LARRY W. FULK, D.C. JAIME N. TRENT, D.C. JUSTIN L. FULK, D.C.

Patient Information

Full Name: ______________________________ Today's Date: ______________
(First) (Middle) (Last)

Address: ______________________________ City: __________ State: ___ Zip: ____________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

E-mail address: ______________________________ Sex: □ Male □ Female

Race / Ethnicity: □ American Indian □ Alaska Native □ Asian □ African American
□ Hispanic or Latino □ Native Hawaiian □ Other Pacific Islander □ White

Primary Language: □ English □ Spanish □ Other: ______________________________

Marital: M S W D Birth Date: ____/____/____ Age: ______ Social Security #: ______-____-_______

Do you have children? □ Yes □ No What ages?______________________________

How were you referred to our office?

□ Friend/Family Member – Who may we thank:______________________________

□ Yellow Pages □ Our Sign □ Newspaper Column □ Fitness Center □ Website □ Mailer

□ Health Screening □ Special Promotion: ______________ □ Other:______________

Occupation: ______________________ Employer: ______________________________

Name of Spouse/Nearest Relative: ______________________________ Phone: ______________

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FULK Chiropractic Nutrition | Acupuncture

LARRY W. FULK, D.C. JAIME N. TRENT, D.C. JUSTIN L. FULK, D.C.

CASE HISTORY

Patient Name: ______________________ Date: __________
(First) (Middle) (Last)

Chief Complaint

What are the symptoms that brought you in to our office? ______________________

Are your symptoms a result of an accident or injury: □ Yes □ No
If "Yes" was the accident/injury related to: □ Work □ Auto □ Other: __________
Please describe the accident or injury: ______________________

Past Conditions

Have you had or do you now have any of the following conditions?

Constitutional
□ Fever
□ Unexplained Weight Loss
□ Unexplained Weight Gain

Eyes/Ears/Nose/Throat
□ Light Bothers Eyes
□ Buzzing in Ears
□ Ringing in Ears
□ Sinus Problems
□ Loss of Smell
□ Loss of Taste

Cardiovascular
□ Chest Pains
□ Chest Tightness
□ High Blood Pressure
□ High Cholesterol
□ Problems Breathing
□ Cold Hands
□ Cold Feet
□ Circulatory Problems
□ Stroke
□ Heart Problems

Gastrointestinal
□ Digestive Problems

Genito-urinary
□ Difficulty Urinating

Neurological
□ Nervousness
□ Irritability
□ Dizziness
□ Depression
□ Memory Loss
□ Anxiety
□ Epilepsy
□ Seizures
□ Convulsions

Other
□ Cancer
□ Rheumatoid Arthritis
□ Osteoarthritis
□ Fatigue
□ Fainting
□ Frequent Colds
□ Diabetes - Type 1
□ Diabetes - Type 2
□ Menstrual Difficulties
□ Sleeping Problems
□ Eating Disorder
□ Alcoholism
□ Drug Addiction
□ HIV Positive

Family Health History

Indicate if any family members have had any of the following conditions? F = Father M = Mother S = Sister B = Brother

______	Arthritis	______	Disc Problems	______	Scoliosis
______	Back Pain	______	Headaches	______	Sinus Trouble
______	Cancer	______	Heart Trouble	______	Stroke
______	Diabetes - Type 1	______	High Blood Pressure	Other:	______
______	Diabetes - Type 2	______	Pinched Nerve	______	

Which of the following most closely describes your smoking history?
□ currently - every day □ currently - some days □ former smoker □ never smoked

Current Medications

Current Medication List - include vitamin supplements (inform the front desk if you need more space)

Medication Name	Dosage	Type
EX: Lisinopril	10 mg	Oral Tablet

Allergies

Drug/Environmental Allergies: ______________________

Surgeries

List any major illnesses, injuries, falls, broken bones, surgeries, or accidents below, **and include dates if possible.**
Women, please include information about pregnancies and childbirth. ______________________

WOMEN ONLY: (THIS SECTION) Is there any possibility you may be pregnant? □ Yes □ No □ ?
Have you: □ Gone through menopause □ Had a hysterectomy

Print Name: ______________________ Date: __________

Sign Name: ______________________ Witness: __________

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NECK DISABILITY INDEX

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 closely describes your problem.**

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.

Personal Care (Washing, Dressing etc.)
A I can look after myself normally without causing extra pain.
B I can look after myself normally but it causes extra pain.
C It is painful to look after 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.

Lifting
A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example 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.

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 because of moderate pain in my neck.
E I can hardly read at all, because of severe pain in my neck.
F I cannot read at all.

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

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 want.
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.
F I cannot concentrate at all.

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.

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

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).

Recreation
A I am able to engage in all recreational activities with no neck pain at all.
B I am able engage in all recreational activities with some neck pain.
C I am able engage in most, but not all recreational activities because of pain in my neck.
D I am able to engage in a few of my usual 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.

Signature:______________________ **Date:**__________

Disability Index Score: ______ %

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LARRY W. FULK, D.C. JAIME N. TRENT, D.C. JUSTIN L. FULK

LOW BACK DISABILITY INDEX

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 closely describes your problem.**

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.

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 increase the pain, but I manage not to change my way of doing it.
D Washing and dressing increase 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.

Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the 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.

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 crutches.
F I am in bed most of the time and have to crawl to the toilet.

Sitting

A I can sit in any chair as long as I like without 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 from sitting more than ½ hour.
E Pain prevents me from sitting more than 10 minutes.
F Pain prevents me from sitting at all.

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 can't stand for more than 10 minutes without increasing pain.
F I avoid standing because it increases the pain.

Sleeping

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

Social Life

A My social life is normal and gives me no pain.
B 1 My social life is normal, but increases my degree of 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 very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

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 me from all forms off travel.
F Pain prevents all forms of travel except that done lying down.

Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Signature:______________________ **Date:**__________

Disability Index Score: [ ] %

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