OAHU SPINE REHAB

Doctors & Therapist from Multiple Working Together for Every Patient.

PATIENT INFORMATION FORM

Date: _____ Patient # _____

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: ☐Male ☐Female

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Insurance Carrier: _____

Policy Number: _____

Name of Subscriber: _____ Date of Birth: _____

Subscriber's Social Security Number: _____

Relationship to Patient: ☐Self ☐Spouse ☐Parent

Are any of these problems related to: ☐Work Injury ☐Auto Accident ☐Other: _____

Who is your Primary Care Provider?

Name: _____ Phone: _____

Occupation: _____ Employer: _____

Emergency Contact and Phone Number: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Spouses Name: _____

Child's Name and Age: _____

Child's Name and Age: _____

Child's Name and Age: _____

Child's Name and Age: _____

How were you referred to our office? _____

Have you consulted a chiropractic before? ☐Yes ☐No When? _____

Signature: _____ Date: _____

Oahu Spine & Rehab 98-1005 Moanalua Rd, SPC 410 Aiea, HI 96701
808-488-5555 www.oahuspineandrehab.com

OAHU SPINE REHAB

Current Health Problems: (What is prompting you to seek our services?)

_____

_____

_____

1. When did you first notice your current symptoms? _____

2. How often do your symptoms occur? ☐Constantly ☐Intermittently

3. Rate your pain on the scale below.

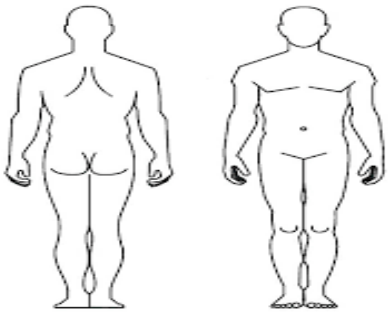
4. Quality of symptoms:
(What does it feel like? Check all that apply)

☐*Numbness* ☐*Tingling*
☐*Dull* ☐*Stiffness*
☐*Aching* ☐*Cramps*
☐*Nagging* ☐*Sharp*
☐*Burning* ☐*Shooting*
☐*Throbbing* ☐*Stabbing*

Other:_____

_____

5. Where does it hurt?
Mark the area(s) on the illustration below.
"O" for current pain *"X" for previous pain*



6. Does the pain radiate to other areas of your body? ☐Yes ☐No

7. What makes the pain better or worse? (Time of day, movement, certain activities, etc.)

_____

_____

8. Prior Interventions: (What have you done to relieve the symptoms?

☐*Prescription medication* ☐*Over-the-counter drugs* ☐*Homeopathic remedies*
☐*Physical therapy* ☐*Surgery* ☐*Acupuncture* ☐*Chiropractic*
☐*Massage* ☐*Ice* ☐*Heat*

9. Does your current condition interfere with your:

Work or Career:	☐*Yes*	☐*No*
Recreational activities:	☐*Yes*	☐*No*
Household responsibilities:	☐*Yes*	☐*No*
Personal relationships:	☐*Yes*	☐*No*

For Office Use Only

Patient Name:

_____

Age: Date of Birth:

_____

Consultation Notes:

Provider Initial: _____

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Oswestry Low Back Pain Scale

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

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The Neck Disability Index

Patient name: _____ File#_____ Date:_____

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 everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the 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 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 gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ 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 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 that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come 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 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 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 (5-7 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 neck pain at all.
- ☐ 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 few of my 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.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

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10. Review of Systems.

Our care focuses on the integrity of your nervous system, which control and regulates your entire body. Please mark any condition that you've **Had** or currently **Have.**

a. Musculoskeletal

Had	*Have*	
☐	☐	Osteoporosis
☐	☐	Knee injuries
☐	☐	Arthritis
☐	☐	Foot/ankle pain
☐	☐	Scoliosis
☐	☐	Shoulder problems
☐	☐	Neck pain
☐	☐	Elbow/wrist pain
☐	☐	Back problems
☐	☐	TMJ issues
☐	☐	Hip disorders
☐	☐	Poor posture
☐		None

b. Neurological & Cardiovascular

Had	*Have*	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Headache
☐	☐	Dizziness
☐	☐	Pins & needles
☐	☐	Numbness
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	High cholesterol
☐	☐	Poor circulation
☐	☐	Angina
☐	☐	Excessive bruising
☐		None

c. Respiratory & Digestive

Had	*Have*	
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Shortness of breath
☐	☐	Pneumonia
☐	☐	Anorexia/bulimia
☐	☐	Ulcer
☐	☐	Food sensitivities
☐	☐	Heartburn
☐	☐	Constipation
☐		None

d. Sensory, Integumentary, Endocrine & Genitourinary

Had	*Have*	
☐	☐	Blurred vision
☐	☐	Ringing in Ears
☐	☐	Hearing loss
☐	☐	Chronic ear infection
☐	☐	Skin cancer
☐	☐	Hair loss
☐	☐	Thyroid issues
☐	☐	Immune disorders
☐	☐	Low energy
☐	☐	Infertility
☐	☐	Bedwetting
☐		None

f. Constitutional

Had	*Have*	
☐	☐	Fainting
☐	☐	Poor appetite
☐	☐	Fatigue
☐	☐	Sudden weight gain/loss
☐	☐	Weakness
☐		None

Past Personal, Family and Social History

Please identify your past health, including accidents, injuries, illnesses and treatments. Please complete each section fully.

11. Illnesses

Had	*Have*	
☐	☐	AIDS
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Arteriosclerosis
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Heart disease
☐	☐	Hepatitis
☐	☐	HIV Positive
☐	☐	Multiple Sclerosis
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Ulcer _____

Other: _____

12. Operations

Surgical interventions, which may or may not have included hospitalization.

☐ Bypass ☐ Cancer
☐ Cosmetic surgery ☐ Eye surgery
☐ Hysterectomy ☐ Pacemaker
☐ Elective Surgery: _____
☐ Spine _____
Other: _____
_____

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13. Treatments

Past	*Current*		*Past*	*Current*	
☐	☐	Acupuncture	☐	☐	Inhaler
☐	☐	Antibiotics	☐	☐	Massage therapy
☐	☐	Birth control pills	☐	☐	Physical therapy
☐	☐	Blood transfusions	☐	☐	Nutritional supplements (list it):
☐	☐	Chemotherapy			_____
☐	☐	Chiropractic care			_____
☐	☐	Dialysis			Medications (prescription & over-the-counter):
☐	☐	Herbs			_____
☐	☐	Homeopathy			_____
☐	☐	Hormone Replacement			_____

14. Injuries *(Have you ever…)*

- ☐ Had a fracture or broken bone
- ☐ Had a spine or nerve disorder
- ☐ Been knocked unconscious
- ☐ Been injured in an accident

15. Family History

Some health issues are hereditary. Tell OSR about the health of your immediate family members.

Relative	*Age (if living)*	*State of Health* Good	Poor	*Illnesses*	*Age at death*	*Cause of death* Natural	Illness
Mother	_____	☐	☐	_____	_____	☐	☐
Father	_____	☐	☐	_____	_____	☐	☐
Sister 1	_____	☐	☐	_____	_____	☐	☐
Sister 2	_____	☐	☐	_____	_____	☐	☐
Brother 1	_____	☐	☐	_____	_____	☐	☐
Brother 2	_____	☐	☐	_____	_____	☐	☐
_____	_____	☐	☐	_____	_____	☐	☐

Are there any other hereditary health issues that you know about? _____

_____

16. Social History

Tell OSR about your stress level and health habits.

"0" No Stress and "5" Great Deal of Stress

Job pressure/stress *0----------1----------2----------3--------- 4----------5*

Alcohol use	☐Daily	☐Weekly	How Much? _____
Coffee use	☐Daily	☐Weekly	How Much? _____
Tobacco use	☐Daily	☐Weekly	How Much? _____
Pain relievers	☐Daily	☐Weekly	How Much? _____
Soft drinks	☐Daily	☐Weekly	How Much? _____
Water intake	☐Daily	☐Weekly	How Much? _____

Hobbies: _____

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17. Activities of Daily Living

How does this condition currently interfere your life and ability to functions?

	No Effect	*Mild Effect*	*Moderate effect*	*Severe Effect*		*No Effect*	*Mild Effect*	*Moderate effect*	*Severe Effect*
Sitting	☐	☐	☐	☐	*Getting in/out of car*	☐	☐	☐	☐
Standing	☐	☐	☐	☐	*Looking over shoulder*	☐	☐	☐	☐
Walking	☐	☐	☐	☐	*Caring for family*	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	*Household chores*	☐	☐	☐	☐
Exercising	☐	☐	☐	☐	*Lifting objects*	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	*Reaching overheads*	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	*Showering or Bathing*	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐	*Dressing myself*	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐					

18. In addition to the main reason for your visit today, what additional health goals do you have?

_____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials

_____ **I instruct the provider to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I acknowledge that OSR is an open office environment and all patients will be treated in close proximity to each other. My visual appearance and words may be overheard by other patients and employees.**

_____ **I acknowledge I have read the OSR policies located at oahuspineandrehab.com/forms and may request a written copy of the Privacy Policy and any other forms. I understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

_____ **I realized that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____**

_____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

_____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I received.**

_____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.**

If the patient is a minor child, print child's full name: _____

Signature: _____ Date (MM/DD/YYYY): _____