Wagner Chiropractic Center
3778 E Union St. • PO Box 5642
Lafayette, IN 47903
Ph. 765-448-1674 • Fax 765-449-0847
www.wagnerchiropractic.org

CONFIDENTIAL PATIENT INFORMATION Date: _____

Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

Age _____ Date of Birth _____ Martial Status: M S W D How many children? _____

Occupation/Employer: _____ Address _____

Name of Insurance Company _____

Insured's Name _____ SS# _____ DOB _____

Name of Spouse _____ Employer _____

Patients nearest Relative _____ Address _____ Phone _____

Referred By _____

Is this condition due to patient's employment? _____

Date symptoms appeared or accident happened _____

Patient ever had same or similar condition: YES _____ NO _____

If yes, when and describe: _____

_____

Have you lost any work? YES _____ NO _____

Date of last physical examination: _____ Female: Are you pregnant? YES _____ NO _____

What operations or illness have you had? _____

_____

Have you ever suffered from?

☐Allergy	☐Poor Posture	☐Tuberculosis	☐Nervousness/Depression
☐Dizziness	☐Sciatica	☐Bruise easily	☐Varicose Veins
☐Headache	☐Spinal Curvatures	☐Hay Fever	☐Bed-Wetting
☐Fatigue	☐Swollen Joints	☐Nosebleeds	☐Frequent Urination
☐Loss of Sleep	☐Colon Trouble	☐Sinus Infection	☐Kidney Infection/Stones
☐Ulcers	☐Diarrhea	☐Cancer	☐Prostate Trouble
☐Itching	☐Difficult Digestion	☐Polio	☐Cramps of Backache
☐Numbness	☐Hemorrhoids	☐Pain Over Heart	☐Excessive Menstrual Flow
☐Arthritis	☐Nausea	☐Poor Circulation	☐Hot Flashes
☐Bursitis	☐Asthma	☐Rapid Heart Beat	☐Irregular Cycle
☐Foot Trouble	☐Colds	☐Slow Heart Beat	☐Lumps in Breast
☐Low Back Pain	☐Deafness	☐Anemia	☐Alcoholism
☐Ear Noises	☐Stroke	☐Diabetes	☐Neck Pain or Stiffness
☐Venereal Disease	☐Enlarged Thyroid	☐Chest Pain	☐Low Blood Pressure
☐Pleurisy	☐Eye Pain	☐Difficult breathing	☐High Blood Pressure
☐Spitting	☐Failing Vision	☐Swelling of Ankles	

Habit:	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Tingling or Numbness in:
☐Shoulders ☐Hips ☐Arms ☐Legs
☐Elbows ☐Knees ☐Hands ☐Feet

Are you wearing Heel Lifts_____ Sole Lifts_____ Inner Soles_____ Arch Supports _____

PLEASE PRINT

DO YOU:
Now take vitamins or minerals? YES_____ NO_____
Think you may need Vitamins or Minerals? YES_____ NO_____
Purpose of Appointment (Major Complaint) _____
_____
What activities aggravate your condition? _____
Is this condition interfering with your: Work_____ Sleep_____ Daily Activities_____ Other_____
How long has it been since you really felt good? _____
What do you believe is wrong with you? _____
Other Doctor's seen for this condition_____ When_____
Have you been treated for any health conditions in the last year? YES_____ NO_____
Describe_____
What medication or drugs are you taking? _____
Remarks and additional information_____

PAYMENT IS EXPECTED AT TIME OF VISIT!
Name of person responsible for payment_____

Are you insured? YES_____ NO_____ Company_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from my insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I further understand that for any reason my account is not paid in full, I am personally responsible for the service rendered to me. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and attorney fees incurred to effect collection of this account. I agree that reasonable collection fees shall be interpreted as 35% of any balance due at the time the account is sent to a collection agency.

Patient Signature: _____ Date: _____
Guardian or Spouse's Signature Authorizing Care_____ Date _____
Information Taken By_____ Date _____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient: _____

Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar environments.

CONDITION	FATHER Age( )	MOTHER Age( )	SPOUSE Age( )	BROTHER(S) Age( ) Age( )		SISTER(S) Age( ) Age( )		CHILDREN Age( ) Age( ) Age( )		
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____

Back Index

Form BI100

rev 3/27/2003

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

Neck Index

Form N1-100

rev 3/27/2003

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.

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.

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).

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.

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.

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.

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.

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.

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.

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