Welcome to Our Office

In order to assist Dr. Fera in evaluating your current health problems, we would ask you to fill out the following forms and questionnaires. It is important that you complete the entire package so that we can determine how best we can help.

Please print the pages enclosed (), and fill in the " New Patient Information", " Symptoms Past and Present" and "Body Pain Diagram" forms. Also fill in the "***Low Back***" and/or "***Neck Pain***" questionnaires (which ever applies). If the problem you are seeking treatment for is neither low back or neck related, please just fill out the "***Body Pain Diagram***".

Sincerely,

Dr. Robert Fera
And Staff

Southside Chiropractic Centre and Acupuncture Clinic

New Patient Information

First Name_____ Initial___ Last Name_____ Sex M / F

Address Information

Street _____ Apt. #_____ City_____ Prov_____

Country_____ Postal/Zip Code_____ Date of Birth (d/m/yr)_____

Home Phone_____ Work Phone_____x_____ Pager/ Cell _____

Email Address_____(We have on line appointment booking services and occasionally publish newsletters which we distribute free of charge. If you are interested in receiving information through e mail please check the following box)

May we contact you though Email Yes No

Current Employment Status (Please Check One) Employed Unemployed Retired Student:School_____

Job Title_____ Employer's Name_____

Employment Address_____

Employment Health Care Insurance Yes No Insurance Company Name _____

Policy Number_____ Group Number_____

OHIP #_____Version Code___ Expiry_____ SIN #_____

If Native Canadian, Band #_____ Registration Number_____

If this is a Workplace Injury Issue, WSIB Claim #_____ Injury Date_____

Employer at Time of Injury_____

How were you referred to this office? (ie Medical Doctor, yellow pages, etc) _____Name_____

Date of onset of your problem_____ Was this an Auto Accident Yes No

If yes, name of your Insurance Company_____ Policy #_____

Have you received prior care for this problem Y N : If Yes, Where_____

Have you seen a Chiropractor in the past Y N: For what reason_____

Have you had X rays for this or any other Problem in the last 2 years Y N, Where_____

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 COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIXED TO BE PAID DIRECTLY TO THIS CHIROPRACTIC WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.**

PATIENT'S/PARENT'S SIGNATURE_____DATE_____

GUARDIAN'S/SPOUSE'S SIGNATURE_____DATE_____

SYMPTOMS: PAST AND PRESENT

Name: _____ File #: _____ Date: _____
(M/D/Y)

- Please check (✓) any conditions or symptoms presently causing you problems.
- Please check (✓) those conditions or symptoms which have been a problem to you in the past.

General Symptoms:
- Loss of consciousness ☐
- Blackouts ☐
- Headache ☐
- Fever ☐
- Sweats ☐
- Fainting ☐
- Dizziness ☐
- Clumsiness ☐
- Loss of sleep ☐
- Numbness, pain or tingling ☐
- Nervousness ☐
- Loss of weight ☐

Muscles & Joints:
- Stiff neck ☐
- Back ache ☐
- Swollen joints ☐
- Painful tail bone ☐
- Foot trouble ☐
- Shoulder pain ☐
- Elbow pain ☐
- Wrist pain ☐
- Hand pain ☐
- Hip pain ☐
- Knee pain ☐
- Arthritis ☐
- Weakness or loss of strength ☐

E.E.N.T.:
- Blurred vision ☐
- Failing vision (one/both eyes) ☐
- Crossed eyes ☐
- Double vision ☐
- Eye pain ☐
- Deafness ☐
- Earache ☐
- Ringing, buzzing, any noise in the ears ☐
- Asthma ☐
- Frequent colds ☐
- Sinus infection ☐
- Enlarged glands ☐
- Enlarged thyroid ☐
- Slurred or other speech problems ☐
- Difficulty swallowing ☐

Respiratory:
- Chronic cough ☐
- Spiting up phlegm ☐
- Spiting up blood ☐
- Chest pain ☐
- Difficult breathing ☐

Cardiovascular
- Bleeding disorder ☐
- High blood pressure ☐
- Pain over the heart ☐
- Stroke ☐
- Hardening of arteries ☐
- Varicose veins ☐
- Swelling of ankles ☐
- Poor circulation ☐
- Heart or blood disease ☐
- Angina ☐

Genitourinary
- Trouble urinating ☐
- Blood in urine ☐
- Kidney infection ☐
- Bed wetting ☐
- Prostate trouble ☐

G.U. for Women
- Painful menstruation ☐
- Excessive flow ☐
- Hot flashes ☐
- Irregular cycle ☐
- Cramps or backache ☐
- Vaginal discharge ☐
- Swollen breasts ☐
- Lumps in breasts ☐

Have you even been on birth control pills? Yes ☐ No ☐

Are you currently taking the birth control pill? Yes ☐ No ☐

pregnancies _____
children _____
abortions _____

Skin:
- Rashes, itching ☐
- Bruise easily ☐
- Dryness ☐
- Boils ☐
- Hives (allergy) ☐
- Poor appetite ☐
- Indigestion ☐
- Excessive hunger ☐
- Belching or gas ☐
- Nausea ☐
- Vomiting (blood?) ☐
- Pain over stomach ☐
- Constipation ☐
- Diarrhea ☐
- Hemorrhoids (piles) ☐
- Jaundice ☐
- Gall bladder trouble ☐
- Intestinal worms ☐
- Ulcer ☐
- Diabetes ☐

Have you ever had any fractures? Yes ☐ No ☐

Have you ever been in a car accident? Yes ☐ No ☐

Have you ever been hospitalized? Yes ☐ No ☐

Have you ever smoked in the past? Yes ☐ No ☐

Are you currently a smoker? Yes ☐ No ☐

Do you take medication on a regular basis? Yes ☐ No ☐

If so, what?

_____

Please inform the Doctor if you have ever tested HIV positive or have been diagnosed with cancer.

LOW BACK PAIN QUESTIONAIRE

Name: _____ File #: _____ Date: _____
(M/D/Y)

Please read instructions:

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

Section 1 – Pain Intensity
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

Section 2 – Personal Care
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing or dressing without help.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. 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 at the most.

Section 4 – Walking
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing plan.

Section 5 – Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one 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 straight away.

Section 6 – Standing
- ☐ I can stand as long as I want without pain
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing plan.
- ☐ I avoid standing because it increases the pain right away.

Section 7 – Sleeping
- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain my normal night's sleep is reduced by less than ½.
- ☐ Because of pain my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents from sleeping at all.

Section 8 – Social Life
- ☐ My social life is normal and give me no pain
- ☐ My social life is normal but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g. dancing etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted by social life to my home.
- ☐ I have hardly any social life because of the pain.

Section 9 – Travelling
- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except when done lying down.

Section 10 – Changing Degree of Plan
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Pain Severity Scale

Rate the Severity of your pain by checking one box on the following scale:

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

NECK DISABILITY INDEX

Name: _____ File #: _____ Date: _____
(M/D/Y)

Please read instructions:

This questionnaire has been designed to give the doctor 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 which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes you 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
- ☐ I can look after myself normally without experiencing extra pain.
- ☐ I can look after myself normally but is causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed; 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 causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. 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 at the most.
- ☐ I cannot lift or carry anything at all.

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 to with moderate pain in my neck.
- ☐ I cannot read as much as I want to 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 on infrequently.
- ☐ I have moderate headaches which come on infrequently.
- ☐ I have moderate headaches which come on frequently.
- ☐ I have severe headaches which come on frequently.
- ☐ I have headaches almost all the time.

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 cannot concentrate at all.

Section 7 - Work
- ☐ I can do as much work as I want to.
- ☐ I 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 cannot 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 cannot 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 cannot drive my car at all.

Section 9 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is only slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed ((1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation
- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain my neck.
- ☐ I can hardly do any of my recreational activities because of pain in my neck.
- ☐ I cannot do any recreational activities at all.

Pain Severity Scale

Rate the Severity of your pain by checking one box on the following scale:

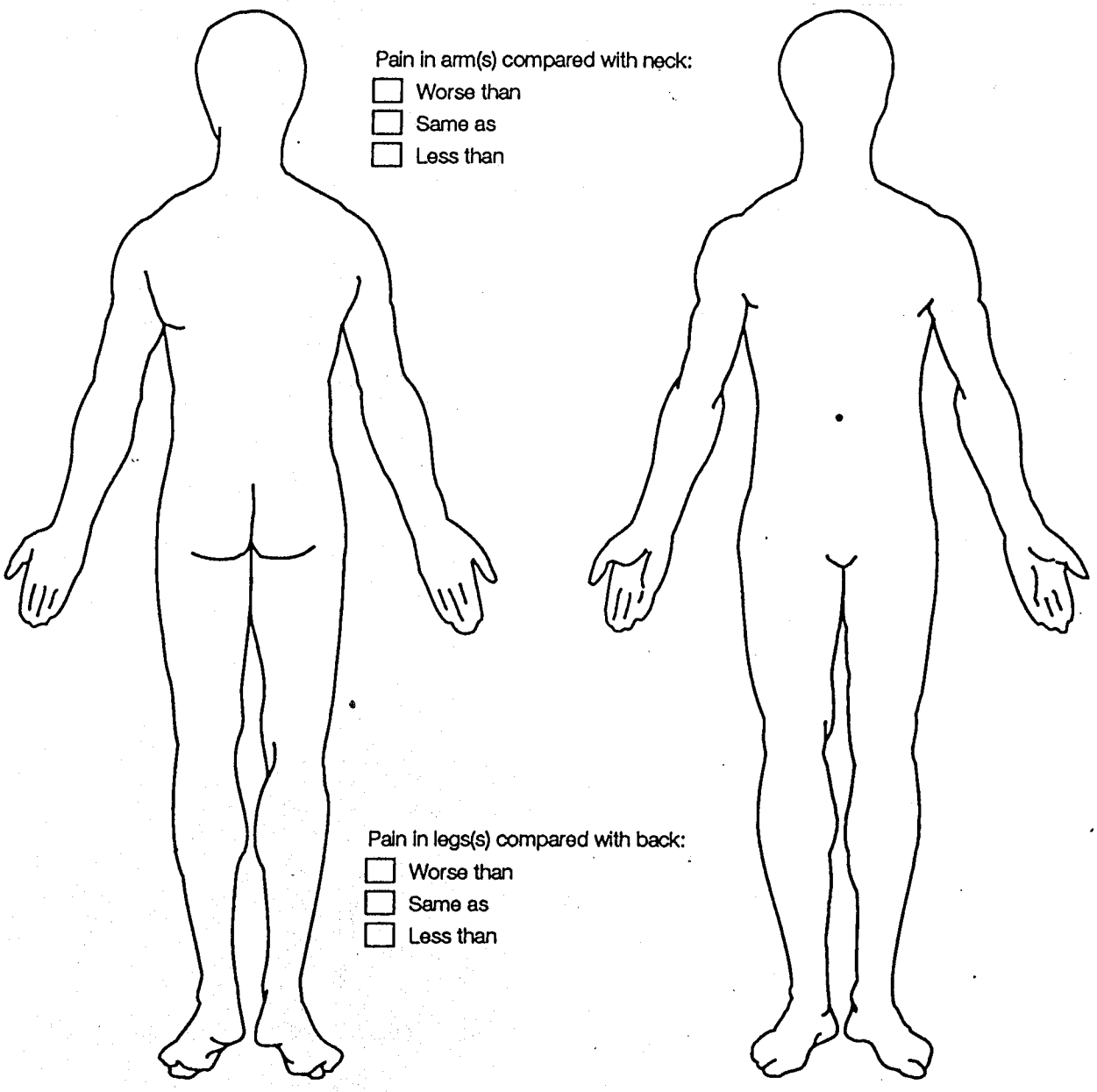
No pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

PATIENT PAIN DRAWING

Name: _____ Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing	Other
▲▲▲	= = =	O O O	x x x	/ / /	• • •



This patient drawing was developed by
the University of Texas Southwestern Medical School Orthopedic Division Spine Care Program.