Personal Injury Questionnaire

Patient Name _____ Date of Injury _____
Your Insurance Co. _____ Policy # _____
Agent Name _____ Agent Phone _____
Driver/Other Vehicle _____ Insurance Co. _____
Policy # _____
Have you retained an attorney? Yes / No
Were there any witnesses? Yes / No If Yes, Names _____

Nature of Accident
Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
Number of people in your vehicle _____ Number of people in other vehicle _____
In what direction were headed ( ) North ( ) South ( ) East ( ) West on (Name of Street) _____
In what direction was the other vehicle headed ( ) North ( ) South ( ) East ( ) West on (Name of Street) _____
Were you struck from ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
At any time did you lose unconsciousness? Yes / No If Yes, for how long _____
Were the police notified? Yes / No If no, why not? _____

In your own words, please describe the accident _____
_____
Did you have any complaints BEFORE THE ACCIDENT? Yes / No If yes, please describe in detail _____
_____

Please describe how you felt:

A. During the accident _____

B. Immediately after the accident _____

C. Later that day _____

D. The next day _____

What are your PRESENT complaints? _____

Do you have any congenital factors (from birth) which relate to this problem? Yes / No If Yes, please describe _____
_____

Do you have any previous illnesses which relate to this case? Yes / No
If yes, please describe, including date(s) and types of accidents, as well as injuries received _____
_____
Where were you taken after the accident? _____
What type of treatment did you receive? _____
Since this injury occurred, are your symptoms ( ) Improving ( ) Getting worse ( ) Same

Have you lost time from work as a result of this accident? Yes / No If Yes, please complete the following questions:
A. Last day worked _____
B. Type of employment _____
C. Present salary _____
D. Are you being compensated for time lost from work? Yes / No If yes, please state type of compensation you are receiving _____

Do you notice any activity restrictions as a result of this injury? Yes / No If yes, please describe in detail _____
_____

Other pertinent information _____

_____ _____
Patient Signature Date

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860

IMPORTANT NOTICES

Do not begin filling out paperwork until you have read these notices!

1. If for **ANY** reason (high deductible, accident, etc.) you DO NOT want your insurance company to be billed for the services rendered by our clinic, please DO NOT provide us with your insurance information. In the event we obtain insurance information from you, we are required by law to submit the charges to your insurance company.

2. We **MUST** have an official job description sent to us from your employer or Human Resources representative. If your employer cannot immediately fax (815-459-3990) or email (info@strelcheckchiro.com) this information to us, please identify your official job description at www.occupationalinfo.org and print a copy for our file.
If you are unemployed, retired, work out of your home or your job duties are not accurately listed on this website, please notify us and we will assist you in completing this requirement.

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
Tel: 815-459-3860
Fax: 815-459-3990
Email: Info@Strelcheckchiro.com

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

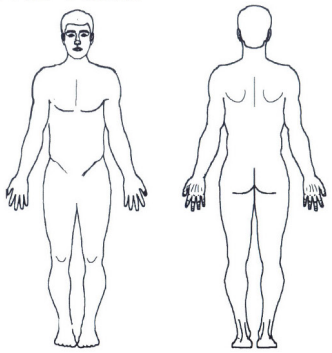
COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began_____
How Problem Began

Current complaint (how you feel today):

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

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

Patient Summary Form

Patient Name _____ Home Phone _____ Email _____
Emergency Contact _____ Relation _____ Phone _____
Referred By _____ Phone _____
Insurance subscriber's date of birth _____
Have you had any previous surgeries, trauma, accidents, falls, etc.? If so, please explain: _____
_____
Are you currently on any medication? Y/N If so, please list _____
What is the medication for? _____
Have you been treated previously for this condition? Y/N
If yes, by whom? (Doctor or Hospital) _____ Release date _____
For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Check box if none of the conditions apply ☐

Past	Present		Past	Present		Past	Present	
[ ]	[ ]	Headaches	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Diabetes
[ ]	[ ]	Neck Pain	[ ]	[ ]	Heart Attack	[ ]	[ ]	Excessive Thirst
[ ]	[ ]	Upper Back Pain	[ ]	[ ]	Chest Pains	[ ]	[ ]	Frequent Urination
[ ]	[ ]	Mid Back Pain	[ ]	[ ]	Stroke	[ ]	[ ]	Smoking/Tobacco Use
[ ]	[ ]	Low Back Pain	[ ]	[ ]	Angina	[ ]	[ ]	Drug/Alcohol Dependence
[ ]	[ ]	Shoulder Pain	[ ]	[ ]	Kidney Stones	[ ]	[ ]	Allergies _____
[ ]	[ ]	Elbow/Upper Arm Pain	[ ]	[ ]	Kidney Disorders	[ ]	[ ]	Depression
[ ]	[ ]	Wrist Pain	[ ]	[ ]	Bladder Infection	[ ]	[ ]	Systemic Lupus
[ ]	[ ]	Hand Pain	[ ]	[ ]	Painful Urination	[ ]	[ ]	Epilepsy
[ ]	[ ]	Hip Pain	[ ]	[ ]	Loss of Bladder Control	[ ]	[ ]	Dermatitis/Eczema/Rash
[ ]	[ ]	Upper Leg Pain	[ ]	[ ]	Prostate Problems	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Knee Pain	[ ]	[ ]	Abnormal Weight Gain/Loss	[ ]	[ ]	Loss of Appetite
[ ]	[ ]	Ankle/Foot Pain	[ ]	[ ]	Abdominal Pain	[ ]	[ ]	Ulcer
[ ]	[ ]	Jaw Pain	[ ]	[ ]	Liver/Gall Bladder Disorder	[ ]	[ ]	Hepatitis
[ ]	[ ]	Joint Pain/Stiffness	[ ]	[ ]	General Fatigue	[ ]	[ ]	Muscular Incoordination
[ ]	[ ]	Arthritis	[ ]	[ ]	Visual Disturbances	[ ]	[ ]	Hormonal Replacement
[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	Dizziness	[ ]	[ ]	Pregnancy
[ ]	[ ]	Cancer	[ ]	[ ]	Tumor	[ ]	[ ]	Birth Control Pills
[ ]	[ ]	Asthma	[ ]	[ ]	Chronic Sinusitis			

Strelcheck Chiropractic and Massage Clinic Policies

1. Payment is due at the time of service, or in accordance with my financial agreement.
2. I understand that an insurance contract is between the patient and the patient's insurance company. Coverage for Chiropractic care varies from company to company and policy to policy. SCC, Inc. as a courtesy and in an effort to serve our patients to the best of our ability will file the insurance claims on behalf of the patient, however. It is the patient's ultimate responsibility to keep the account current. SCC, Inc. cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.
3. Patients involved in litigation (lawsuits) are, as others, ultimately responsible for their treatment charges.
4. We reserve the right to bill for missed appointments.
5. I agree to pay all amounts due for services rendered by the Strelcheck Chiropractic Clinic, Inc. (SCC, Inc.) upon rendering of services and further agree to reimburse said clinic for all fees and costs incurred in the collection of such amounts, including, but not limited to reasonable attorney fees. I understand that if my bill is not paid, my information will be given to a collection agency.
6. I authorize release of my medical information necessary to process my claims. I authorize payment of benefits to Strelcheck Chiropractic Clinic for services rendered to me.
7. X-rays are the property of Strelcheck Chiropractic Clinic.

My signature is an acknowledgement that I have read the policies above and agree to abide by the same.

Patient Signature: _____ Date: _____

Our professional and personal concern is with just two things; your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help. Thank you for your time and effort in providing us with this information.

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860

BACK DISABILITY INDEX

Name: _____ Date: _____

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

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: Sleeping
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless)
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless)
- ☐ My sleep is completely disturbed (5+ hrs sleepless)

Section 3: Sitting
- ☐ I can sit in any chair as long as I want without pain
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ I avoid sitting because it increases pain immediately

Section 4: Standing
- ☐ I can stand as long as I want without pain
- ☐ I have some pain with standing and it does not increase
- ☐ I cannot stand for longer than 1 hour without increasing pain
- ☐ I cannot stand for longer than ½ hour without increasing pain
- ☐ I cannot stand for longer than 10 min. without increasing pain
- ☐ I avoid standing because it increases pain immediately

Section 5: Walking
- ☐ I have no pain while walking
- ☐ I have some pain while walking and it does not increase
- ☐ I cannot walk more than 1 mile without increasing pain
- ☐ I cannot walk more than ¼ mile without increasing pain
- ☐ I cannot walk at all without increasing pain

Section 6: 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 can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, and I wash with difficulty and stay in bed

Section 7: 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 I can manage if they are conveniently placed, 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 only lift very light weights
- ☐ I cannot lift or carry anything

Section 8: Driving
- ☐ I can drive my car without any back pain
- ☐ I can drive my car as long as I want with slight pain in my back
- ☐ I can drive my car as long as I want with moderate pain in my back
- ☐ I can't drive my car as long as I want because of moderate pain in my back
- ☐ I can hardly drive at all because of severe pain in my back
- ☐ I can't drive my car at all

Section 9: Recreation
- ☐ I am able to engage in all my recreation activities with no back pain at all
- ☐ I am able to engage in all my recreation activities, with some pain in my back
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my back
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my back
- ☐ I can hardly do any recreation activities because of pain in my back
- ☐ I can't do any recreation activities at all

Section 10: Degree of Pain
- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is definitely getting better
- ☐ My pain seems to be getting better with slow improvement
- ☐ My pain is neither getting better or worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

FOR OFFICE USE ONLY:

Score: ___/50 Transform to percentage score x 100 = % points

Scoring: For each section the total possible score is 5. If the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
40 (total possible score) x 100 = 40%

If one section is missed or not applicable the score is calculated:

Example: 16 (total scored)
35 (total possible score) x 100 = 45.7%

Minimum Detectable Change (90% confidence): 4 points or 10% points

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860

NECK DISABILITY INDEX

Name: _____ Date: _____

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

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 can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, and 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 I can manage if they are conveniently placed, 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 only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: 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 in my neck
- ☐ 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 5: Headaches
- ☐ I have no headaches at all
- ☐ I have slight headaches, which come infrequently
- ☐ I have moderate headaches, which come infrequently
- ☐ I have moderate headaches, which come frequently
- ☐ I have severe headaches, which come frequently

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: 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

Section 8: Driving
- ☐ I can 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 at all because of severe pain in my neck
- ☐ I can't drive my car at all

Section 9: Sleeping
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless)
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless)
- ☐ My sleep is completely disturbed (5+ hrs sleepless)

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

Score: ___/50 Transform to percentage score x 100 = % points

Scoring: For each section the total possible score is 5. If the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

Example: 16 (total scored)
45 (total possible score) x 100 = 35.5%

Minimum Detectable Change (90% confidence): 5 points or 10% points

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860

NAME:_____ **DATE:**_____

WORKING TOGETHER TO ACHIEVE MORE

As we strive to create mutually beneficial relationships for our patients, please share with us your health care providers name, address and phone number. We would like to invite him/her to be a part of our Strelcheck Preferred & Valued Physician Program.

Patient Referral Name _____#_____Town Located _____
Family Physician _____#_____Town Located _____
OB-GYN _____#_____Town Located _____
Dentist _____#_____Town Located _____
Specialist _____#_____Town Located _____
Other Health Care Professionals _____#_____Town Located _____

HEALTH CONTINUUM

SEVERE SYMPTOMS	MODERATE SYMPTOMS	MILD SYMPTOMS	REPORTING SOME RELIEF	FEELING BETTER	SYMPTOMS GONE	FEELING GREAT	ENJOYING OPTIMUM HEALTH
_____	/ _____	/ _____	/ _____	/ _____	/ _____	/ _____	/ _____

Please mark "A" on Health Continuum showing how you feel today and mark "B" showing where you want to be.

Please check any boxes below that you are interested in or feel you would benefit from in achieving your health goals. The doctor will review and make recommendations.

☐ **I am not interested in any of these at this time**

MASSAGE THERAPY
- ☐ Stress Relief
- ☐ Deep Tissue/Therapeutic
- ☐ Increase circulation
- ☐ Energy work
- ☐ Lymph draining
- ☐ Other _____

PHYSICAL THERAPY
- ☐ Increase strength/energy
- ☐ Increase range of motion/Stretching
- ☐ Traction/De-compression/Flexion-Distraction
- ☐ Pain control/E-stim
- ☐ Scar tissue/adhesion breakdown
- ☐ Physiotape/Kinesotaping
- ☐ Therapeutic ultrasound
- ☐ Stability/Proprioceptive/Balance training
- ☐ Posture correction
- ☐ Other _____

SUPPORTS
- ☐ Orthotics
- ☐ Lumbo/Sacral Belt
- ☐ Extremity Brace
- ☐ Topical Analgesic/Liquid Ice & Liquid Heat
- ☐ Ice Packs
- ☐ Leg Spacer
- ☐ Lumbar Support
- ☐ Other _____

NUTRITION
- ☐ Weight loss issues
- ☐ Energy issues
- ☐ Sugar handling/Diabetes issues
- ☐ Digestion issues
- ☐ Allergy issues
- ☐ Immune system issues
- ☐ Detox
- ☐ Sleep issues
- ☐ Hormonal/Reproductive issues
- ☐ Other _____

NUTRITION CURRENTLY TAKING ☐NONE
1. _____
2. _____
3. _____
4. _____
5.
6. _____

GENERALIZED HEALTH
- ☐ Blood Testing/Urine Analysis
- ☐ MRI/CT Scan
- ☐ Yoga/Pilates/Cross-training/Aerobics
- ☐ Natural Childbirth Classes
- ☐ Post X-rays

CARDIAC SCREENING QUESTIONNAIRE

Name: _____ Date: _____

Check box if all answers below are No ☐

		Y	N
1.	Have you ever had any of the following?		
	a. Episodes of passing out	[ ]	[ ]
	b. Unusual shortness of breath	[ ]	[ ]
	c. Unexplained fatigue	[ ]	[ ]
	d. Frequent dizziness or lightheadedness	[ ]	[ ]
2.	Do you ever experience chest tightness, heaviness, pressure, or pain?	[ ]	[ ]
3.	Are you currently taking any of the following medications? (please circle)		
	a. Anti-Anginals? (Nitroglycerin, Nitro-Bid, Isordil, Isosorbide Dinitrate, Nitro-patch)	[ ]	[ ]
	b. Calcium Channel Blockers? (Cardizem, Ditiazem, Isoptin,Calan, Verapamil, Nifedipine, Procardia, Adalat)	[ ]	[ ]
	c. Beta Blockers? (Corgard, Lopressor, Tenormin, Metaprolol, Propanolol, Inderal, Visken, Timolol, Atenolol)	[ ]	[ ]
	d. Anti-arrhythmics? (Quindine, Quinaglute, Norpace, Pronestyl, Procan-SR, Procainamide, Tambacor, Amiadarone, Mexitil, Tocainide, Encainide, Tonocard, Enkaid)	[ ]	[ ]
	e. Digitalis? (Lanoxin, Digoxin)	[ ]	[ ]
	f. Diuretics (water pills)? (Lasix, Oretic, Esidrex, Spironciactone, Aldactone)	[ ]	[ ]
	g. Anti-hypertensives (blood pressure pills)? (Aldomet, Capropril, Capoten, Apresoline, Minipress, Maxide, Dyazide, Vasotec, Minoxidil, Indapamide, Lozol, Methyl Dopa, Catapres)	[ ]	[ ]
4.	Have you ever had palpitations, skipped beats an irregular beat, or slow beat?	[ ]	[ ]
5.	Do you have a family history of cardiac sudden death? (brothers, sisters, parents grandparents, children)	[ ]	[ ]

		Y	N
6.	Are you a heart patient currently under the care of a doctor?	[ ]	[ ]
7.	Do you have a history of rheumatic fever?	[ ]	[ ]
8.	Do you have mitral valve prolapse?	[ ]	[ ]
9.	Do you have a history of heart murmer?	[ ]	[ ]
10.	Are you over 70?	[ ]	[ ]
11.	Do you have high blood pressure?	[ ]	[ ]
12.	Do you have a pacemaker? Type: _____ Rate: _____	[ ]	[ ]
13.	Have you ever had a MI (heart attack)? If so, when? _____	[ ]	[ ]
14.	Do you have chronic lung disease, bronchitis, emphysema, wheezing or asthma?	[ ]	[ ]
15.	Have you ever had heart surgery? If so, when? _____	[ ]	[ ]
16.	Have you ever had an abnormal exercise test? (e.g., treadmill)	[ ]	[ ]
17.	Have you ever had an abnormal EKG?	[ ]	[ ]
18.	Do you have a history of any of the following:		
	a. High cholesterol	[ ]	[ ]
	b. Smoking more than one pack of cigarettes per day	[ ]	[ ]
	c. Diabetes	[ ]	[ ]
	d. High blood pressure	[ ]	[ ]
	e. Family history of heart attacks	[ ]	[ ]
	f. Being more than 30 lbs. overweight	[ ]	[ ]

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860

LOW BACK PAIN DAILY FUNCTION STATEMENTS

Name: _____ Date: _____

When your back hurts, you may find it difficult to do some of the things you normally do. This list contains sentences that people have used to describe themselves when they have back pain. When you read a sentence that describes the way you are feeling ***today***, mark the box next to it. If the sentence does not describe you, then leave the space blank and go on to the next one.

Check this box if **all** of the answers below apply to you ☐
Check this box if **none** of the answers below apply to you ☐

Because of the pain in my back, I :

- ☐ Stay at home most of the time
- ☐ Stay in bed most of the time
- ☐ Lie down to rest more often.
- ☐ Only stand up for short periods of time
- ☐ Sit down for most of the day
- ☐ Sleep less
- ☐ Go up stairs more slowly than usual
- ☐ Use a handrail to get upstairs
- ☐ Find it difficult to turn over in bed
- ☐ Only walk short distances
- ☐ Walk more slowly than usual
- ☐ Change position frequently to try and make my back comfortable
- ☐ Get dressed more slowly than usual
- ☐ Get dressed with help from someone else
- ☐ Have trouble putting on my socks (or stockings)
- ☐ Find it difficult to get out of a chair
- ☐ Have to hold on to something to get out of a reclining chair
- ☐ Try not to bend or kneel down.
- ☐ Am not doing any of the jobs that I usually do around the house
- ☐ Ask other people to do things for me
- ☐ Avoid heavy jobs around the house
- ☐ Am more irritable and bad tempered with people
- ☐ Do not have a very good appetite

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860