

Patient Personal/Confidential Data

No. _____
Name: _____ Date of Birth: _____ Age: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Social Security # _____ Home Phone: _____ Cell Phone: _____ E-Mail: _____
Employer: _____ Address: _____ Work #: _____
Name of spouse: _____ SS#: _____ # of Children: _____
Spouse employer: _____ Address: _____
How did you learn of this clinic? _____
Nearest Relative not living with you? _____ Phone# _____
Who is responsible for payment? Self Spouse Other: _____

Patient's Insurance:

Spouse's Insurance:

Name of Insurance Co. _____ Name of Insurance Co. _____
Address: _____ Address: _____
ID & Group# _____ ID & Group # _____
Phone # _____ Phone # _____

Purpose of your appointment and list your complaints: _____

Date of Illness: _____ Time: _____ AM PM Location : _____

How did the injury occur? Auto On the job Other _____

Please describe the circumstances and what makes the condition better or worse? _____

Other doctors seen for this condition? _____

have you been treated by a doctor for any other health conditions within the last year? Yes No

If yes, please describe: _____

INSURANCE INFORMATION

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN AGREEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS CHIROPRACTIC OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE CO. AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS CHIROPRACTIC OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

Signature Patient: _____ Signature Physician: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge. Including, and not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

Patient's Signature: _____ Date: _____

Parent (Guardian) Signature: _____ Date: _____

HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES NO

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

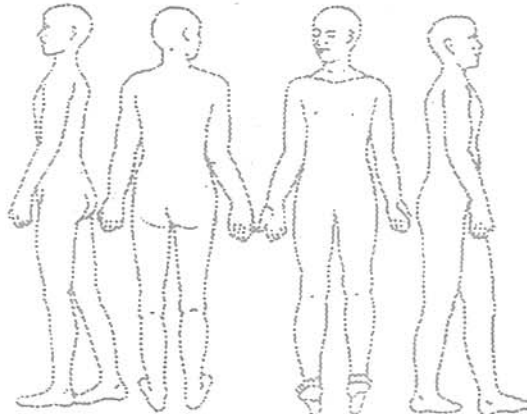
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- _____

SYMPTOM LOCALIZATION



- P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

..... DO NOT WRITE BELOW THIS LINE.....

Patient Accepted? Yes No Doctor's Signature _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may apply to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity

1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

Section 2 – Personal Care

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

Section 3 – Lifting

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

Section 4 – Reading

1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want to with moderate pain in my neck.
4. I cannot read as much as I want because of moderate pain in my neck.
5. I cannot read as much as I want because of severe pain in my neck.
6. I cannot read at all.

Section 5 – Headaches

1. I have no headaches at all.
2. I have slight headaches, which come infrequently.
3. I have moderate headaches, which come infrequently.
4. I have moderate headaches, which come frequently.
5. I have severe headaches, which come frequently.
6. I have headaches almost all of the time.

Section 6 – Concentration

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

Section 7 – Work

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

Section 8 – Driving

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

Section 9 – Sleeping

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

Section 10 – Recreation

1. I am able to engage in all of my recreational activities, with no neck pain at all.
2. I am able to engage in all of my recreational activities, with some pain in my neck.
3. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
4. I am able to engage in a few of my usual recreational activities because of pain in my neck.
5. I can hardly do any recreational activities because of pain in my neck.
6. I cannot do any recreational activities at all.

Comments: _____

Patient's Signature: _____ Date: _____

CURRENT SYMPTOMS

Name: _____ Date: _____

NECK PAIN

DATE OF ONSET:

- Sudden
- Gradual
- Chronic

CAUSE OF PAIN

- Unknown
- Accident
- Slip/Fall
- Work Injury

AGGRAVATING SYMPTOMS

- Bending
- Twisting
- Lifting
- Standing
- Sitting
- Laying Down
- All Movements
- Others _____

DURATION

- Constant
- Frequent
- Comes & Goes

WHAT HELPS

- Rest
- Pain Meds
- Ice
- Heat
- Lying Down
- Sitting
- Nothing
- Other: _____

DESCRIPTION

- Sharp
- Burning
- Stabbing
- Deep

DESCRIPTION

- Dull
- Achy
- Stiff
- Numbness
- Tingling
- Other: _____

RADIATE

- Head (L-R)
- Shoulder (L-R)
- Arm/Hand (L-R)
- Fingers (L-R)

SEVERITY of PAIN: NONE → 0 1 2 3 4 5 6 7 8 9 10 ← SEVERE

UPPER/MID BACK PAIN

DATE OF ONSET:

- Sudden
- Gradual
- Chronic

CAUSE OF PAIN

- Unknown
- Accident
- Slip/Fall
- Work Injury

AGGRAVATING SYMPTOMS

- Bending
- Twisting
- Lifting
- Standing
- Sitting
- Laying Down
- All Movements
- Others _____

DURATION

- Constant
- Frequent
- Comes & Goes

WHAT HELPS

- Rest
- Pain Meds
- Ice
- Heat
- Lying Down

- Sitting
- Standing
- Nothing

DESCRIPTION

- Sharp
- Burning
- Stabbing
- Deep
- Dull
- Achy
- Stiff
- Other: _____

SEVERITY of PAIN: NONE → 0 1 2 3 4 5 6 7 8 9 10 ← SEVERE

LOW BACK PAIN

DATE OF ONSET:

- Sudden
- Gradual
- Chronic

CAUSE OF PAIN

- Unknown
- Accident
- Slip/Fall
- Work Injury

AGGRAVATING SYMPTOMS

- Bending
- Twisting
- Lifting
- Standing
- Sitting
- Laying Down
- All Movements
- Others _____

DURATION

- Constant
- Frequent
- Comes & Goes

WHAT HELPS

- Rest
- Pain Meds
- Ice
- Heat
- Lying on Back
- Sitting
- Walking
- Nothing

DESCRIPTION

- Sharp
- Burning
- Stabbing
- Deep

DESCRIPTION

- Dull
- Achy
- Stiff
- Numbness
- Tingling
- Other: _____

RADIATE

- Hip (L-R)
- Thigh (L-R)
- Knee (L-R)
- Leg (L-R)
- Foot (L-R)
- Toes (L-R)

SEVERITY of PAIN: NONE → 0 1 2 3 4 5 6 7 8 9 10 ← SEVERE

CURRENT SYMPTOMS

Name: _____ Date: _____

HEADACHE PAIN

DATE OF ONSET:

- Sudden
- Gradual
- Chronic

CAUSE OF PAIN

- Unknown
- Accident
- Slip/Fall
- Work Injury

AGGRAVATING

SYMPTOMS

- Bending
- Twisting
- Walking
- Standing
- Sitting
- Laying Down
- All Movements
- Others _____

DURATION

- Constant
- Frequent
- Comes & Goes

WHAT HELPS

- Rest
- Pain Meds
- Ice
- Heat
- Lying on Back
- Sitting
- Standing
- Walking

DESCRIPTION

- Sharp
- Pounding
- Stabbing
- Deep

DESCRIPTION

- Dull
- Achy
- Throbbing
- Numbness
- Tingling
- Other: _____

LOCATION

- Back of Head
- Top of Head
- Forehead
- Behind Eyes

SEVERITY of PAIN: NONE → 0 1 2 3 4 5 6 7 8 9 10 ← SEVERE

LIST OTHER PAINS:

DATE OF ONSET:

- Sudden
- Gradual
- Chronic

CAUSE OF PAIN

- Unknown
- Accident
- Slip/Fall
- Work Injury

AGGRAVATING

SYMPTOMS

- Bending
- Twisting
- Lifting
- Standing
- Sitting
- Walking
- Laying Down
- All Movements
- Others _____

DURATION

- Constant
- Frequent
- Comes & Goes

WHAT HELPS

- Rest
- Pain Meds
- Ice
- Heat
- Lying on Back
- Sitting
- Standing
- Walking

DESCRIPTION

- Sharp
- Burning
- Stabbing
- Deep
- Dull

DESCRIPTION

- Achy
- Stiff
- Numbness
- Tingling
- Other: _____

SEVERITY of PAIN: NONE → 0 1 2 3 4 5 6 7 8 9 10 ← SEVERE

Use the letters below to indicate the type and location of your complaints. Please complete the front/sides/back.

KEY: A=ACHE B=BURNING N=NUMBNESS P=PAIN O=OTHER

