

## **IMPORTANT NOTICES**

### **Do not begin filling out paperwork until you have read these notices!**

1. If for **ANY** reason (high deductible, accident, etc.) you **DO NOT** want your insurance company to be billed for the services rendered by our clinic, please **DO NOT** provide us with your insurance information. In the event we obtain insurance information from you, we are required by law to submit the charges to your insurance company.
  
2. We **MUST** have an **official** job description sent to us from your employer or Human Resources representative. If your employer cannot immediately fax (815-459-3990) or email ([info@strelcheckchiro.com](mailto:info@strelcheckchiro.com)) this information to us, please identify your official job description at [www.occupationalinfo.org](http://www.occupationalinfo.org) and print a copy for our file.  
If you are unemployed, retired, work out of your home or your job duties are not accurately listed on this website, please notify us and we will assist you in completing this requirement.

Strelcheck Chiropractic and Massage Clinic  
10 N. Virginia Street · Crystal Lake · Illinois · 60014  
Tel: 815-459-3860  
Fax: 815-459-3990  
Email: [Info@Strelcheckchiro.com](mailto:Info@Strelcheckchiro.com)

## GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain **presently** prevents you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst.

Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0    1    2    3    4    5    6    7    8    9    10

---

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0    1    2    3    4    5    6    7    8    9    10

---

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0    1    2    3    4    5    6    7    8    9    10

---

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0    1    2    3    4    5    6    7    8    9    10

---

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0    1    2    3    4    5    6    7    8    9    10

---

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0    1    2    3    4    5    6    7    8    9    10

---

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

SCORE \_\_\_\_\_ [60]

BENCHMARK = 5 \_\_\_\_\_

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Patient Primary Language \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Health Plan \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Spouse Name \_\_\_\_\_  
Spouse Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Care Physician Name \_\_\_\_\_ PCP Phone \_\_\_\_\_

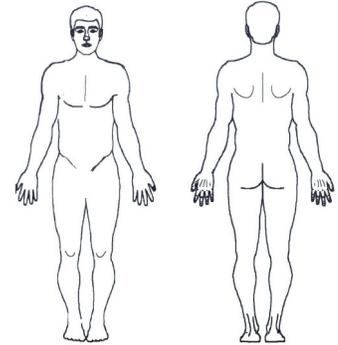
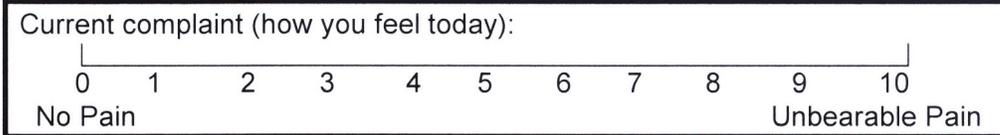
MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

**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**



How often are your symptoms present?  
(Occasional)  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

**In general would you say your overall health right now is:**

Excellent  Very Good  Good  Fair  Poor

**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:**

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence                          | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Recent Fever                                     | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Currently Pregnant, # Weeks _____   |
| <input type="checkbox"/> Stroke (Date) _____                              | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness   |
| <input type="checkbox"/> Taking Birth Control Pills                       | <input type="checkbox"/> Pain Unrelieved by Position or Rest   |
| <input type="checkbox"/> Dizziness/Fainting                               | <input type="checkbox"/> Pain at Night   |
| <input type="checkbox"/> Numbness in Groin/Buttocks                       | <input type="checkbox"/> Visual Disturbances   |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____                     | <input type="checkbox"/> Surgeries _____   |
| <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Tobacco Use - Type _____  |
| <input type="checkbox"/> Epilepsy/Seizures                                | Frequency _____/Day  |
| <input type="checkbox"/> Other Health Problems (Explain) _____            | <input type="checkbox"/> 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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

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



# BACK DISABILITY INDEX

Name: \_\_\_\_\_

Date: \_\_\_\_\_

This questionnaire has been designed to give us 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 the one box that applies to you.** We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that 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: Sleeping

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

## Section 3: Sitting

- I can sit in any chair as long as I want without pain
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than 1 hour
- Pain prevents me from sitting more than ½ hour
- Pain prevents me from sitting more than 10 minutes
- I avoid sitting because it increases pain immediately

## Section 4: Standing

- I can stand as long as I want without pain
- I have some pain with standing and it does not increase
- I cannot stand for longer than 1 hour without increasing pain
- I cannot stand for longer than ½ hour without increasing pain
- I cannot stand for longer than 10 min. without increasing pain
- I avoid standing because it increases pain immediately

## Section 5: Walking

- I have no pain while walking
- I have some pain while walking and it does not increase
- I cannot walk more than 1 mile without increasing pain
- I cannot walk more than ¼ mile without increasing pain
- I cannot walk at all without increasing pain

## Section 6: 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 can manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, and I wash with difficulty and stay in bed

## Section 7: 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 placed, 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 only lift very light weights
- I cannot lift or carry anything

## Section 8: Driving

- I can drive my car without any back pain
- I can drive my car as long as I want with slight pain in my back
- I can drive my car as long as I want with moderate pain in my back
- I can't drive my car as long as I want because of moderate pain in my back
- I can hardly drive at all because of severe pain in my back
- I can't drive my car at all

## Section 9: Recreation

- I am able to engage in all my recreation activities with no back pain at all
- I am able to engage in all my recreation activities, with some pain in my back
- I am able to engage in most, but not all of my usual recreation activities because of pain in my back
- I am able to engage in a few of my usual recreation activities because of pain in my back
- I can hardly do any recreation activities because of pain in my back
- I can't do any recreation activities at all

## Section 10: 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 with slow improvement
- My pain is neither getting better or worse
- My pain is gradually worsening
- My pain is rapidly worsening

## FOR OFFICE USE ONLY:

Score: \_\_\_/50    Transform to percentage score  $x 100 =$     % points

Scoring: For each section the total possible score is 5. If the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example:            16 (total scored)  
                      40 (total possible score)  $x 100 = 40\%$

If one section is missed or not applicable the score is calculated:

Example:            16 (total scored)  
                      35 (total possible score)  $x 100 = 45.7\%$

Minimum Detectable Change (90% confidence): 4 points or 10% points

Strelcheck Chiropractic and Massage Clinic  
10 N. Virginia Street · Crystal Lake · Illinois · 60014  
815-459-3860

# NECK DISABILITY INDEX

Name: \_\_\_\_\_

Date: \_\_\_\_\_

This questionnaire has been designed to give us 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 the one box that applies to you.** We realize you may consider that two or more statements in any one section relate to you, but please just mark the box that 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 can manage most of my personal care
- I need help every day in most aspects of self care
- I do not get dressed, and 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 placed, 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 only lift very light weights
- I cannot lift or carry anything

## 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 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 moderate headaches, which come infrequently
- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently

## 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 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 can't 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 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 mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5+ 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

---

Score: \_\_\_/50      Transform to percentage score  $x 100 =$     % points

---

Scoring: For each section the total possible score is 5. If the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example:            16 (total scored)  
                      50 (total possible score)  $x 100 = 32\%$

If one section is missed or not applicable the score is calculated:

Example:            16 (total scored)  
                      45 (total possible score)  $x 100 = 35.5\%$

Minimum Detectable Change (90% confidence): 5 points or 10% points

Strelcheck Chiropractic and Massage Clinic  
10 N. Virginia Street · Crystal Lake · Illinois · 60014  
815-459-3860

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

## WORKING TOGETHER TO ACHIEVE MORE

As we strive to create mutually beneficial relationships for our patients, please share with us your health care providers name, address and phone number. We would like to invite him/her to be a part of our Strelcheck Preferred & Valued Physician Program.

Patient Referral Name _____	#	Town Located _____
Family Physician _____	#	Town Located _____
OB-GYN _____	#	Town Located _____
Dentist _____	#	Town Located _____
Specialist _____	#	Town Located _____
Other Health Care Professionals _____	#	Town Located _____

### HEALTH CONTINUUM

SEVERE SYMPTOMS	MODERATE SYMPTOMS	MILD SYMPTOMS	REPORTING SOME RELIEF	FEELING BETTER	SYMPTOMS GONE	FEELING GREAT	ENJOYING OPTIMUM HEALTH
/	/	/	/	/	/	/	/

**Please mark "A" on Health Continuum showing how you feel today and mark "B" showing where you want to be.**

**Please check any boxes below that you are interested in or feel you would benefit from in achieving your health goals. The doctor will review and make recommendations.**

**I am not interested in any of these at this time**

#### MASSAGE THERAPY

- Stress Relief
- Deep Tissue/Therapeutic
- Increase circulation
- Energy work
- Lymph draining
- Other \_\_\_\_\_

#### PHYSICAL THERAPY

- Increase strength/energy
- Increase range of motion/Stretching
- Traction/De-compression/Flexion-Distracton
- Pain control/E-stim
- Scar tissue/adhesion breakdown
- Physiotape/Kinesotaping
- Therapeutic ultrasound
- Stability/Proprioceptive/Balance training
- Posture correction
- Other \_\_\_\_\_

#### SUPPORTS

- Orthotics
- Lumbo/Sacral Belt
- Extremity Brace
- Topical Analgesic/Liquid Ice & Liquid Heat
- Ice Packs
- Leg Spacer
- Lumbar Support
- Other \_\_\_\_\_

#### NUTRITION

- Weight loss issues
- Energy issues
- Sugar handling/Diabetes issues
- Digestion issues
- Allergy issues
- Immune system issues
- Detox
- Sleep issues
- Hormonal/Reproductive issues
- Other \_\_\_\_\_

#### NUTRITION CURRENTLY TAKING NONE

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

#### GENERALIZED HEALTH

- Blood Testing/Urine Analysis
- MRI/CT Scan
- Yoga/Pilates/Cross-training/Aerobics
- Natural Childbirth Classes
- Post X-rays

## CARDIAC SCREENING QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Check box if all answers below are No

	Y	N		Y	N
1. Have you ever had any of the following?			6. Are you a heart patient currently under the care of a doctor?		
a. Episodes of passing out	[ ]	[ ]		[ ]	[ ]
b. Unusual shortness of breath	[ ]	[ ]	7. Do you have a history of rheumatic fever?	[ ]	[ ]
c. Unexplained fatigue	[ ]	[ ]	8. Do you have mitral valve prolapse?	[ ]	[ ]
d. Frequent dizziness or lightheadedness	[ ]	[ ]	9. Do you have a history of heart murmur?	[ ]	[ ]
2. Do you ever experience chest tightness, heaviness, pressure, or pain?	[ ]	[ ]	10. Are you over 70?	[ ]	[ ]
3. Are you currently taking any of the following medications? (please circle)			11. Do you have high blood pressure?	[ ]	[ ]
a. Anti-Anginals? (Nitroglycerin, Nitro-Bid, Isordil, Isosorbide Dinitrate, Nitro-patch)	[ ]	[ ]	12. Do you have a pacemaker? Type: _____ Rate: _____	[ ]	[ ]
b. Calcium Channel Blockers? (Cardizem, Diltiazem, Isoptin, Calan, Verapamil, Nifedipine, Procardia, Adalat)	[ ]	[ ]	13. Have you ever had a MI (heart attack)? If so, when? _____	[ ]	[ ]
c. Beta Blockers? (Corgard, Lopressor, Tenormin, Metoprolol, Propanolol, Inderal, Visken, Timolol, Atenolol)	[ ]	[ ]	14. Do you have chronic lung disease, bronchitis, emphysema, wheezing or asthma?	[ ]	[ ]
d. Anti-arrhythmics? (Quindine, Quinaglute, Norpace, Pronestyl, Procan-SR, Procainamide, Tambacor, Amiadarone, Mexitil, Tocainide, Encainide, Tonocard, Enkaid)	[ ]	[ ]	15. Have you ever had heart surgery? If so, when? _____	[ ]	[ ]
e. Digitalis? (Lanoxin, Digoxin)	[ ]	[ ]	16. Have you ever had an abnormal exercise test? (e.g., treadmill)	[ ]	[ ]
f. Diuretics (water pills)? (Lasix, Oretic, Esidrex, Spironactone, Aldactone)	[ ]	[ ]	17. Have you ever had an abnormal EKG?	[ ]	[ ]
g. Anti-hypertensives (blood pressure pills)? (Aldomet, Capropril, Capoten, Apresoline, Minipress, Maxide, Dyazide, Vasotec, Minoxidil, Indapamide, Lozol, Methyl Dopa, Catapres)	[ ]	[ ]	18. Do you have a history of any of the following:		
4. Have you ever had palpitations, skipped beats an irregular beat, or slow beat?	[ ]	[ ]	a. High cholesterol	[ ]	[ ]
5. Do you have a family history of cardiac sudden death? (brothers, sisters, parents grandparents, children)	[ ]	[ ]	b. Smoking more than one pack of cigarettes per day	[ ]	[ ]
			c. Diabetes	[ ]	[ ]
			d. High blood pressure	[ ]	[ ]
			e. Family history of heart attacks	[ ]	[ ]
			f. Being more than 30 lbs. overweight	[ ]	[ ]

Strelcheck Chiropractic and Massage Clinic  
10 N. Virginia Street · Crystal Lake · Illinois · 60014  
815-459-3860

## LOW BACK PAIN DAILY FUNCTION STATEMENTS

Name: \_\_\_\_\_

Date: \_\_\_\_\_

When your back hurts, you may find it difficult to do some of the things you normally do. This list contains sentences that people have used to describe themselves when they have back pain. When you read a sentence that describes the way you are feeling ***today***, mark the box next to it. If the sentence does not describe you, then leave the space blank and go on to the next one.

Check this box if **all** of the answers below apply to you

Check this box if **none** of the answers below apply to you

### **Because of the pain in my back, I :**

- Stay at home most of the time
- Stay in bed most of the time
- Lie down to rest more often.
- Only stand up for short periods of time
- Sit down for most of the day
- Sleep less
- Go up stairs more slowly than usual
- Use a handrail to get upstairs
- Find it difficult to turn over in bed
- Only walk short distances
- Walk more slowly than usual
- Change position frequently to try and make my back comfortable
- Get dressed more slowly than usual
- Get dressed with help from someone else
- Have trouble putting on my socks (or stockings)
- Find it difficult to get out of a chair
- Have to hold on to something to get out of a reclining chair
- Try not to bend or kneel down.
- Am not doing any of the jobs that I usually do around the house
- Ask other people to do things for me
- Avoid heavy jobs around the house
- Am more irritable and bad tempered with people
- Do not have a very good appetite

Strelcheck Chiropractic and Massage Clinic  
10 N. Virginia Street · Crystal Lake · Illinois · 60014  
815-459-3860