NECK DISABILITY INDEX

Please check the sentence that is most applicable to you

Name: _____ ***Date:*** _____

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, 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 with moderate pain in my neck.
_ I cannot 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 which come infrequently.
_ I have moderate headaches which come frequently.
_ I have severe headaches which 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 cannot 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 cannot 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 cannot drive my car at all.

Section 9 – Sleeping

_ I have no trouble sleeping.
_ My sleep is slightly disturbed (less than 1 hour sleepless).
_ My sleep is mildly disturbed (1-2 hours sleepless).
_ My sleep is moderately disturbed (2-3 hours sleepless).
_ My sleep is greatly disturbed (3-5 hours sleepless).
_ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

_ I am able to engage in all my recreation activities with no neck pain
_ I am able to engage in all my recreation activities, with some pain in my neck.
_ 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 a few of my usual recreation activities because of pain in my neck.
_ I can hardly do any recreation activities because of pain in my neck.
_ I cannot do any recreation activities at all.

SCORE:_____

OSWESTRY DISABILITY INDEX (BACK PAIN)

Please check the sentence that is most applicable to you

Name: _____ ***Date:*** _____

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 but it is very painful.
_ 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 my personal care.
_ I need help every day in most aspects of self-care.
_ I do not get dressed, 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 (i.e. on a table).
_ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently placed
_ I can lift only very light weights.
_ I cannot lift or carry anything at all.

Section 4 – Walking

_ Pain does not prevent me walking any distance.
_ Pain prevents me walking more than 1mile.
_ Pain prevents me walking more than ¼ of a mile.
_ Pain prevents me walking more than 100 yards.
_ I can only walk using a stick or crutches.
_ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

_ I can sit in any chair as long as I like.
_ I can sit in my favorite chair as long as I like.
_ Pain prevents me from sitting for more than 1 hour.
_ Pain prevents me from sitting for more than ½ hour.
_ Pain prevents me from sitting for more than 10 minutes.
_ Pain prevents me from sitting at all.

Section 6 – Standing

_ I can stand as long as I want without extra pain.
_ I can stand as long as I want but it gives me extra pain.
_ Pain prevents me from standing more than 1 hour.
_ Pain prevents me from standing for more than ½ an hour.
_ Pain prevents me from standing for more than 10 minutes.
_ Pain prevents me from standing at all.

Section 7 – Sleeping

_ My sleep is never disturbed by pain.
_ My sleep is occasionally disturbed by pain.
_ Because of pain, I have less than 6 hours sleep.
_ Because of pain, I have less than 4 hours sleep.
_ Because of pain, I have less than 2 hours sleep.
_ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

_ My sex life is normal and causes no extra pain.
_ My sex life is normal but causes some extra pain.
_ My sex life is nearly normal but is very painful.
_ My sex life is severely restricted by pain.
_ My sex life is nearly absent because of pain.
_ Pain prevents any sex life at all.

Section 9 – Social Life

_ My social life is normal and causes me no extra pain.
_ My social life is normal but increases the degree of pain.
_ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
_ Pain has restricted my social life and I do not go out as often.
_ Pain has restricted social life to my home.
_ I have no social life because of pain.

Section 10 – Traveling

_ I can travel anywhere without pain.
_ I can travel anywhere but it gives extra pain.
_ Pain is bad but I manage journeys of over two hours.
_ Pain restricts me to short necessary journeys under 30 minutes.
_ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.
_ No
_ Yes (if yes, please state the type of treatment you have received)

SCORE:_____

HEALTH HISTORY FORM

Patient's Name: _____ **Date:** _____

PERSONAL INFORMATION:

DOB		Age		Gender		Blood Pressure	
Family Status		Height		Weight		Pulse	
# of Children		Age of Children		Dominant Side			
How Often Do you:	Smoke?		Drink?			Exercise?	

JOB INFORMATION:

Job Title		F/T P/T	Missed Time From Work? Y N	Returned To Work? Y N
Job Duties	Sit Stand Walk	Lift Carry Push Pull Bend Stoop Squat Kneel Reach Grip		
Student		F/T P/T	Missed Time From School? Y N	Returned To School? Y N

MEDICAL HISTORY:

	Y	N		Y	N		Y	N
Blood pressure (high / low)			Chronic neck problems			Infectious disease		
High cholesterol			Chronic back problems			HIV		
Heart attack			Disc bulge/herniation			Hepatitis (A, B or C)		
Heart disease			Disc degeneration			Ear / Hearing problems		
Phlebitis/Varicose veins			Sciatica			Eye / Vision Problems		
Stroke / CVA			Osteoarthritis			Ringing in ears		
Pacemaker / Other device			Rheumatoid arthritis			Are you pregnant?		
Diabetes			Osteoporosis			Due date:		
Skin problems			Headache			Blood disorders		
Allergies / Hypersensitivity			Dizziness / Vertigo			Depression		
Cancer			Scoliosis			Anxiety		
Unexplained weight loss			Fibromyalgia			Nervousness		
Thyroid problems			Chronic Fatigue			Schizophrenia		
Numbness			Asthma			Other: (knee, shoulder, hip, etc)		
Digestive problems			Bronchitis					
Kidney problems			Emphysema					
Liver problems			Shortness of breath					
Gynecological condition			Chronic cough					

Have you suffered any:	Date	Description
Falls		
Head injuries		
Broken bones		
Dislocations		
Work related/Sports injuries		
Previous MVA		
Surgeries/Hospitalizations		
Psychological treatment		
Other		

CURRENT MEDICATIONS/SUPPLEMENTS LIST:

Medication Name	Dose	What Condition Is It For?

FAMILY MEDICAL HISTORY:

Condition	Family Member	Condition	Family Member

PRIOR HISTORY OF CHIEF COMPLAINT(S):

Complaint	Details/Treatment

CHIROPRACTIC SUBJECTIVE REPORT

Patient Name: _____ **Date of Evaluation:** _____

HEADACHES	VAS: / 10 O Improvement O Worse O No Change
Location	O Frontal R O/O Temporal O Parietal L R / L Occipital O Eyes
Frequency	O Constant O Frequent O Occasional
Description	O dull O aching O sharp O pulling O tight O tingling O throbbing O other _____
Aggravation	O Noise O Light O other _____
Relief	O Rest O heat O cold O therapy O meds O nothing O other _____

NECK / UPPER BACK	VAS: / 10 O Improvement O Worse O No Change
Location	O Left O Right O Anterior O Posterior O Lateral O Medial O Inferior O Superior
Frequency	O Constant O Frequent O Occasional
Description	O dull O aching O sharp O pulling O tight O tingling O throbbing O other _____
Aggravation	O flexion O extension O L / R rotation O L / R lateral flexion O sitting O standing O stooping O walking O sleeping O reaching O lifting O carrying O pushing O pulling O other _____
Relief	O Rest O heat O cold O therapy O meds O nothing O other _____
Radiating	Pain radiates to: O R / L Shoulder O R / L Upper arm O R / L Lower arm O R / L Hands & Fingers Other: _____

MID BACK	VAS: / 10 O Improvement O Worse O No Change
Location	O Left O Right O Anterior O Posterior O Lateral O Medial O Inferior O Superior
Frequency	O Constant O Frequent O Occasional
Description	O dull O aching O sharp O pulling O tight O tingling O throbbing O other _____
Aggravation	O flexion O extension O L / R rotation O L / R lateral flexion O sitting O standing O stooping O walking O sleeping O reaching O lifting O carrying O pushing O pulling O O O bending O squatting O kneeling O rise from sit O ascend stairs O descend stairs O other _____
Relief	O Rest O heat O cold O therapy O meds O nothing O other _____

LOW BACK	VAS: / 10 O Improvement O Worse O No Change
Location	O Left O Right O Anterior O Posterior O Lateral O Medial O Inferior O Superior
Frequency	O Constant O Frequent O Occasional
Description	O dull O aching O sharp O pulling O tight O tingling O throbbing O other _____
Aggravation	Lumbar O flexion O extension O L / R rotation O L / R lateral flexion Hip O L / R flexion O L / R extension O L / R adduction O L / R abduction O L/ R INT rotation O L/ R EXT rotation O sitting O standing O stooping O walking O sleeping O reaching O lifting O carrying O pushing O pulling O bending O squatting O kneeling O rise from sit O ascend stairs O descend stairs O other _____
Relief	O Rest O heat O cold O therapy O meds O nothing O other _____
Radiating	Pain radiates to: O R / L Buttocks O R / L Upper leg O R / L Lower leg O R / L Foot & Toes Other: _____

COMMENTS					
NERVOUSNESS/ANXIETY	YES	NO	SLEEP DIFFICULTIES	YES	NO
NAUSEA	YES	NO	DIZZINESS	YES	NO
VOMITING	YES	NO	EXTREMITIES		

CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a

damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____ Date: _____ 20____.
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____ 20____
Signature of Chiropractor

PATIENT: _____ **CHIROPRACTIC INITIAL ASSESSMENT** DATE (m,d,y): _____

SPINAL PALPATION		
L		R
	C0	
	C1	
	C2	
	C3	
	C4	
	C5	
	C6	
	C7	
	T1	
	T2	
	T3	
	T4	
	T5	
	T6	
	T7	
	T8	
	T9	
	T10	
	T11	
	T12	
	L1	
	L2	
	L3	
	L4	
	L5	
	SI	

RANGE OF MOTION

	CERVICAL					THORACIC					LUMBAR				
	0%	25%	50%	75%	100%	0%	25%	50%	75%	100%	0%	25%	50%	75%	100%
Flexion															
Extension															
R – Lat Flex															
L – Lat Flex															
R – Rotation															
L – Rotation															

SOFT TISSUE PALPATION

	CERVICAL					THORACIC					LUMBAR			
	HT L	HT R	SP L	SP R		HT L	HT R	SP L	SP R		HT L	HT R	SP L	SP R
Upper Traps					Mid / Low Traps					Erectors				
Splenius Capitus					Rhomboids					QL				
Subocciptal					Erectors T1-T4					Psoas				
Levator Scap					Erectors T5-T9					ITB / TFL				
SCM					Erectors T10-L2					Piriformis				
Masseters					Latissimus					Hamstrings				

SPINAL ORTHOPEDIC TESTS

C/S	L	R	L/S	L	R	SI	L	R
Valsalva			Trendelberg			Gaenslen		
Houles			Valsalva			Thigh Thrust		
Jackson's			Kemps			Iliac comp		
Compression			SLR			PA PSIS		
Kemps			Braggards					
Soto Hall			Bowstrings					
Shoulder Depression			Thomas					
Brudzinski			Fabere					
			Gaenslen					
T/S			Maignes					
Sternal Compression			Yeoman					

L	CN TESTS-CEREBRAL TEST	R
	Cranial Nerve 2-12	
	Rhomberg's/Pronator Drift	
	Heel Toe Walking	
	Rapid Alt. Mvts	
	Finger to Nose	

NEUROLOGICAL TESTING

	Sensory S/D			Motor X/5			DTR	
C4								
C5								
C6								
C7								
C8							0 = no response	
T1							1+= low	
L1							2+= average	
L2							3+= brisker	
L3							4+= vbrsk,clonus	
L4								
L5								
S1								
S2								

DIAGNOSIS/NOTES: