating.
- (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 pain.
- (1) I can look after myself but it causes extra pain.
- (2) I can look after myself but have to change my way of doing things to not cause pain.
- (3) I can look after myself but must go slowly and carefully.
- (4) I can look after myself but need some help daily.
- (5) I am unable to take care of myself because of pain.

## Lifting

- (0) I can lift heavy weight without extra pain.
- (1) I can lift heavy weights off of the floor but with pain.
- (2) I can lift heavy weights but it severely increases the pain.
- (3) I can lift heavy weight if carefully positioned (ie. on a table).
- (4) I can't lift light weights even when carefully positioned.
- (5) I cannot lift or carry anything at all.

## Driving/Traveling

- (0) I can drive/travel without any neck pain.
- (1) I have some neck pain when I drive/travel.
- (2) I can't drive/travel longer than 90 minutes due to pain.
- (3) I can't drive/travel longer than 30 minutes due to pain.
- (4) I avoid driving/traveling due to pain.
- (5) Driving/traveling causes severe pain.

## Recreation

- (0) I can do all recreational activities with no pain.
- (1) I can do all recreational activities with pain.
- (2) I can do the major but not all recreational activities.
- (3) I can do a few usual recreational activities.
- (4) I can do very little recreational activities.
- (5) I can't do any recreational activities.

## Headaches

- (0) I have no headaches.
- (1) I have 1 headache per month.
- (2) I have 2 headaches per month.
- (3) I have 1 headache per week.
- (4) I have 3 headaches per week.
- (5) I have headaches almost daily.

Neck Index Score:

# BACK INDEX includes: LOW BACK, HIPS and LEGS

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) 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 comes and goes and is very severe.
- (5) The pain is very severe and does not change much.

## 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).

## Sitting

- (0) I can sit as long as I like with no back pain.
- (1) I can only sit in my favorite chair as long as I like.
- (2) I can sit for 1 hour before having pain.
- (3) Pain prevents me from sitting more than ½ hour.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) I can't sit at all due to pain.

## Standing

- (0) I can stand as long as I want without pain.
- (1) I have pain while standing but doesn't increase with time.
- (2) I can stand for 60 minutes without pain.
- (3) I can stand for 30 minutes without pain.
- (4) I can stand 10 minutes without pain.
- (5) I can't stand at all without having pain.

## 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 pain.
- (1) I can look after myself but it causes extra pain.
- (2) I can look after myself but have to change my way of doing things to not cause pain.
- (3) I can look after myself but must go slowly and carefully.
- (4) I can look after myself but need some help daily.
- (5) I am unable to take care of myself because of pain.

## Lifting

- (0) I can lift heavy weight without extra pain.
- (1) I can lift heavy weights off of the floor but with pain.
- (2) I can lift heavy weights but it severely increases the pain.
- (3) I can lift heavy weight if carefully positioned (ie. on a table).
- (4) I can't lift light weights even when carefully positioned.
- (5) I cannot lift or carry anything at all.

## Driving/Traveling

- (0) I can drive/travel without any back pain.
- (1) I have some back pain when I drive/travel.
- (2) I can't drive/travel longer than 90 minutes due to pain.
- (3) I can't drive/travel longer than 30 minutes due to pain.
- (4) I avoid driving/traveling due to pain.
- (5) Driving/traveling causes severe pain.

## Recreation

- (0) I can do all recreational activities with no pain.
- (1) I can do all recreational activities with pain.
- (2) I can do the major but not all recreational activities.
- (3) I can do a few usual recreational activities.
- (4) I can do very little recreational activities.
- (5) I can't do any recreational activities.

## Walking

- (0) I have no pain while walking.
- (1) I have some pain while walking but doesn't increase with distance.
- (2) I can't walk more than 1 mile without pain.
- (3) I can't walk more than ½ mile without pain.
- (4) I can't walk more than 1 block without pain.
- (5) I can't walk without pain.

Back Index Score: