ALIGN Chiropractic
SPINE & SPORTS REHAB

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Date:_____

Name:_____ DOB:_____ Date of Accident:_____

1. Name of Employer at time of accdent:_____
2. Length of time worked their prior to accident:_____
3. Type of work being done at time of injury:_____

_____

4. In your own words, please describe the accident:_____

_____

_____

_____

5. Have you been treated by another doctor for this accident: ☐ Yes ☐ No

a. If yes, please list doctor's name and address:_____

_____

b. What type of treatment did you receive ?: _____

c. How long were you treated by this doctor ?: _____

6. Is your condition: ☐ Getting better ☐ Getting worse ☐ No change

7. Are you currently taking any medication for this condition ?: ☐ Yes ☐ No

a. If yes, please list the name and dosage:_____

_____

8. Prior to this accident, have you ever had physical complaints similar to what you have now ?: ☐ Yes ☐ No ☐ Not Sure

a. If yes, describe:_____

_____

_____

b. Were these similar complaints the result of a previous accident(s) ? ☐ Yes ☐ No If yes, please describe:_____

_____

_____

9. Have you returned to work since this accident ?: ☐ Yes ☐ No

b. If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS:

BACK PAIN (Complete this section *only* if your pain is related to your back):

1. Currently, I have pain in my: ☐ Low Back ☐ Mid Back ☐ Upper Back
2. My back pain began: ☐ Gradually ☐ Suddenly
3. I have pain: ☐ Constantly (81-100%) ☐ Frequently (51-80%) ☐ Occasionally (26-50%) ☐ Intermittently (25% or less)
4. Does your pain travel or radiate ?: ☐ No ☐ Yes
   a. If yes, where: ☐ Right leg ☐ Left leg ☐ Both legs ☐ Other:_____
5. Do you have any tingling and/or numbness associated with your pain ?: ☐ No ☐ Yes
   a. If yes, where: ☐ Right leg ☐ Left leg ☐ Both legs ☐ Other:_____

BACK DISABILITY INDEX: Please answer ***every section.*** Circle ***only one letter*** in each section that best describes you ***today.***

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 fairly severe at the moment.
D. The pain is very 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 (washing, dressing, etc.)
A. I can look after myself normally without causing extra pain
B. I can look after myself normally but it is very painful.
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, 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 conveniently positioned, e.g. 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 only lift very light weights at most
F. I cannot lift or carry anything at all.

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 1/4 mile.
D. Pain prevents me from walking more than 100 yards.
E. I can only walk while using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
A. I can sit in any chair as long as I like.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1 hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

SECTION 6 - Standing
A. I can stand as long as I want without extra pain.
B. I can stand as long as I want but it gives me extra pain.
C. Pain prevents me from standing more than 1 hour.
D. Pain prevents me from standing more than 1/2 hour.
E. Pain prevents me from standing for more than 10 minutes.
F. Pain prevents me from standing at all.

SECTION 7 - Sleeping
A. My sleep is never disturbed by pain.
B. My sleep is occasionally disturbed by pain.
C. Because of pain I have less than 6 hours' sleep.
D. Because of pain I have less than 4 hours' sleep.
E. Because of pain I have less than 2 hours' sleep.
F. Pain prevents me from sleeping at all.

SECTION 8 - Sex Life (if applicable)
A. My sex life is normal and causes me no extra pain.
B. My sex life is normal, but causes me some extra pain.
C. My sex life is nearly normal, but is very painful.
D. My sex life is severely restricted by pain.
E. My sex life is nearly absent because of pain.
F. Pain prevents any sex life at all.

SECTION 9 - Social Life
A. My social life is normal and causes me no extra pain.
B. My social life is normal, but increases the degree of pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
D. Pain has restricted my social life and I do not go out as often.
E. Pain has restricted my social life to my home.
F. I have no social life because of the pain.

SECTION 10 - Traveling
A. I can travel anywhere without pain.
B. I can travel anywhere but I get extra pain.
C. Pain is bad but I manage journeys over 2 hours.
D. Pain restricts me to journeys of less than 1 hour.
E. Pain restricts me to necessary journeys under 30 minutes.
F. Pain prevents me from traveling except to receive treatment.

NECK PAIN (Complete this section *only* if your pain is related to your neck):

1. My neck pain began: ☐ Gradually ☐ Suddenly
2. I have pain: ☐ Constantly (81-100%) ☐ Frequently (51-80%) ☐ Occasionally (26-50%) ☐ Intermittently (25% or less)
3. Does your pain travel or radiate ?: ☐ No ☐ Yes
   a. If yes, where: ☐ Right arm ☐ Left arm ☐ Both arms ☐ Other:_____
4. Do you have any tingling and/or numbness associated with your pain ?: ☐ No ☐ Yes
   a. If yes, where: ☐ Right arm ☐ Left arm ☐ Both arms ☐ Other:_____

NECK DISABILITY INDEX: Please answer ***every section.*** Circle ***only one letter*** in each section that best describes you ***today.***

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 (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.

SECTION 3 - 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, 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.

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 because of moderate pain in my neck.
E. I cannot read as much as I want 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 want 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 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 my usual work.
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 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 at all because of severe pain in my neck.
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 of my recreational activities without any neck pain.
B. I am able to engage in all of my recreational activities with some pain in my neck.
C. I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D. I am able to engage in a 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.

JOB DESCRIPTION:

1. In a typical workday, I: (***Circle*** *# of hours/activity)*

Sit:	1	2	3	4	5	6	7	8	Hours
Stand:	1	2	3	4	5	6	7	8	Hours
Walk:	1	2	3	4	5	6	7	8	Hours

2. On the job, I perform the following activities (***Place an "X"*** in box that best describes your frequency of listed activity):

	Not at all	Occasionally (33% or less)	Frequently (34% to 66%)	Continuously (More than 66%)
Bend/Stoop				
Squat				
Crawl				
Climb				
Reach Overhead				
Crouch				
Kneel				
Standing				
Pushing/Pulling				
Lifting				

3. On the job, I lift: (Answer only if you perform lifting activity on your job.; ***Place an "X"*** in the box that describes your frequency):

	Not at all	Occasionally (33% or less)	Frequently (34% to 66%)	Continuously (More than 66%)
Up to 10 pounds				
11 to 24 pounds				
25 to 34 pounds				
35 to 50 pounds				
51 to 74 pounds				
75 to 100 pounds				

4. Do you have to perform any bending activity while doing any lifting at work: ☐ Yes ☐ No

5. Are your feet used for repetitive movements, such as in operating foot controls: ☐ Yes ☐ No

6. Do you use your hands for any repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right Hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left Hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. Are you required to work on unprotected heights?: ☐ Yes ☐ No If yes, explain:_____

_____

_____

8. Are you required to be around moving machinery?: ☐ Yes ☐ No If yes, explain:_____

_____

_____

9. Are you exposed to marked changes in temperature and humidity?: ☐ Yes ☐ No If yes, explain:_____

_____

_____

10. Are you required to drive automotive equipment?: ☐ Yes ☐ No If yes, explain:_____

_____

11. Are you exposed to dust, fumes, and/or gases?: ☐ Yes ☐ No If yes, explain:_____

_____

_____

Patient Signature:_____ Date:_____

_____ Date:_____

Leonard J. Kielbasa, DC, CCSP, Cert. MDT