General Information

Name:___________________________________ Birth Date:____/____/____ Age:_____ Today's Date:____/____/____

Address:____City:________________________State:______Zip:____________

S.S.#_______-_____-________Home#(   )_______-________Cellular#(   )_____-_______Work#(   )_____-_______Ext____

E-Mail Address:____Occupation:_______________________________________

Employer's Name: _______________________________________City:___________________State/Zip:_______________

____(M) ____(F) ____Single ____Married ____Divorced ____Widowed   Name of Spouse:_________________________

Name(s) & Age(s) of Kid(s):______________________________________Referred by:_______________________________

Your Health Profile

Why this form is important ~ As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious and sometimes not until it is too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess you current status and more accurately determine your true health potential.

The Beginning Years- Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History – Please check the items that apply to you

___ Mother smoked/drank/drugs during pregnancy ___ Epidural/Meds during labor ___Breech Vaginal Delivery
___ C-Section ___ Forceps Delivery ___ Vacuum Extractor Used
___ Labor Induced ___ Complications
___ Other ____

Childhood to Adult Years (ages 0 to Present) – Please check those items that apply to you

____ Childhood Illness ____Very Active ____ Antibiotics/Other Meds ____ Vaccinated
____ Severe Emotional Trama(s)____
____ Present Smoker ____ Former Smoker ____ OTC/Prescription Meds ____ AlcoholDrug Use
____ Surgery/Stitches ____ Activein Sports ____ Car Accidents ____ Work Injury
____ High Stress Job ____ High Personal Stress ____ Sit a lot ____ Drive a lot
____ Poor Sleep ____ Not Enough Sleep ____ Poor/Inadequate Diet ____ No Exercise
____ Flat Feet ____ Wear Orthotics/Lifts ____ Severe Health Problems ____ Serious/Hard Falls
____ Broken Bones ____ Other Injuries ____
____ Have been under Chiropractic Care in the past ~ How long ago was your last adjustment? ________________________

Addressing the Issues that brought you to our office

** If your have no symptoms or complaints and you are here for wellness care, please check here ____ " **Wish to have Chiropractic Wellness Services"** and skip to **" Family Health Profile"** near the bottom of this form. Otherwise, please continue.

Reason for Contacting Our Office (s): ____
____

How has this affected your life? ____
____

If you have pain, is it… ___Sharp ___Dull ___Constant ___Intermittent ___Traveling ___Radiating
___Mild ___Moderate ___Moderately Severe ___Severe ___Intolerable
Since it began, is it.. ___About the Same ___Getting Better ___Getting Worse ___Variable
Has this condition occurred before? ___Yes ___No

What makes it worse? ____
What makes it better? ____
Does it interfere with… ___Work ___Sleep ___Walking ___Sitting ___Exercise ___Hobbies ___Family Activities
Did you have an injury? ___Yes ___No If Yes, explain____
How long have you have this problem? ____
Is there a time of day that is worse typically? ___Yes ___No If yes, when? __________________________
Other doctors/treatments you have tried for this problem (Please list): ____Chiropractor______________________
____Medical Doctor ____
____Other ____

** Please check all recurring or severe symptoms you have ever had, even if they do not seem related to your current problem(s):

___Headaches/Migraines
___Impotence/Miscarriage
___Loss of Balance
___Nervousness/Anxiety
___Stomach Upset
___Tension/Stress
___Cold Feet
___Hot Flashes
___Heartburn/Reflux
___Ulcers
___Pins & Needles in legs/feet
___Pins & Needles in arms
___Dizziness/Vertigo
___Numbness in fingers
___Fatigue
___Sleeping Problems
___Diarrhea/Constipation/Gas
___Cold Sweats
___High Blood Pressure
___Jaw/TMJ Problems
___Recurring Infection
___Loss of smell
___Buzzing/Ringing in ears
___Numbness in toes
___Depression
___Neck Stiffness/Pain
___Foot Problems
___Light Bothers Eyes
___Pre-Menstrual Synd. (PMS)
___Infertility
___Back Stiffness/Pain
___Sinus/Allergies
___Loss of Taste
___Irritability/Moody
___Cold Hands
___Shortness of Breath
___Problems Urinating
___Menopause
___Other: ____

<u>Family Health Profile</u> – In our office, we are not only interested in your health & well being, but also in that of your family and loved ones. Please mention below any health conditions or concerns you many have about your…

Children: ____
Spouse: ____
Parents: ____
Siblings: ____
Others: ____

Do you: Drink Bottled Water? ___ Yes ___ NO Belonged to a Health Club? ___ Yes ___ NO
Consumed Vitamins or Supplements? ___ Yes ___ NO

Are or do you think you may be pregnant? ___Yes ___No

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge.
I agree to allow this office to examine me for further evaluation.

Signature: ____ Date: _____/_____/_____

Privacy Notice

This notice is effective as of (Date)________________. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have read and fully understand the privacy notice at Broderick Family Chiropractic. I also understand that a copy of this notice is available to me at my request.

____________________________ __________________________ ________
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

______________________ ____________________________ _________
Personal Representative Printed Personal Representative Signature Date

____
Description of the authority to act on behalf of the patient.

Broderick Family Chiropractic
123 Egg Harbor Rd, Suite 307, Sewell, NJ 08080 - 856-228-4477

Low Back Index

Patient Name ___________________________Signature___________________________ Date _______________

This questionnaire will give your provider information about how your low 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 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).

Pain and Medication
(0) I can tolerate the pain without having to use pain medication.
(1) The pain is bad, but I manage without having to take pain medication.
(2) Pain medication provides me with complete relief from pain.
(3) Pain medication provides me with moderate relief from pain
(4) Pain medication provides me with little relief from pain
(5) Pain medication has no effect on my pain.

Walking
(0) Pain does not prevent me from walking any distance.
(1) Pain prevents me from walking more than 1 mile. (1 mile=1.6km)
(2) Pain prevents me from walking more than 1/2 mile.
(3) Pain prevents me from walking more than 1/4 mile.
(4) I can walk only with crutches or a cane.
(5) I am in bed most of the time and have to crawl to the toilet.

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 for more than 1 hour.
(3) Pain prevents me from sitting for more than 1/2 hour.
(4) Pain prevents me from sitting for more than 10 minutes.
(5) Pain prevents me from sitting.

Personal Care
(0) I can look after myself normally without causing extra pain.
(1) I can look after myself normally but it increases my 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.

Social Life
(0) My social life is normal and does not increase my pain.
(1) My social life is normal, but it increases my pain level.
(2) Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
(3) Pain prevents me from going out often.
(4) Pain has restricted my social life to my home.
(5) I have hardly any social life because of my pain.

Standing
(0) I can stand as long as I want without increased pain.
(1) I can stand as long as I want, but it increases my pain.
(2) Pain prevents me from standing more than 1 hour.
(3) Pain prevents me from standing more than 1/2 hour.
(4) Pain prevents me from standing more than 10 minutes.
(5) Pain prevents me from standing at all.

Traveling
(0) I can travel anywhere without increased pain.
(1) I can travel anywhere, but it increases my pain.
(2) My pain restricts my travel over 2 hours.
(3) My pain restricts my travel over 1 hour.
(4) My pain restricts my travel to short necessary journeys under ½ hour.
(5) My pain prevents all travel except for visits to the physician/therapist or hospital.

Employment/House making
(0) My normal homemaking/job activities do not cause pain.
(1*)* My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
(2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming.
(3) Pain prevents me from doing anything, but light duties.
(4) Pain prevents me from doing even light duties.
(5) Pain prevents me from performing any job or house making chores.

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

Broderick Family Chiropractic
123 Egg Harbor Rd, Suite 307, Sewell, NJ 08080 - 856-228-4477

Neck Index

Patient Name ____________________________Signature____________________________ 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 like with no neck pain.
(1) I can read as much as I like with slight neck pain.
(2) I can read as much as I like 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 which come almost all the time.

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