



# Irwin Family Chiropractic

Irwin Family Chiropractic  
2351 S Shields St. Ste 2J  
Fort Collins, CO 80526  
(970) 472-8333

## Patient Information and History

Date \_\_\_\_\_

**1** PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State \_\_\_\_\_ Zip \_\_\_\_\_

Birthday: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Parents (if minor) \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated

Spouse Name: \_\_\_\_\_

# Children \_\_\_\_\_

How did you Hear about us? \_\_\_\_\_

**2** INSURANCE

Who is responsible? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance ID number \_\_\_\_\_

Group / Claim number \_\_\_\_\_

Is patient covered by additional insurance? \_\_\_\_\_

Insurance Company \_\_\_\_\_

Subscriber # and name \_\_\_\_\_

Birth Date \_\_\_\_\_ Group# \_\_\_\_\_

**3** ACCIDENT INFORMATION

Is your condition due to an accident? \_\_\_\_\_ Date: \_\_\_\_\_

Type of Accident? \_\_\_\_\_

Have you reported the Accident? \_\_\_\_\_

Insurance  Workers Comp  Employer

Additional Information \_\_\_\_\_

**4** CONTACT INFORMATION

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Best way to reach you?  Home  Cell  Work

Emergency \_\_\_\_\_

**5** PATIENT CONDITION

What is your major complaint? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Have you had the problem before? \_\_\_\_\_

Is this condition getting worse? \_\_\_\_\_ Does anything make it better? \_\_\_\_\_

How would you describe your condition?  Burning  Sharp  Shooting  Dull  Aching  Stiff  Tingling

Throbbing  Swelling Other \_\_\_\_\_

Does this condition interfere with your  Work  Sleep  Daily Routine  Recreation

Specific activities/movements that are painful \_\_\_\_\_



# Health History

What other treatments have you had for this condition?

- Chiropractic
- Orthopedic
- Physical Therapy
- Medication
- Surgery

Are you under care for this condition (if yes who?) \_\_\_\_\_

Have you had previous Chiropractic Care? If yes explain \_\_\_\_\_

Date of Last:    Physical Exam \_\_\_\_\_    Spinal X-Ray \_\_\_\_\_    MRI \_\_\_\_\_  
                          Spinal Exam \_\_\_\_\_    Dental X-Ray \_\_\_\_\_    CT \_\_\_\_\_

List Medication / Supplements \_\_\_\_\_

Check any of the following conditions you have had:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS                 | <input type="checkbox"/> Ear Ringing         | <input type="checkbox"/> Neck Pain            |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Poor Circulation     |
| <input type="checkbox"/> Arm / Shoulder Pain  | <input type="checkbox"/> Headaches-Migranes  | <input type="checkbox"/> Prostate Problems    |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Hemorrhoids         | <input type="checkbox"/> Sciatica             |
| <input type="checkbox"/> Bladder Problems     | <input type="checkbox"/> Herniated Disc      | <input type="checkbox"/> Shingles             |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Infection      |
| <input type="checkbox"/> Chronic fatigue      | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Deafness             | <input type="checkbox"/> Irregular cycle     | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> TMJ                  |
| <input type="checkbox"/> Digestion Problems   | <input type="checkbox"/> Leg Pain            | <input type="checkbox"/> Venereal disease     |
| <input type="checkbox"/> Earache              | <input type="checkbox"/> Low Back Pain       | <input type="checkbox"/> Vertigo/Dizziness    |

### STRESSORS

- |   |             |       |
|---|-------------|-------|
| <input type="checkbox"/> Smoking                | Packs/Day   | _____ |
| <input type="checkbox"/> Alcohol                | Drinks/Week | _____ |
| <input type="checkbox"/> Coffee/Caffeine Drinks | Cups/Day    | _____ |
| <input type="checkbox"/> High Stress Level      | Reason      | _____ |

### EXERCISE

- None
- Moderate
- Daily
- Heavy

Have you had any:	Description	Date
<input type="checkbox"/> Automobile Accidents	_____	_____
<input type="checkbox"/> Surgeries	_____	_____
<input type="checkbox"/> Falls / Head Injury	_____	_____

Please circle any of the following that may be affected by your complaint

- |                               |                                  |                              |                         |
|-------------------------------|----------------------------------|------------------------------|-------------------------|
| almost any movement           | dressing                         | lifting children             | squatting               |
| bathing                       | driving                          | lying down                   | standing                |
| bending                       | eating                           | playing sports               | stooping                |
| bicycling                     | exercising                       | pulling                      | stretching              |
| boating                       | extended computer use            | pushing                      | moving in the morning   |
| carrying                      | gardening                        | reaching                     | turning                 |
| carrying groceries            | getting comfortable              | repetitive motions           | twisting                |
| changing positions            | getting dressed                  | running                      | typing                  |
| cleaning                      | getting up from lying or sitting | shaving                      | urinating               |
| climbing stairs               | going to the bathroom            | sitting for extended periods | walking                 |
| concentrating                 | golfing                          | sking                        | walking short distances |
| cooking                       | has difficulty with standing     | sleeping                     | walks with a limp       |
| coughing and sneezing         | intercourse                      | snowboarding                 | weightlifting           |
| crawling                      | household chores                 | socializing                  | working                 |
| daily child care              | jumping                          | spending time out of bed     | yard work               |
| difficulty getting out of bed | kneeling                         |                              |                         |
|                               | lifting                          |                              |                         |

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/17/2003

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your 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

- Ⓐ 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 very severe.
- ⑤ The pain is very severe and does not vary much.

## Sleeping

- Ⓐ 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 sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## Sitting

- Ⓐ 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 more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## Standing

- Ⓐ I can stand as long as I want without pain.
- ① I have some pain while 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 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## Walking

- Ⓐ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## Personal Care

- Ⓐ I do 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 increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases 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.

## Lifting

- Ⓐ 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.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## Traveling

- Ⓐ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect 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.

## Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- ① My pain fluctuates but overall 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.

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

Back  
Index  
Score

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# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_

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

- Ⓐ 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

- Ⓐ 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

- Ⓐ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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 almost all the time.

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

Neck  
Index  
Score



How do you modify what you do in order to get through the day with your pain?

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How does it affect your work?

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How does it bother you at home?

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How does it bother you during outside activities?

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