Pace Chiropractic Clinic
Scott Arnold, DC, DACNB
4497 Hwy 90
Pace, FL 32571

Patient History

Date _____

Name _____ DOB _____ Gender M/F

Address _____ City _____ State/Zip _____

Phone Number _____ E-mail _____

Primary Care Physician _____ Occupation _____

Emergency Contact _____ Marital Status _____

Spouse's Name _____ Spouse's DOB _____

1. List Main Complaints you are having. (in order of importance)

_____

_____

2. Date your complaints started.

_____

3. Rate your pain, by circling a number.

NO PAIN UNBEARABLE PAIN

1 2 3 4 5 6 7 8 9 10

4. How did the pain start?

❑ Suddenly ❑ Gradually

❑ Other (Please Explain) _____

_____

5. Is pain getting:

❑ Better ❑ Worse

❑ Staying the Same

6. What makes the problem worse?

❑ Exercise ❑ Bending forward

❑ Sitting ❑ Bending backward

❑ Standing ❑ Coughing

❑ Walking ❑ Sneezing

❑ Other _____

7. What makes the problem better?

❑ Lying down ❑ Ice

❑ Sitting ❑ Heat

❑ Standing ❑ Exercise

❑ Walking ❑ Nothing

❑ Manipulation ❑ Medication

❑ Other _____

8. Have you had this problem in the past?

❑ Yes ❑ No

9. Have you had any of these diagnostic studies for this problem?

		Date
X-rays	❑	_____
MRI	❑	_____
CT Scan	❑	_____
Nerve Conduction Study / EMG	❑	_____

10. What treatments have you had for this problem?

❑ Physical Therapy

❑ Adjustment / Manipulation

❑ Pain Management

❑ Surgery or Hospitalization

❑ Other _____

_____

Which treatments were helpful?

_____

_____

_____

11. Have you had or do you have any of the following conditions? Check **YES** or **NO**.

Yes No

- ❑ ❑ Cancer- Type/When _____
- ❑ ❑ Diabetes - Type _____
- ❑ ❑ Past / Current use of Cortisone or prednisone
- ❑ ❑ Osteoporosis
- ❑ ❑ Bowel / Bladder problems
- ❑ ❑ Recent fever
- ❑ ❑ Stomach Problems
- ❑ ❑ Arthritis / Gout
- ❑ ❑ Breathing / Chest problems
- ❑ ❑ Sexual difficulties
- ❑ ❑ Unexplained weight loss or gain
- ❑ ❑ Heart problems / High blood pressure
- ❑ ❑ Epilepsy / Stroke
- ❑ ❑ Do you smoke
- ❑ ❑ Alcohol / Drug problems in past
- ❑ ❑ Other _____

If yes please explain: _____

_____

_____

_____

12. Are you pregnant?

❑ Yes ❑ No

13. Are you working?

❑ Yes ❑ No

Last day on job? _____

14. What medication are you currently taking for this problem?

_____

_____

15. List all other current medications and/or vitamins.

_____

_____

_____

16. What are your leisure time activities?

_____

_____

_____

17. List past surgeries and hospitalizations.

_____

_____

_____

_____

18. Do you have any additional information that would be helpful in understanding your problem?

_____

_____

_____

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

Name (Please Print): _____ Date: _____

Age: _____ Date Of Birth: _____ Occupation: _____

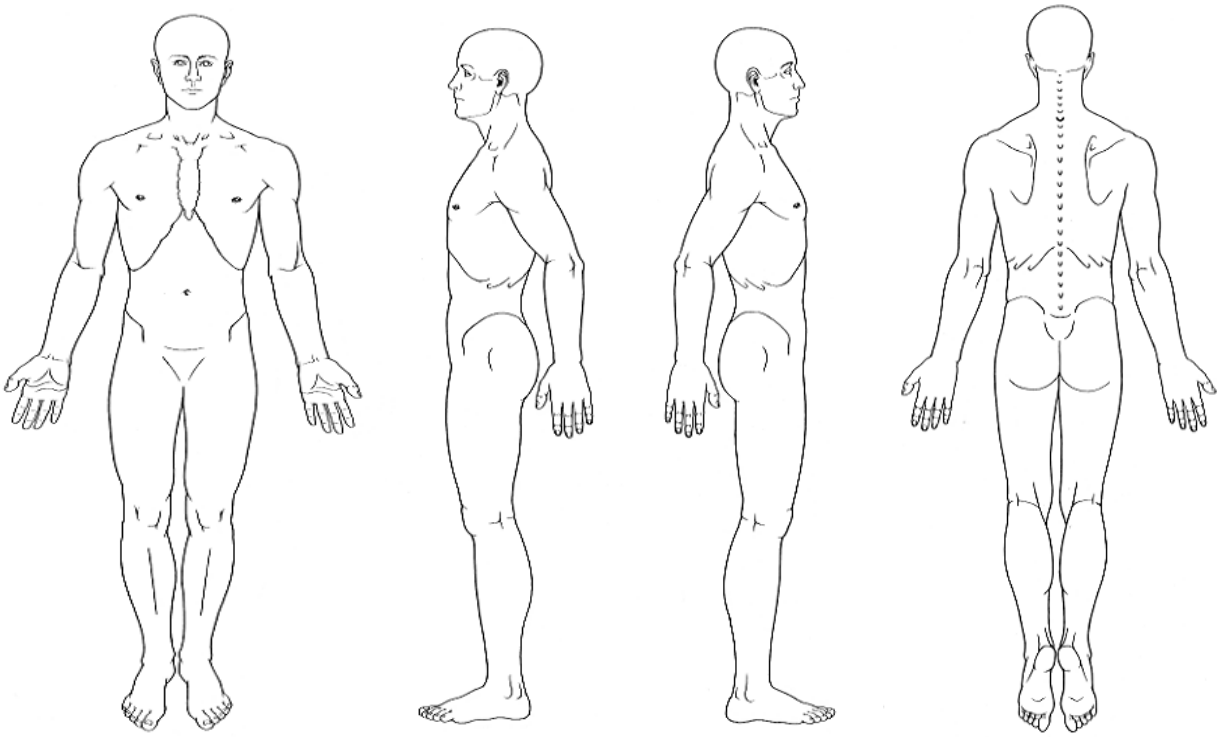
How long have you had this pain? _____ Years _____ Months _____ Weeks

Is this your first episode of this pain? _____ Yes _____ No

Name of Major Medical Health Insurance_____

NOW USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW
(Please remember to complete both sides of this form)

KEY: A= ACHE B= BURNING N= NUMBNESS S= STABBING
P= PINS & NEEDLES O= OTHER



OVER PLEASE

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed. **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** A score of 0 means no disability at all, and a score of 10 signifies that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

1. **Family/ Home Responsibilities.** This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. **Recreation.** This category includes hobbies, sports, and other similar leisure activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. **Social Activity.** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. **Occupation.** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. **Self Care.** This category includes activities which involve personal maintenance and independent daily living (e.g., taking shower, driving, getting dressed, etc.).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. **Life-Support Activity.** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

TOTAL SCORE: _____ SIGNATURE: _____ DATE: _____