DeLand Chiropractic & Spinal Decompression

Demographics, Medical History, Medication Update

Patient name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email: _____ **Phone:** _____

Past Medical History:

O Diabetes I / II / Pre-Diabetes	O Congestive Heart Failure	O Hypo/Hyper Thyroid
O Coronary Artery Disease	O Kidney Disease/Stones	O Celiac Disease
O Heart Attack	O Blood Clotting Issue	O Acid Reflux / GERD
O High Blood Pressure	O Gout	O Osteoarthritis
O Stroke	O Liver Disease / Hepatitis_____	O Gallbladder Disease
O High Cholesterol / Triglycerides	O Constipation / Diarrhea	O Ulcer

O Cancer _____

O Autoimmune Disease _____

O Psychiatric / Emotional Disease _____

O Surgery / Hospitalizations _____

Current Medications / Supplements

1._____ 2._____

3._____ 4._____

5._____ 6._____

Signature: _____ **Date:** _____

PAIN DISABILITY QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in every day activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work Normally — Unable to work at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

5. Does your pain affect your ability to lift overhead, grasp objects or reach for things?
No problems — Can not do at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?
No problems — Can not do at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

8. Has your income declined since your pain began?
No decline — Lost all income
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

9. Do you have to take pain medication every day to control your pain?
No medication needed — Need medication throughout the day
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

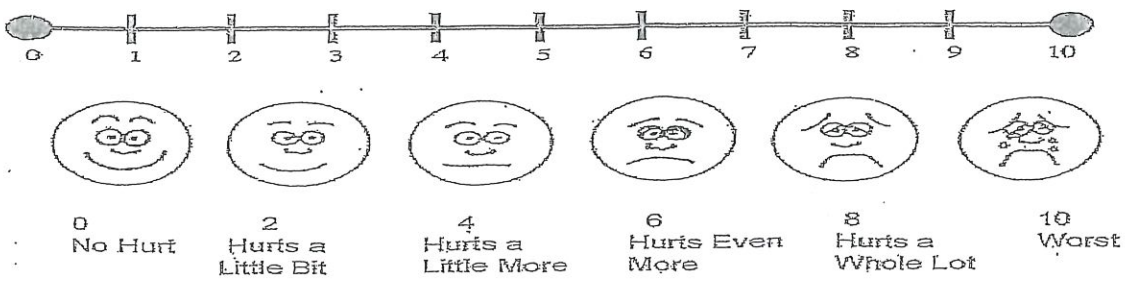
11. Does your pain interfere with your ability to see the people who are important to you?
No problem — Never see them
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

12. Does your pain interfere with recreational activities and hobbies?
No interference — Total interference
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

13. Do you need the help of your family and friends to complete everyday tasks?
Never need help — Need help all the time
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10



Name_____ Date _____

Instrumental Activities of Daily Living Scale (I.A.D.L.)

Choose the option below that best describes your ability:

1. Ability to use the telephone: a. Operates telephone on own initiative. Able to look up and dial numbers, etc. b. Dials a few well-known numbers. c. Answers telephone, but does not dial. d. Does not use telephone at all.	**2. Laundry:** a. Does personal laundry completely. b. Launders small items. c. All laundry must be done by others.
3. Shopping: a. Takes care of all shopping needs independently. b. Shops independently for small purchases. c. Needs to be accompanied on any shopping trip. d. Completely unable to shop.	**4. Mode of transportation:** a. Travels independently on public transportation or drives own car. b. Arranges own travel via taxi, but does not otherwise use public transportation. c. Travels on public transportation when accompanied by another. d. Travel limited to taxi or automobile with assistance of another. e. Does not travel at all.
5. Food Preparation: a. Plans, prepares and serves adequate meals independently. b. Prepares adequate meals if supplied with the ingredients. c. Heats, serves and prepares meals or is able to prepare meals, but does not maintain adequate diet. d. Needs to have meals prepared and served.	**6. Responsibility for own medications:** a. Is responsible for taking medication in correct dosages at correct time. b. Takes responsibility if medication is prepared in advance in separate dosage. c. Is not capable of dispensing own medication.
7. Housekeeping: a. Maintains house alone or with occasional assistance. b. Performs light daily tasks such as dish washing, bed making, etc. c. Performs light daily tasks unsuccessfully. d. Needs help with all home maintenance tasks. e. Does not participate in any housekeeping tasks.	**8. Ability to handle finances:** a. Manages financial matters independently (budgets, check writing, etc. b. Manages day-to-day purchases, but needs help with major purchasing, etc. c. Incapable of handling money.

Katz Basic Activities of Daily Living (ADL) Scale

Check "yes" if you are able to do the task independently or "no" if you are unable.

	YES	NO
1. Bathing – Able to bath without assistance.		
2. Dressing – Able to dress without assistance.		
3. Toileting – Able to use toilet or urinal without assistance.		
4. Transferring – Moves in and out of bed or chair alone.		
5. Continence – Controls bowel and bladder completely by self		
6. Feeding – Feeds self without assistance.		