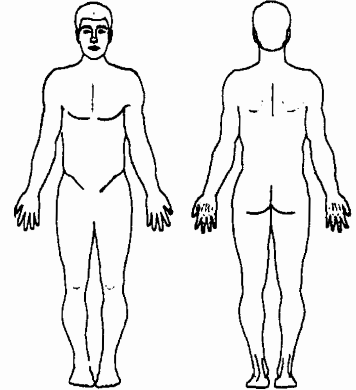
Barger Chiropractic
Health Status

Please fill out as completely as possible

Patient Name ________________ Birthdate ________ Sex M / F
Address ________________ City ________ Status: S M W D
State ____ Zip ______ Telephone (____) ________ Cell # ________
Occupation ________ Employer ________ Work Phone ________
Address ________ City ________ State ____ Zip ______
Subscriber Name ________________ Health Plan: ________
Subscriber ID # ________ Group # ________ Spouse Name ________
Spouse Employer ________ City ________ State ____ Zip ______
Primary Care Dr. ________________ **Email** ________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



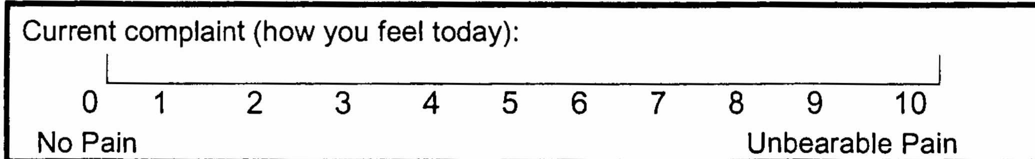
DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-back Pain ☐ Low Back Pain
☐ Other ________________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: ________________

How Problem Began: ________________



Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

How often are your symptoms present?

(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: ________________ **What areas were taken?** ________

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date) ________
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) ________
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) ________

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks ________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries ________
☐ Medications ________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature ________________ **Date** ________

How were you referred? Friend Family Physician Websites: docbarger Folsomchiropractor

Please circle who referred you

Barger Chiropractic
Symptom Intensity and Frequency Form

Date: __________ Patient: ______________________

SECTION 1: Describe on a scale of 1-10 how intense your pain is currently
0-No Symptoms exists
1 to 3-Mild, pain that is an annoyance
4 to 7-Moderate, pain that restricts or limits your ability to perform activities
8 to 10-Severe, pain disables you from doing anything

SECTION 1 CURRENT PAIN INTENSITY LEVELS

Pain Intensity	None	Mild Discomfort Ache/Stiff			Moderate Hurts/Sore/Bearable Sensation				Severe Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand R/L	0	1	2	3	4	5	6	7	8	9	10
Mid Back	0	1	2	3	4	5	6	7	8	9	10
Low Back	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot R/L	0	1	2	3	4	5	6	7	8	9	10

SECTION 2a: CURRENT PAIN FREQUENCY LEVELS
Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	Occasional		Intermittent			Frequent			Constant	
Neck	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand R/L	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low-Back	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot R/L	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

SECTION 2b:CURRENT HEADACHE FREQUENCY & DURATION
During the past week or since the accident/injury of applicable circle the frequency (if less than 1 week) you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

Headache Frequency	None	1 per Week	2 per Week	3 per Week	4 per Week	5 per Week	6 per Week	Daily
Headache Duration (in hours)								

Signature: ______________________________

FUNCTIONAL RATING INDEX

For use With **Neck and/or Back Problems** Only

Patient Name______________________________

In order to properly assess your condition, we must understand how much your **Neck and or/Back** problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed	Moderately disturbed	Greatly disturbed	Totally disturbed

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain, no restriction	Mild Pain no restrictions	Moderate Pain need to go slowly	Moderate Pain need assistance	Severe Pain need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any Activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional pain 25% of day	Intermittent pain 50% of day	Frequent pain 75% of day	Constant pain 100% of day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with Any weight

9. Walking

0	1	2	3	4
No pain any distance	Increased pain after 1 mile	Increased pain after1/2 mile	Increased pain After 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after Several hours	Increased pain After several hours	Increased pain after 1 hour	Increased pain After 1/2 hour	Increased pain with any standing

Patient Signature______________________________ **Date**____________________