Welcome to the Whole Health and Wellness Office of Dr. Mary Medwar!

In order to better serve you, please fill out the following attached forms *thoroughly and completely. Please bring completed paperwork to your appointment. Failure to do so will result in a rescheduled appointment and you will be charged a $75.00 rescheduling fee.*

- ☐ New Patient Information Forms (4 pages)
- ☐ Pain Drawing (2 pages)
- ☐ Revised Oswestry (2 pages)
- ☐ Please bring any x-rays, MRI's and/or lab work
- ☐ Please bring your current insurance card and a photo ID

YOUR INITIAL APPOINTMENT IS ON: _____ for 60 minutes

Please arrive 15 minutes early to confirm paperwork/information

YOUR REPORT OF FINDINGS APPOINTMENTAND FIRST ADJUSTMENT IS

ON:_____ for 30 minutes

We Look Forward to Meeting You!!!

New Patient Information Form - pg 1

PLEASE PRINT CLEARLY

Name:_____ **Date:**_____

First *Middle* *Last*

Physical Address:_____

City:_____ **State:**_____ **Zip:**_____

Mailing Address (if different): _____

City:_____ **State:**_____ **Zip:**_____

Cell #:_____ **Home #:**_____ **Work #:**_____

Cell Phone Provider:_____ **Email Address:**_____

Emergency Contact:_____ **Relationship:**_____

Phone #1:_____ **Phone #2:**_____

Who/How were you referred to us?:_____

Employment Status:_____

Occupation:_____ **Employer:**_____

Date of Birth:_____ **Age:**_____ **Sex:**_____ **Height:**_____ **Weight:**_____

Social Security #_____ **Credit Card #**_____ **Exp date**_____

Insurance Information:

Subscriber:_____ Relationship to patient_____

Subscriber date of birth:_____ SS#_____

Insurance Company:_____ ID number_____

Is patient covered by additional insurance? □ yes □ no

Subscriber:_____ Relationship to patient_____

Subscriber date of birth:_____ SS#_____

Insurance Company:_____ ID number_____

Assignment and Release: I certify that I, my dependent(s), have insurance coverage with_____ and assign directly to Dr. Mary Medwar all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

X_____ _____

Signature of Patient, Parent, Guardian or Representative Print name of Patient, Parent, Guardian or Representative

Date_____ Relationship to patient_____

New Patient Information Form-pg 2

PLEASE PRINT CLEARLY

How would you rank your overall health (Circle One)? Excellent/Fair/Poor/Other:_____

What is your chief complaint(s)/reason(s) you are here? (Feel free to continue on the back of this sheet if needed):

_____

_____

_____

_____

Have you received treatment for above complaint(s)? _____

If yes, please provide details/specifics: _____

_____

_____

_____

When did your symptoms first appear?_____

_____

_____

_____

_____

_____

Is this condition getting progressively worse? ☐ yes ☐ no ☐ unknown

Rate the severity of your condition: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

If you are in pain, how often is it? ☐Random ☐Intermittent ☐Constant ☐Other ☐N/A

Does your condition interfere with: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Does not interfere with my daily routine

Activity or movement that is painful to perform: ☐ Sitting ☐ Standing ☐Walking ☐ Bending

☐ Lying down ☐Other _____ ☐ None

Have you had previous blood work, x-rays, MRI's etc. for your condition? Please list any with approximate dates that apply.

_____

_____

_____

_____

_____

_____

_____

_____

_____

New Patient Information Form - pg 3

PLEASE PRINT CLEARLY

Please list all current pharmaceutical medications you are taking with their dosage information:

☐ I'm not currently taking any medications

1.) _____ 5.)_____

2.) _____ 6.) _____

3.) _____ 7.) _____

4.) _____ 8.) _____

Are you currently under the care of a Primary Care Physician? ☐ yes ☐ no

If so, what is their name? _____ City/State (of Office Location):_____

Have you been under the care of a Chiropractor? ☐ yes ☐ no

If so, what is their name? _____ City/State (of Office Location):_____

Please list any Nutritional Supplements/Vitamins you are taking and their dosages:

1.) _____ 5.)_____

2.) _____ 6.) _____

3.) _____ 7.) _____

4.) _____ 8.) _____

Tobacco use: □ Current daily smoker (# of cigarettes per day_____) □ Former smoker □Never a smoker

Smoking start date: _____smoking quit date:_____

Interest in quitting: 0 - 1 - 2 - 3 - 4 - 5 - 6 -7 - 8 - 9 -10 (0 = no interest, 10 = extremely interested)

Caffeine intake: ☐ I do not have caffeine □Socially only ☐ 1-2 per day (8 oz) ☐ 3 or more per day (8 oz)

Alcohol use: ☐ I do not use alcohol ☐ Socially ☐ 1-2 per day (8 oz) ☐ 3 or more per day (8 oz)

Have you been diagnosed with: ☐ High Blood Pressure ☐ Asthma ☐ Diabetes (☐ type I ☐type II)

Please list any major illnesses you have had with an approximate date of onset:

1.) _____ 5.)_____

2.) _____ 6.) _____

3.) _____ 7.) _____

New Patient Information Form - pg 4

PLEASE PRINT CLEARLY

Please list any accidents, injuries, or surgeries you have had with an approximate date of onset:

1.) _____ 4.)_____

2.) _____ 5.) _____

3.) _____ 6.) _____

Please list any children (including any non-biological children) under your care:

Name:	Age:	Sex:	Any health/physical conditions/concerns?
1.)_____	____	____	_____
2.) _____	____	____	_____
3.) _____	____	____	_____
4.) _____	____	____	_____

Is there any history of serious illness in your family? Circle any that apply.

Cancer / Type I Diabetes / Type II Diabetes / Heart Disease / Stroke / Other:

Please list types of cancer:

1.) _____

2.) _____

3.) _____

Please list any others:

1.) _____

2.) _____

3.) _____

Is there anything we can help you with to make you happier? _____

_____

_____

_____

I have filled out and answered the above information to the best of my ability.

SIGNED: _____ **DATE:** _____

Office Use Only

Height:	Weight:	BMI:	BP:	Pulse:

Revised Oswestry Questionnaire

Name: _____

Date: _____

INSTRUCTIONS: This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage your everyday activities. Please answer each section by marking the ONE CHOICE that most applies to you. We realize you may feel that more than one statement may relate to you, but PLEASE JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Pain Intensity	**Personal Care (Washing, Dressing, Etc.)**
❑ 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.	❑ 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.
Lifting	**Walking**
❑ I can lift heavy weights without extra pain. ❑ I can lift heavy weights, but it causes 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 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 at the most.	❑ Pain does not prevent me from walking any distance. ❑ Pain prevents me from walking more than one mile. ❑ Pain prevents me from walking more than ½ mile. ❑ Pain prevents me from walking more than ¼ mile. ❑ I can only walk while using a cane or on crutches. ❑ I am in bed most of the time and have to crawl to the toilet.
Sitting	**Standing**
❑ I can sit in any chair as long as I like without pain. ❑ I can only sit in my favorite chair as long as I like. ❑ Pain prevents me from sitting more than one hour. ❑ Pain prevents me from sitting more than ½ hour. ❑ Pain prevents me from sitting more than ten minutes. ❑ Pain prevents me from sitting at all.	❑ I can stand as long as I want without pain. ❑ I have some pain while standing, but it does not increase with time. ❑ I cannot stand for longer than one hour without increasing pain. ❑ I cannot stand for longer than ½ hour without increasing pain. ❑ I cannot stand for longer than ten minutes without increasing pain. ❑ I avoid standing because it increases the pain straight away.

Sleeping	Social Life
❑ 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.	❑ My social life is normal and gives me no pain. ❑ My social life is normal, but increases the degree of my 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 the pain.
Traveling	**Changing Degree of Pain**
❑ 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.	❑ 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.

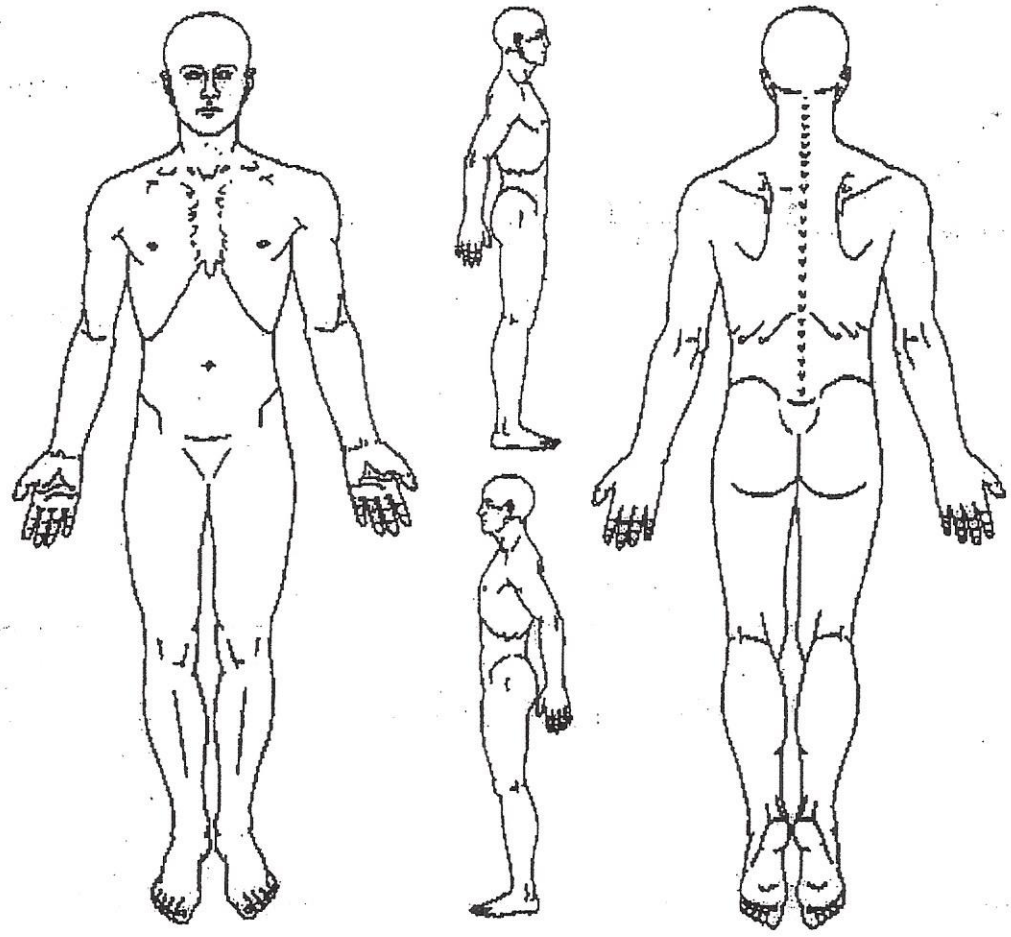
The Pain Drawing

Name_____ DATE_____

How long have you had pain? _____years _____months _____weeks

Using the symbols below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.

A = ACHE **P** = PINS & NEEDLES **N** = NUMBNESS
B = BURNING **S** = STABBING **O** = OTHER



Please fill out other side →

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

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 the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

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1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

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

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

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

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.