CHIROPRACTIC

Bringing Out The Best In You

Patient _____

Doctor _____

Date _____ Case # _____

⊙ New Patient

Welcome To Our Office

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Is it okay to contact you at work? ❍ no ❍ yes Work # _____

E-mail address _____ Web site _____

SS# _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed

Spouse's name _____ Phone #(s) _____

Children's names and ages _____

_____

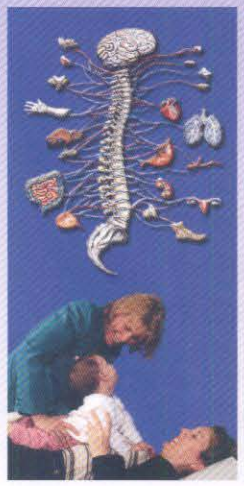
Do you have any pets? ❍ no ❍ yes If yes, please tell us what kind(s) _____

_____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

Favorite hobbies or interests _____



What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes

If yes, please tell us the doctor's name _____

Were you pleased with your care? ❍ no ❍ yes

How did you find out about our office? _____

Is this appointment related to ❍ work ❍ sports ❍ auto ❍ personal injury ❍ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone _____

Are you receiving care from other health professionals? ❍ no ❍ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ❍ no ❍ yes If yes, what month? _____

This form continues. Please turn the page.

Current Health

What are your most pressing health concerns? _____

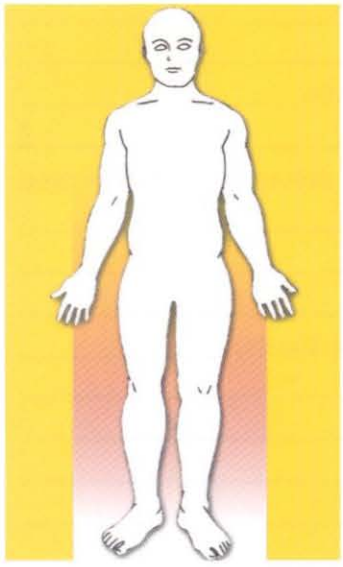
_____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent
❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.



❍ Front _____

_____

_____

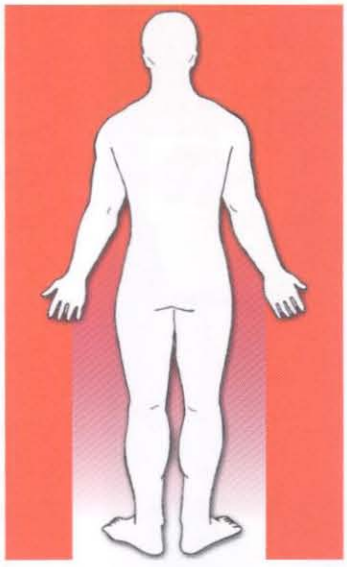
_____

❍ Back _____

_____

_____

_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking ❍ bending ❍ lying down ❍ weather

Please explain _____

Do you feel ❍ cramps ❍ burning ❍ other _____
❍ swelling ❍ stiffness

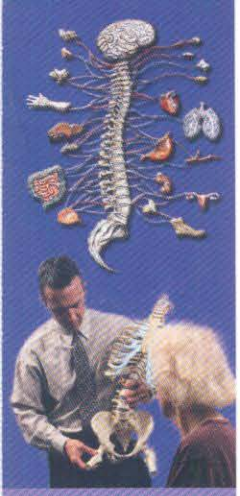
Do your symptoms interfere with ❍ work ❍ sleep ❍ other _____
❍ day-to-day activities ❍ play

Please explain _____

_____

On a scale of 1-10 *(1 least, 10 most)*, please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10



Health History

Do you have, or have you had, any of the following (*please check ☑ all that apply*)

- ❍ pneumonia
- ❍ mumps
- ❍ influenza
- ❍ rheumatic fever
- ❍ smallpox
- ❍ pleurisy
- ❍ polio
- ❍ chickenpox
- ❍ thyroid disease
- ❍ diabetes
- ❍ epilepsy
- ❍ cancer
- ❍ depression
- ❍ whooping cough
- ❍ anemia
- ❍ eczema
- ❍ measles
- ❍ arthritis
- ❍ heart disease
- ❍ rashes

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you use

- ❍ coffee
- ❍ tea
- ❍ artificial sweeteners
- ❍ sugar
- ❍ alcohol
- ❍ cigarettes
- ❍ recreational drugs

Have you ever suffered from (*please check ☑ all that apply*)

- ❍ neck pain
- ❍ low back pain
- ❍ headache
- ❍ migraines
- ❍ arm back/tingling
- ❍ shoulder pain
- ❍ hand pain/tingling
- ❍ leg pain/tingling
- ❍ jaw pain
- ❍ chest pain
- ❍ lung problems
- ❍ heart problems
- ❍ abnormal blood pressure
- ❍ irregular heartbeat
- ❍ ankle swelling
- ❍ cold extremities
- ❍ blurred vision
- ❍ vision problems
- ❍ difficulty breathing
- ❍ stuffy nose
- ❍ allergies
- ❍ fainting
- ❍ weight loss
- ❍ poor appetite
- ❍ excessive appetite
- ❍ nervousness
- ❍ confusion
- ❍ depression
- ❍ dental problems
- ❍ excessive thirst
- ❍ frequent nausea
- ❍ vomiting
- ❍ prostate problem
- ❍ breast pain/lump
- ❍ cramps
- ❍ painful urination
- ❍ bladder trouble
- ❍ excessive urination
- ❍ discolored urine
- ❍ gas/bloating after meals
- ❍ heartburn
- ❍ colitis
- ❍ irritable bowel
- ❍ black or bloody stools
- ❍ constipation
- ❍ hemorrhoids
- ❍ liver problems
- ❍ stroke
- ❍ paralysis
- ❍ tingling
- ❍ numbness
- ❍ fatigue
- ❍ dizziness
- ❍ loss of sleep
- ❍ difficulty hearing
- ❍ ear pain

If applicable, date of last menstrual period _____

Past injuries can affect present health (*please check ☑ all that apply*)

- ❍ falls/accidents
- ❍ sports injuries
- ❍ spinal tap
- ❍ use(d) a cane or walker
- ❍ knocked unconscious
- ❍ head injuries
- ❍ broken bones
- ❍ surgery
- ❍ extensive dental work
- ❍ fights
- ❍ dislocations
- ❍ traction
- ❍ dental appliances

If yes to any of the above, please describe _____

_____

_____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

_____

Do any friends or relatives see chiropractors? ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you?

❍ no ❍ yes If yes, please tell us. _____

_____

_____

_____

Notes _____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care?

❍ Cash ❍ Check ❍ Credit Card # _____ Exp. _____

Insurance co. _____ Group Policy # _____

Address _____ Phone # _____

Insured's name _____

Relation _____ Insured's employer _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)

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Welcome to our wellness center,

Today we are here to discover your goals and priorities as it relates to your health and wellness. Your answers will help us determine how we can best help you.

Let's get started...

On a scale of 1 – 10, rate the importance for you to achieve the following:
1 = not important 10 = necessary

Get fit	1	2	3	4	5	6	7	8	9	10
Eat better	1	2	3	4	5	6	7	8	9	10
Reduce stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Reduce pain	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my posture	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Learn about wellness	1	2	3	4	5	6	7	8	9	10
Learn about wellness products that are right for me	1	2	3	4	5	6	7	8	9	10
Other _____	1	2	3	4	5	6	7	8	9	10

Which of the above would you say is the most important goal for you to achieve and why?

_____

_____

_____

Have you ever attempted to accomplish this goal in the past? Yes No

If yes, what happened and what prevented you from maintaining your results? _____

_____

Do you have any questions or comments? _____

_____

_____

_____

Remember: your health is your greatest asset, the more of it you have the healthier you are.

We look forward to helping you Discover Wellness.

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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 THEONE 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 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 wan 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: _____

ROLAND MORRIS DISABILITY INDEX

Name:_____ **Date:**_____
File#_____
(Please Print)

When your back hurts, you may find it difficult sometimes to do some of the things you normally do. Please check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- ☐ I stay home most of the time because of my back.
- ☐ I change positions 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 of the 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.
- ☐ Because of my back, I have to hold on to something to get out of the easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I try to not bend or kneel.
- ☐ I find it very 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.
- ☐ I have trouble putting my socks (stockings) on because of my back.
- ☐ I only walk short distances because of my back pain.
- ☐ I sleep less well because of my back pain.
- ☐ Because of my 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 my back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the day because of my back.

Form by Roland M. Morris, Morris R. Spine 1983; 8(2): 141-144. Lippincott-Raven Publishers

Chiropractic HIPPAA Form

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protection health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or using, a civil, criminal, or administrative action or proceeding, and protecting health information that is subject to law that prohibits access to protection health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or release disclose any part of your protection health information for purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this Notice Of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an account of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name_____ Signature_____ Date_____