



210 South Street  
Carrollton, Georgia 30117

**(770) 834-6669**

CONFIDENTIAL PATIENT HEALTH HISTORY

Your Title ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Miss ( ) Ms. ( ) Rev. ( ) Sister ( ) Rabbi

Full Name \_\_\_\_\_ Preferred to be called: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender ( ) Male ( ) Female

Race ( ) Caucasian ( ) African American ( ) Hispanic ( ) Asian ( ) Am. Indian ( ) Unspecified ( ) Other

Check Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Social Security # \_\_\_\_\_

Work Status: ( ) Employed ( ) Unemployed ( ) Retired ( ) Student parttime ( ) Student fulltime

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_

Referred by \_\_\_\_\_

Your Spouses' Name \_\_\_\_\_ # of Children \_\_\_\_\_

Spouse Employer \_\_\_\_\_ Spouses work phone \_\_\_\_\_

Name of person to contact in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_

Their home and work phone number \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_

Their phone number \_\_\_\_\_

Health Insurance ( ) Yes I am Insured ( ) I have NO insurance ( ) Yes but I don't know my info

**Please hand INSURANCE CARD to front desk**

Policy Holder ( ) Self ( ) Spouse ( ) Parent/Child ( ) Other

Insured Name \_\_\_\_\_

Insured Address \_\_\_\_\_

Insured City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured Birthdate \_\_\_\_\_ Insured Gender: ( ) Male ( ) Female

Insured Phone \_\_\_\_\_ Insured Employer \_\_\_\_\_

Is this an auto accident? Y/N Do you have an attorney Y/N

Firm Name \_\_\_\_\_ Attorney Name \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Auto Insurance \_\_\_\_\_ Phone Adjuster \_\_\_\_\_

Claim Address \_\_\_\_\_

Claim # \_\_\_\_\_ Policy # \_\_\_\_\_ Med Pay Y/N Limitations \_\_\_\_\_

In order to determine if care can be of benefit to you, this office will extend the courtesy of an initial consultant without charge. If the doctor might be able to help you with your condition, are you interested in seeking care? ( ) Yes ( ) Unsure

**THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.**

I attest that the above information is true and correct to the best of my knowledge. I further understand that any changes incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or statement.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Present Complaints** (please circle the appropriate ones)

Headache	Depression	Constipation	Pins and needles in hands
Mental dullness	Rib Pain	Unbalanced	Right Left
Loss of memory	Back stiffness	Chest pain	Pins and needles in legs
Dizzy	Shortness of breath	Ears ringing/buzzing	Right Left
Neck pain	Upper back stiffness	Midback pain	Midback stiffness
Fainting	Lower back stiffness	Blurred vision	Double vision
Upper back pain	Eye strain/pain	Loss of taste	Loss of smell
Lower back pain	Fear	Tension	Knee pain
Neck restriction	Irritability	Pins and needles in arms	Elbow pain
Nervousness	Head seems heavy	Right / Left	Hand/finger pain
Feet/hands cold	Confusion		

Difficulty in: ( ) Standing ( ) Sitting ( ) Bending ( ) Walking

Pain radiating to: ( ) Right Arm ( ) Left Arm ( ) Right Leg ( ) Left Leg ( ) Neck ( ) Base of Skull  
( ) Ribs ( ) Shoulders

Cannot lift: ( ) Light ( ) Moderate ( ) Heavy ( ) Repetitive

OTHER \_\_\_\_\_

Since the time this (these) complaints(s) began, what, if anything, have you tried that **did not** work?

\_\_\_\_\_

Has the problem interrupted your sleep? ( ) Yes / ( ) No How: \_\_\_\_\_

List any doctors or therapists that you have seen for this complaint:

- 1. \_\_\_\_\_ Specialty \_\_\_\_\_
- 2. \_\_\_\_\_ Speciality \_\_\_\_\_
- 3. \_\_\_\_\_ Speciality \_\_\_\_\_

List any operations that you've had and approximate dates:

- 1. \_\_\_\_\_ Date \_\_\_\_\_ Dr. \_\_\_\_\_
- 2. \_\_\_\_\_ Date \_\_\_\_\_ Dr. \_\_\_\_\_
- 3. \_\_\_\_\_ Date \_\_\_\_\_ Dr. \_\_\_\_\_
- 4. \_\_\_\_\_ Date \_\_\_\_\_ Dr. \_\_\_\_\_

Are you allergic to any medications? Please list \_\_\_\_\_

Are you taking any medications? Please list \_\_\_\_\_

**Please complete the inform on the opposite side. Thank You!**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



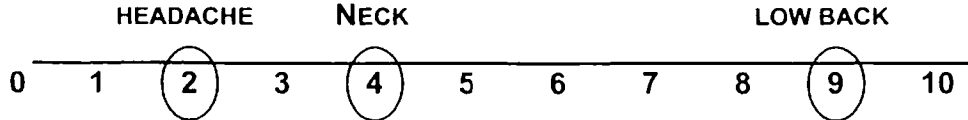
# QUADRUPLE VISUAL ANALOGUE SCALE

Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

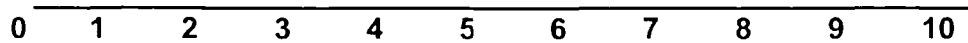
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

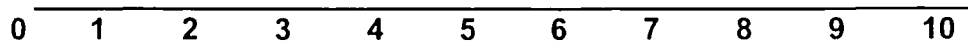
**EXAMPLE:**



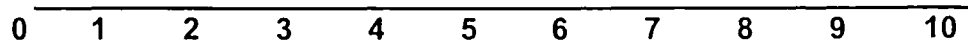
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

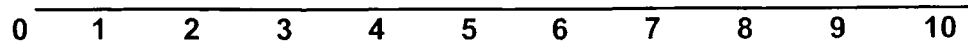


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? \_\_\_\_\_%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? \_\_\_\_\_%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

## HEADACHE DISABILITY INDEX

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SCORES TOTAL: \_\_\_\_\_; E \_\_\_\_\_; F \_\_\_\_\_  
 (100) (52) (48)

**INSTRUCTIONS: Please CIRCLE the correct response:**

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F2. Because of my headaches I feel restricted in performing my routine daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E3. No one understands the effect my headaches have on my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E5. My headaches make me angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E6. Sometimes I feel that I am going to lose control because of my headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F7. Because of my headaches I am less likely to socialize.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E9. My headaches are so bad that I feel I am going to go insane.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E10. My outlook on the world is affected by my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E11. I am afraid to go outside when I feel a headache is starting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E12. I feel desperate because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E14. My headaches place stress on my relationships with family or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F15. I avoid being around people when I have a headache.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F17. I am unable to think clearly because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F18. I get tense (e.g. muscle tension) because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F19. I do not enjoy social gatherings because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E20. I feel irritable because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F21. I avoid traveling because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E22. My headaches make me feel confused.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E23. My headaches make me feel frustrated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F24. I find it difficult to read because of my headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F25. I find it difficult to focus my attention away from my headaches and on other things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

## NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box which applies to you.** We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

### 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.
- I can't 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 which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.  
 (Score x 2) / (Sections x 10) = %ADL

### 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 only 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 can't do any work at all.

### Section 8 – Driving

- I 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 can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't drive my car at all.

### Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

### Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- 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 can't do any recreation activities at all.

Comments \_\_\_\_\_ %ADL

## SHOULDER PAIN SCORE

Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

	<u>None</u>	<u>Light</u>	<u>Average</u>	<u>Severe</u>
Pain at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightly pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems caused by pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incapability of lying on the painful side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>None</u>	<u>Till halfway the upper arm</u>	<u>Till the elbow</u>	<u>Past the elbow</u>
Degree of radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Pain Scale:

Indicate on the line below the number between 0 and 100 that best describes your pain.

No pain is 0  Unbearable pain is 100



## LOW BACK PAIN DISABILITY QUESTIONNAIRE (ROLAND-MORRIS)

Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

SCORE: \_\_\_\_\_

When your back hurts, you may find it difficult to do some of the things you normally do.  
Mark only the sentences that describe you today.

- I stay at home most of the time because of my back.
- I change position frequently to try and get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more often.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back.
- I stand up only for short periods of time because of my back.
- Because of my back, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back pain.
- I have trouble putting on my socks (or stockings) because of pain in my back.
- I sleep less well because of my back.
- Because of back pain, I get dressed with help from someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of back pain, I am more irritable and bad tempered with people than usual.
- Because of my back pain, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

Patient's Name \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

### Low Back Disability Questionnaire (Revised Oswestry)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which MOST CLOSELY describes your problem.

#### Section 1- Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe
- The pain is severe and does not vary much.

#### Section 2- Personal Care (Washing, Dressing, Etc.)

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

#### 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.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights, at the most.

#### Section 4- Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can only walk using a cane or on 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 without pain.
- 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 pain.
- I have some pain while standing, but it does not increase with time.
- Cannot stand for more than 1 hour without increasing pain.
- I cannot stand for more than 30 minutes without increasing pain.
- I cannot stand for more than 10 minutes without increasing pain.
- I avoid standing, because it increases the pain straight away.

### Section 7- Sleeping

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

### Section 8- Social Life

- My social life is normal and gives me no 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. e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of pain.

### Section 9- Traveling

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

### Section 10- Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.