

Date: _____ (PLEASE PRINT) ID# _____

PATIENT INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Cell Phone Carrier: _____

Sex: _____ Age: _____ DOB: _____ Circle: Married/Single/Widowed/Divorced/Separated

Employer: _____ Work Phone: _____

Soc. Sec#: _____ Name of Spouse: _____

Email Address: _____ Preferred Method of Contact: _____

Referred to This Office By: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who is Responsible For Your Bill, You and _ Spouse _ Worker's Comp _ Auto Insurance _ Medicare _ Medicaid

_ Other: _____

_ Personal Health Insurance (Name) _____ Health Card # _____

Current Health Condition

Purpose of This Appointment: _____

Other Doctor Seen For Condition: Y/N (circle one)

If yes, Name of Doctor: _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has It Occurred Before: Y/N (circle one)

Is Condition: ___ Job Related ___ Auto Accident ___ Home Injury ___ Fall ___ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident to Your Employer? Y/ N (circle one)

Medication You Now Take: ___ Nerve Pills ___ Pain Killers/Muscle Relaxers ___ Blood Pressure Medication
___ Insulin ___ Other: _____

Do You Wear A Shoe Lift? Y/N (circle one)

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

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PATIENT INFORMATION

Patient Name: _____

Past Health History

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other: _____

Major Accidents or Falls: _____

Hospitalizations (Other Than Above): _____

Previous Chiropractic Care: Y/N (circle one)

If yes, Doctor's Name and Date of Last Visit: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

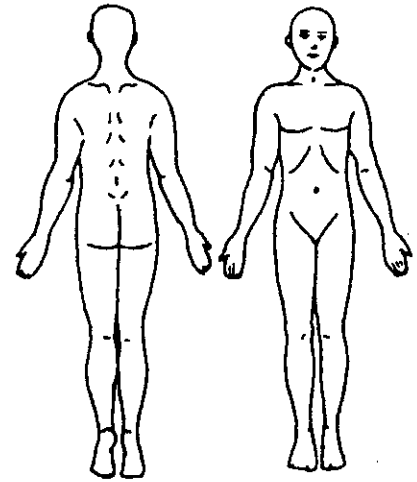
- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature _____

**PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS**

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Relationship

Date Signed ___ / ___ / ___

Patient Name _____

Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by circling the one statement that applies to you. If two or more statements in one section apply please circle the one statement that most closely describes your problem.

Pain Intensity

- 0 I have no pain at the moment
- 1 The pain is very mild at the moment
- 2 The pain comes and goes and is moderate
- 3 The pain is fairly severe at the moment
- 4 The pain is very severe at the moment
- 5 The pain is the worse imaginable at the moment

Sleeping

- 0 I have no trouble sleeping
- 1 My sleep is slightly disturbed (less than 1 hour sleepless)
- 2 My sleep is mildly disturbed (1-2 hours sleepless)
- 3 My sleep is moderately disturbed (2-3 hours sleepless)
- 4 My sleep is greatly disturbed (3-5 hours sleepless)
- 5 My sleep is completely disturbed (5-7 hours sleepless)

Reading

- 0 I can read as much as I want with no neck pain
- 1 I can read as much as I want with slight neck pain
- 2 I can read as much as I want with moderate neck pain
- 3 I cannot read as much as I want because of moderate neck pain
- 4 I can hardly read at all because of severe neck pain
- 5 I cannot read at all because of neck pain

Concentration

- 0 I can concentrate fully when I want with no difficulty
- 1 I can concentrate fully when I want with slight difficulty
- 2 I have a fair degree of difficulty concentrating when I want
- 3 I have a lot of difficulty concentrating when I want
- 4 I have a great deal of difficulty concentrating when I want
- 5 I cannot concentrate at all

Work

- 0 I can do as much work as I want
- 1 I can only do my usual work but no more
- 2 I can only do most of my usual work but no more
- 3 I cannot do my usual work
- 4 I can hardly do any work at all
- 5 I cannot do any work at all

Please turn page over

(Continued)

Personal Care

- 0 I can look after myself normally without causing extra pain
- 1 I can look after myself normally but it causes extra pain
- 2 It is painful to look after myself and I am slow and careful
- 3 I need some help but I manage most of the personal care
- 4 I need help every day in most aspects of self care
- 5 I do not get dressed, I wash with difficulty and stay in bed

Lifting

- 0 I can lift heavy weights without extra pain
- 1 I can lift heavy weights but it causes extra pain
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table)
- 3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- 4 I can only lift very light weights
- 5 I cannot lift or carry anything at all

Driving

- 0 I can drive my car without any neck pain
- 1 I can drive my car as long as I want with slight neck pain
- 2 I can drive my car as long as I want with moderate neck pain
- 3 I cannot drive my car as long as I want because of moderate neck pain
- 4 I can hardly drive at all because of severe neck pain
- 5 I cannot drive my car at all because of neck pain

Recreation

- 0 I am able to engage in all my recreation activities without neck pain
- 1 I am able to engage in all my usual recreation activities with some neck pain
- 2 I am able to engage in most but not all of my usual recreation activities because of neck pain
- 3 I am only able to engage in a few of my usual recreation activities because of neck pain
- 4 I can hardly do any recreation activities because of neck pain
- 5 I cannot do any recreation activities at all

Headaches

- 0 I have no headaches at all
- 1 I have slight headaches which come infrequently
- 2 I have moderate headaches which come infrequently
- 3 I have moderate headaches which come frequently
- 4 I have severe headaches which come frequently
- 5 I have headaches almost all the time

Back Index

Patient Name _____

Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by circling the one statement that applies to you. If two or more statements in one section apply, please circle the one statement that most closely describes your problem.

Pain Intensity

- 0 The pain comes and goes and is very mild
- 1 The pain is mild and does not vary much
- 2 The pain comes and goes and is moderate
- 3 The pain is moderate and does not vary much
- 4 The pain comes and goes and is very severe
- 5 The pain is very severe and does not vary much

Sleeping

- 0 I get no pain in bed
- 1 I get pain in bed but it does not prevent me from sleeping well
- 2 Because of pain my normal sleep is reduced by less than 25%
- 3 Because of pain my normal sleep is reduced by less than 50%
- 4 Because of pain my normal sleep is reduced by less than 75%
- 5 Pain prevents me from sleeping at all

Sitting

- 0 I can sit in any chair as long as I like
- 1 I can only sit in my favorite chair as long as I like
- 2 Pain prevents me from sitting more than 1 hour
- 3 Pain prevents me from sitting more than ½ hour
- 4 Pain prevents me from sitting more than 10 minutes
- 5 I avoid sitting because it increases pain immediately

Standing

- 0 I can stand as long as I want without pain
- 1 I have some pain while standing but it does not increase with time
- 2 I cannot stand for longer than 1 hour without increasing pain
- 3 I cannot stand for longer than 1/2 hour without increasing pain
- 4 I cannot stand for longer than 10 minutes without increasing pain
- 5 I avoid standing because it increases pain immediately

Walking

- 0 I have no pain while walking
- 1 I have some pain while walking but it doesn't increase with distance
- 2 I cannot walk for more than 1 mile without increasing pain
- 3 I cannot walk more than ½ mile without increasing pain
- 4 I cannot walk more than 1/4 mile without increasing pain
- 5 I cannot walk at all without increasing pain

Please turn page over

(Continued)

Personal Care

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

Lifting

- 0 I can lift heavy weights without extra pain
- 1 I can lift heavy weights but it causes pain
- 2 Pain prevents me from lifting heavy weights off the floor
- 3 Pain prevents me from lifting heavy weights off the floor, but I can manage
- 4 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
- 5 I can only lift very light weights

Traveling

- 0 I get no pain while traveling
- 1 I get some pain while traveling but none of my usual forms of travel make it worse
- 2 I get extra pain while traveling but it does not cause me to seek alternate forms of travel
- 3 I get extra pain while traveling which causes me to seek alternate forms of travel
- 4 Pain restricts all forms of travel except that done while lying down
- 5 Pain restricts all forms of travel

Social Life

- 0 My social life is normal and gives me no extra pain
- 1 My social life is normal but increases the degree of pain
- 2 Pain has no significant affect on my social life apart from limiting my more energetic interests (dancing)
- 3 Pain has restricted my social life and I do not go out very often
- 4 Pain has restricted my social life to my home
- 5 I have hardly any social life because of pain

Changing degree of pain

- 0 My pain is rapidly getting better
- 1 My pain fluctuates but overall is definitely getting better
- 2 My pain seems to be getting better but improvement is slow
- 3 My pain is neither getting better or worse
- 4 My pain is gradually worsening
- 5 My pain is rapidly worsening