Lozier Natural Health Center, PC

Integrative Treatments for Whole Body Health

Last Name: ___________________ First: ___________________________________
Address: ____
City: ______________________ State: ___________ Zip: ____________________
Home Phone: (______) __________________Cell: (_____)_______________________
Email: ____
Date of Birth: _________________ Sex: ☐Male ☐Female
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other
Social Security #: _____________Referred to this office by: ______________

Have you been treated by a physician for any condition in the past year?
☐Yes ☐No If yes by whom? ______________________________
Describe condition: ____

Have you received Chiropractic Care before? ☐ Yes ☐ No
Are you currently receiving Chiropractic Care? ☐ Yes ☐ No

List Current Medications:

1. _________________________ 6. ________________________
2. _________________________ 7. ________________________
3. _________________________ 8.________________________
4. _________________________ 9. ________________________
5. _________________________ 10. _______________________

Any known medication allergies? ☐ Yes ☐ No
List: _____________________________________

List nutritional/ herbal supplements you are currently taking:

1. ____________________________ 4. ______________________
2. ____________________________ 5. ______________________
3. ____________________________ 6.______________________

AUTO ACCIDENT QUESTIONNAIRE

Dear patient:
We need this confidential information answered completely to help us access your need for care. If we do not sincerely believe your condition will respond to chiropractic care, we will not access you as a patient. Thank you.

NAME: ______________________________**DATE OF BIRTH**____________ SS#__________________

NATURE OF AUTO ACCIDENT- Please explain in detail how your accident happened:

1. What was the time and date of your present injury? Date: ___________ Time:________ AM/PM

2. Please explain in detail how your accident happened. (Please include location and conditions.)
____

____

You were heading: □ North □South □East □ West on _____________________ (street or highway)

Other vehicle was headed: □North □South □ East □West on ______________(Street or Highway)

Were police notified? □ Yes □No - You were struck from □ Behind □ Front □ Left side □Right side

You were: □ Driver □ Passenger □ Front seat □ Back seat □ Using seat belt □ Not using seatbelt

3. Did you come in contact with any objects? □ Yes □ No
If yes, what objects (Door, Steering wheel, etc)? ____

4. What parts of your body came in contact with the above object(s)? _______________________________

5. Where did you feel pain or unusual feeling immediately after the accident? _________________________
____

6. Were you unconscious as a result of the injury? _______ If yes, how long? _________________________

7. Were you bleeding as a result of the accident? ________________ Where? _______________________

8. Were you taken to the hospital after your accident? □Yes □ No By ambulance? □Yes □ No
If so, where? _____________________________________
Treating Doctor's name: ______________________ _____DC _____MD _____DO _____DDS

9. Describe the doctor's diagnosis: ____

10. What treatment did you receive? ____

11. Are you still under a doctor's care? □ Yes □ No
If yes, please explain. ____

Past History:

1. Have you ever injured this area before? □ Yes □ No If yes, when? ______________________________

2. If injured before did you lose time from work? □ Yes □ No

3. Have you been involved in any previous accidents of any kind? ☐ Yes ☐ No
If yes, please explain dates and details.____

4. Have you been treated previously by a chiropractor? ☐ Yes ☐ No
If yes, please explain____

PRESENT INFORMATION DISABILITY:

1. Did you lose any time from work? ☐ Yes ☐ No If yes, date of lost time________________________

2. Have you returned to work? ☐ Yes ☐ No If yes, date returned to work________________________

3. Job description: ____

4. Are your work activities restricted as a result of the accident? ________________________

5. Do you have to favor any part of your body in your work? ________________________

6. Since this injury, are your symptoms: ☐ Improving ☐ Getting worse ☐ Same
Please explain ____

7. Do any diseases or accidents affect your employment? ________________________

INSURANCE INFORMATION:

1. Name of driver of vehicle in which you were injured: ________________________

Driver's Insurance Co.: ______________ Agent's name:______________ Phone:______________

POLICY #________________________ CLAIM # ______________

OTHER CARS INSURANCE:

2. NAME OF DRIVER OF VEHICLE (IF ANY): ________________________

Insurance Co.: ______________ Policy Holder:______________ Policy # ______________

CLAIM # ______________ ADJUSTER: ________________________

LEGAL REPRESENTATION:

1. Have you retained an attorney? ☐ Yes ☐ No
If yes, name and address? ____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

________________________ ________________________
Patient's signature Date

________________________ ________________________
Doctors Signature (Upon review) Date

Lozier Natural Health Center, PC

Headache Disability Index

Name: ______________ Date: _________ Age: _____ Scores Total: ______ E_____F____

Instructions: Please Circle the Correct response:

1. I have headaches: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one a week
2. My headache is: (1) mild (2) moderate (3) severe

Instructions: PLEASE READ CAREFULLY: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped			
F2. Because of my headaches I feel restricted in performing my routine daily activities			
E3. No one understands the effect my headaches have on my life			
F4. I restrict my recreational activities because of my headaches.			
E5. My headaches make me angry.			
E6. Sometimes I feel that I am going to lose control because of my headaches.			
F7. Because of my headaches I am less likely to socialize			
E8. My spouse/ significant other, family and friends have no idea what I am going through because of my headaches			
E9. My headaches are so bad that I feel I am going insane.			
E10. My outlook on the world is affected by my headaches			
E11. I am afraid to go outside when I feel a headache starting			
E12. I feel desperate because of my headaches.			
F13. I am concerned that I am paying penalties at work or at home because of			
E14. My headaches place stress on my relationships with family or friends			
F15. I avoid being around people when I have a headache			
F16. I believe my headaches are making it difficult for me to achieve my goals.			
F17. I am unable to think clearly because of my headaches.			
F18. I get tense (e.g. muscle tension) because of my headaches			
F19. I do not enjoy social gatherings because of my headaches.			
E20. I feel irritated because of my headaches			
F21. I avoid traveling because of my headaches			
E22. My headaches make me feel confused			
E23. My headaches make me feel frustrated.			
F24. I find it difficult to read because of my headaches			
F25. I find it difficult to focus my attention away from my headaches and on other things			

Lozier Natural Health Center, PC

Neck Pain Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1—Pain Intensity

A I have no pain at the moment
B The pain is very mild at the moment
C The pain is moderate at the moment
D The pain is fairly severe at the moment
E The pain is very severe at the moment
F The pain is the worst imaginable at the moment

SECTION 2—Personal Care

A I can look at myself normally without causing extra pain
B I can look at myself normally, but it causes extra pain
C It is painful to look at myself and I am slow and careful
D I need some help, but manage most of my personal care
E I need help every day in most aspects of self care
F I do not get dressed; I wash with difficulty and stay in bed

SECTION 3 – Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are positioned, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
E I can lift very light weights
F I cannot lift or carry anything at all

SECTION 4 – Reading

A I can read as much as I want to with no pain in my neck
B I can read as much as I want to with slight pain in my neck
C I can read as much as I want to with moderate pain in my neck
D I cannot read as much as I want to because of moderate pain in my neck
E I cannot read as much as I want to because of severe pain in my neck
F I cannot read at all

SECTION 5 – Headaches

A I have no headaches at all
B I have slight headaches which come infrequently
C I have moderate headaches which come infrequently
D I have moderate headaches which come frequently
E I have severe headaches which come frequently
F I have headaches almost all the time

SECTION 6—Concentration

A I can concentrate fully when I want to with no difficulty
B I can concentrate fully when I want to with slight difficulty
C I have a fair degree of difficulty in concentrating when I try to
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to
F I cannot concentrate at all

SECTION 7—Work

A I can do as much work as I want to
B I can only do my usual work, but no more
C I can do most of my usual work, but no more
D I cannot do my usual work
E I can hardly do any work at all
F I cannot do any work at all

SECTION 8—Driving

A I can drive my car without any neck pain
B I can drive my car as long as I want with slight neck pain
C I can drive my car as long as I want with moderate neck pain
D I cannot drive my car as long as I want because of moderate neck pain
E I can hardly drive at all because of severe neck pain
F I cannot drive my car at all

SECTION 9—Sleeping

A I have no trouble sleeping
B My sleep is slightly disturbed (less than 1 hour sleepless)
C My sleep is mildly disturbed (1-2 hours sleepless)
D My sleep is moderately disturbed (2-3 hours sleepless)
E My sleep is greatly disturbed (3-5 hours sleepless)
F My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10 – Recreation

A I am able to engage in all my recreational activities with no neck pain at all
B I am able to engage in all my recreational activities with some neck pain at all
C I am able to engage in most, but not all of recreational activities because of pain in my neck
D I am able to engage in few of my recreational activities because of pain in my neck
E I can hardly do any recreational activities because of pain in my neck
F I cannot do any recreational activities at all

Patient Signature:______________________________ Date:______________
Comment:____

NECK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print):______________________________ DATE__________________

AGE:______________DATE OF BIRTH:____________ OCCUPATION________________________

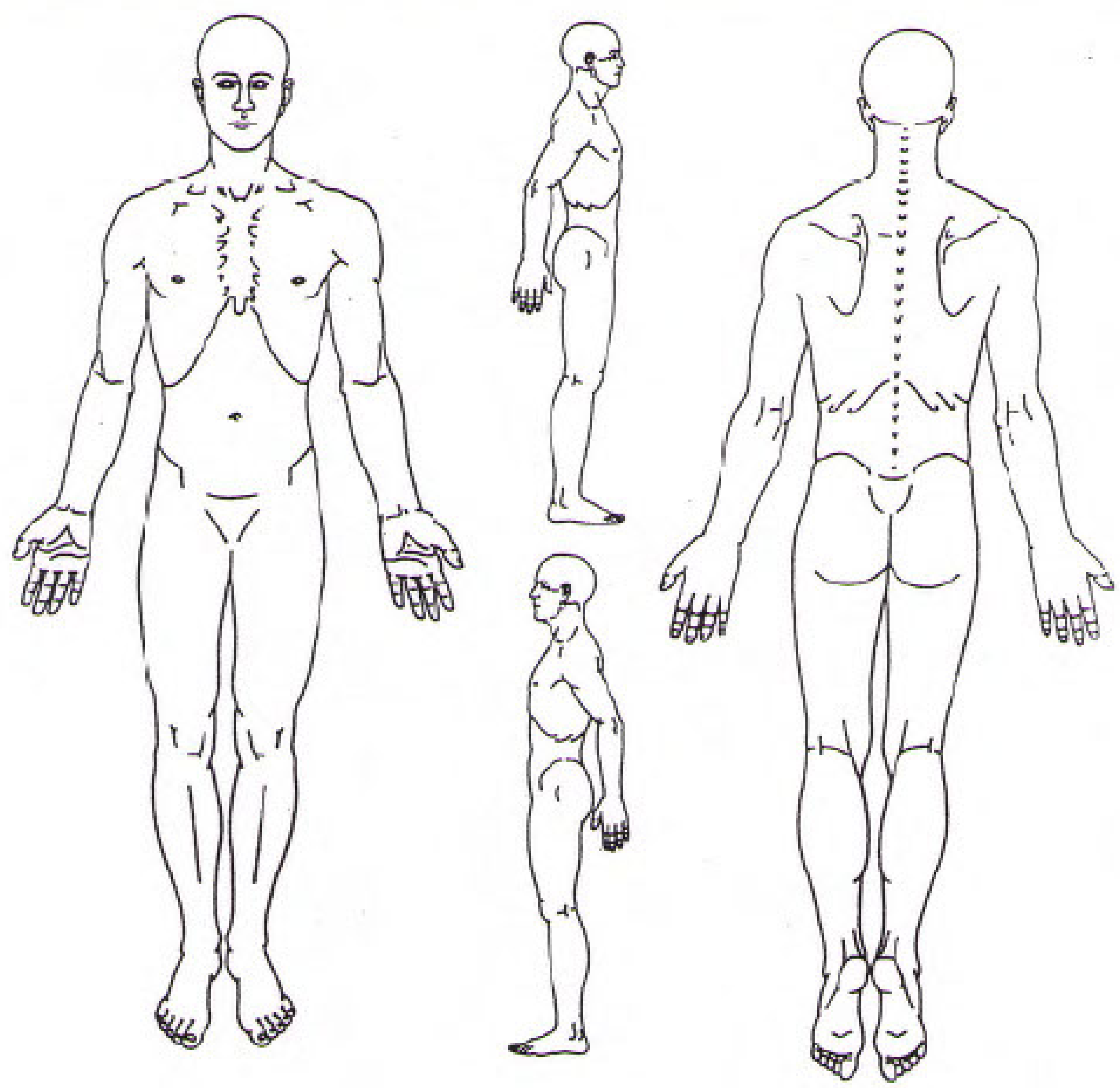
HOW LONG HAVE YOU HAD BACK PAIN? ______YEARS______MONTHS ________WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? _______YES _______NO

USE THE LETTER 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
P=PINS AND NEDLES **S**= STABBING **O**=OTHER



Lozier Natural Health Center, PC

Revised Oswesrty Low Back Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1—Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2—Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to ` change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are positioned, on a table.
E Pain prevents me from lifting heavy weights, but I can manage to lift light to medium weights if they are conveniently positioned.
F I can only lift light weights at the most

SECTION 4 – Walking

A Pain does not prevent me from walking any distance
B Pain prevents me from walking more than one mile
C Pain prevents me from walking more than ½ mile.
D Pain prevents me from walking more than ¼ mile
E I can only walk while using a cane or on crutches
F I am in bed most of the time and have to crawl to the bathroom

SECTION 5 – Sitting

A I can sit in any chair as long as I like without any pain.
B I can only sit in my favorite chair as long as I like
C Pain prevents me from sitting more than one hour
D Pain prevents me sitting more than a half hour
E Pain prevents me from sitting more than ten minutes
F Pain prevents me from sitting at all

SECTION 6—Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than ½ hour without increasing pain
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away

SECTION 7—Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal nights sleep is reduced by less than one quarter.
D Because of pain my normal nights sleep is reduced by less than a half hour.
E Because of pain, my normal nights sleep is reduced by less than three- quarters.
F Pain prevents me from sleeping at all.

SECTION 8—Social Life

A My social life is normal and gives me no pain
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g, dancing, etc
D Pain has restricted my social life and I do not go out often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of my pain

SECTION 9—Traveling

A I get no pain while traveling
B I get some pain while traveling, but none of my usual forms of travel make it any worse
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all form of travel.
F Pain prevents all forms of travel except while done lying down

SECTION 10 – Changing degree of pain

A My pain is rapidly getting better
B My pain fluctuates, but over all is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present
D My pain in neither getting better or worse
E My pain is gradually worsening.
F My pain is rapidly worsening.

Patient Signature:______________________________ Date:_______________
Comment:____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print):______________________________ DATE______________

AGE:__________ DATE OF BIRTH:__________ OCCUPATION______________________

HOW LONG HAVE YOU HAD BACK PAIN? ______YEARS______MONTHS ________WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ______YES ______NO

USE THE LETTER BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form)

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