

Patient history

Name: _____ DOB: _____ Address: _____
 City: _____ Zip: _____ Phone: _____
 Occupation: _____ Employer: _____ Married: y/n
 children: _____ Who can we thank for referring you? _____

Major complaint: _____

How long have you had it: _____ Approximate date of onset: _____

Pain level at its best: _____ at its worst: _____ Does it interfere with: work__ sleep__ recreation__
 daily routine.

Is it painful when you: Sit _____ Stand _____ Walk _____ Bend _____ Lie Down _____

Type of pain (all that apply): sharp__ dull__ throbbing__ numb/tingly__ achy__ shooting
 Burning__ cramps__ stiffness__ swelling__ other _____

What percentage of the day do you feel it: _____ Is it constant: Y/N How many lost work
 days: _____ Have you had a similar condition in the past: Y/N When? _____

Is this related to a work or auto accident: Y/N When was your last visit to a chiropractor:
 _____ Chiropractor last seen; _____

Were You Helped? _____ Did they recommend a spinal stability Plan: Y/N

Did you follow the recommendations Y/N

____ Fractures ____ Auto accidents ____ accidental falls ____ Concussions ____ back curvature
 ____ anxiety/depression ____ arthritis ____ diabetes ____ swollen/painful joints ____ epilepsy ____ skin
 issues ____ cancer ____ colds ____ mental disorders ____ anemia ____ excess sweating ____ tremors
 ____ light sensitivity ____ allergies or asthma ____ sinus ____ light headed upon rising ____ craving
 sweet or salty ____ Eating disorders ____ Trouble sleeping ____ trouble concentrating ____ memory
 loss ____ learning disabled ____ headache ____ neck pain R/L ____ numbness or tingling in arms,
 hands or fingers ____ jaw pain ____ head seems heavy ____ pain when in the same position too
 long ____ shoulder pain R/L ____ Dizziness ____ ringing in ears ____ Hearing loss ____ ear infections
 ____ Blurred or double vision ____ upper back pain ____ mid back pain ____ Low back pain
 ____ Numbness or tingling in the buttocks, legs, feet or toes ____ pain when cough sneeze or strain
 with stools ____ hip pain ____ foot trouble ____ chest pain ____ lung issues ____ stroke
 ____ heart problems ____ high or low blood pressure ____ varicose veins ____ liver trouble ____ gall
 bladder issues ____ digestive issues ____ colon trouble ____ diarrhea/constipation
 ____ Hemorrhoids ____ prostate problems ____ impotence ____ kidney trouble ____ kidney stones
 ____ frequent urination ____ menstrual problems ____ menopause ____ Breast issues
 ____ pregnant ____ bedwetting

Exercise	Work activity	Habits	Injuries/Surgeries	approximate date
____ None	____ Sitting	____ Smoking	Falls _____	
____ Moderate	____ Standing	____ Alcohol	Head injuries _____	
____ Daily	____ Light labor	____ Caffeine	Surgeries _____	
____ Heavy	____ Heavy labor	____ Stress	Broken Bones _____	

What is your health philosophy _____

How do you want us to handle your problem: _____ Temporary relief (help symptom but do not fix the problem)?
_____ Correction (Correct the problem to prevent pain and gain stability)

Please tell us what your expectations are of us? _____

What are your current hobbies? _____

How are your current issues affecting your activities? _____

Rate on a scale of 1-10 (10 being most and 1 being least)

_____ Desire to get rid of your current condition

_____ Desire to prevent the same condition in the future

_____ prevent arthritis, spinal instability

Please list all current prescription drugs and supplements you are currently taking.

Who else have you seen for this condition: _____

How long have you been seeing? _____ What did they do to help? _____

Please feel free to discuss our fees we will go over our "Good Faith" estimate required by the new healthcare laws.

FOR DOCTOR

Soap: _____

Signature: _____ Date: _____

Oswestry Questionnaire

PLEASE READ: This questionnaire gives the doctor information as to how your pain affects your ability to manage everyday life. Please answer each section by selecting only ONE CHOICE which most applies to you right now.

Neck Disability Index

Section 1: Pain Intensity	
A	No neck pain.
B	Mild, constant pain.
C	Moderate, intermittent pain.
D	Moderate, constant pain.
E	Severe, intermittent pain.
F	Severe, constant pain.
Section 2: Personal Care (washing, dressing, etc.)	
A	No neck pain looking after myself.
B	No increased pain while looking after myself.
C	Increased pain while looking after myself.
D	Significant pain while looking after myself.
E	Severe pain while looking after myself.
F	I cannot look after myself & stay in bed.
Section 3: Lifting	
A	No pain when lifting heavy objects.
B	Slight pain when lifting heavy objects.
C	Cannot lift heavy objects off floor.
D	Can lift light/medium objects only from table.
E	Can only lift light objects.
F	Cannot lift anything at all.
Section 4: Reading	
A	No neck pain while reading.
B	Slight pain while reading.
C	Moderate pain, does not limit my reading.
D	Moderate pain, limits my reading.
E	Severe pain, limits my reading.
F	Cannot read due to severe pain.
Section 5: Headaches	
A	No headaches.
B	Occasional, slight headaches.
C	Occasional, moderate headaches.
D	Frequent, moderate headaches.
E	Frequent, severe headaches.
F	Headaches almost all the time.

Section 6: Concentration	
A	No difficulty concentrating.
B	Slight difficulty concentrating.
C	Moderate difficulty concentrating.
D	A lot of difficulty concentrating.
E	Great deal of difficulty.
F	Cannot concentrate at all.
Section 7: Work (Daily Activities)	
A	I can do as much as I want to.
B	I can do only my usual activities.
C	I can do most of my usual activities.
D	I cannot do my usual activities.
E	I can hardly do any of my usual activities.
F	I cannot do any of my usual activities.
Section 8: Driving	
A	No neck pain while driving.
B	Slight pain while driving.
C	Moderate pain, does not limit my driving.
D	Moderate pain, limits my driving.
E	Severe pain, limits my driving.
F	Cannot drive due to severe pain.
Section 9: Sleeping	
A	No trouble sleeping.
B	Less than 1 hour of disturbed sleep.
C	1-2 hours of disturbed sleep.
D	2-3 hours of disturbed sleep.
E	3-5 hours of disturbed sleep.
F	5+ hours of disturbed sleep.
Section 10: Recreation (Not Daily Activities)	
A	No pain during activities.
B	Occasional pain, but does not limit activities.
C	Occasional pain, but does limit activities.
D	Frequent pain during activities.
E	Severe pain during activities.
F	I cannot do any activities.

Low Back Pain Disability Index

Section 1: Pain Intensity	
A	No low back pain.
B	Mild, constant pain.
C	Moderate, intermittent pain.
D	Moderate, constant pain.
E	Severe, intermittent pain.
F	Severe, constant pain.
Section 2: Personal Care (washing, dressing, etc.)	
A	No low back pain looking after myself.
B	No increased pain while looking after myself.
C	Increased pain while looking after myself.
D	Significant pain while looking after myself.
E	Severe pain while looking after myself.
F	I cannot look after myself & stay in bed.
Section 3: Lifting	
A	No low back pain when lifting heavy objects.
B	Slight pain when lifting heavy objects.
C	Cannot lift heavy objects off floor.
D	Can lift light/medium objects only from table.
E	Can only lift light objects.
F	Cannot lift anything at all.
Section 4: Walking	
A	No low back pain while walking at all.
B	Some back pain, but does not increase with distance.
C	Pain limits distance to less than 1 mile.
D	Pain limits distance to less than 1/2 mile.
E	Pain limits distance to less than 1/4 mile.
F	I cannot walk without increased pain.
Section 5: Sitting	
A	I can sit in any chair without pain.
B	I can sit only in my favorite chair.
C	I can only sit for less than 1 hour.
D	I can only sit for less than 30 minutes.
E	I can only sit for less than 15 minutes.
F	Pain prevents me from sitting at all.

Section 6: Standing	
A	No pain when standing at all.
B	Some pain when standing, but does not increase with time.
C	I can stand for less than 1 hour.
D	I can stand for less than 30 minutes.
E	I can stand for less than 15 minutes.
F	Standing causes severe pain.
Section 7: Sleeping	
A	I have no low back pain while sleeping.
B	Pain does not prevent me from sleeping well.
C	1-2 hours of restless sleep because of pain.
D	2-3 hours of restless sleep because of pain.
E	3-5 hours of restless sleep because of pain.
F	5+ hours of restless sleep because of pain.
Section 8: Social Life	
A	Pain does not prevent me from my social life.
B	I have increased pain during my social life.
C	Pain keeps me from being more energetic in my social life.
D	Pain restricts my social life.
E	Severe pain restricts my social life to home only.
F	I hardly have a social life because of severe pain.
Section 9: Travelling (longer than 20-30 minutes)	
A	I have no pain while traveling.
B	I have mild pain while traveling.
C	Pain increases while traveling longer distances.
D	Pain causes me to find other ways to travel.
E	Pain keeps me from using all forms of travel.
F	I can only travel while lying down.
Section 10: Changing Degree of Pain	
A	My pain is rapidly getting better.
B	My pain fluctuates, but is definitely getting better.
C	My pain is better and improving slowly.
D	My pain is staying about the same.
E	My pain is gradually getting worse.
F	My pain is rapidly getting worse.

CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to muscle spasms, soreness, aggravation of symptoms, rib fracture, bruising / discoloration of treated or other areas and headache. There is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Printed Name _____

Signature _____

Date _____

