PATIENT INFORMATION

WELCOME! Please allow our staff to photocopy all available insurance cards.

PLEASE PRINT

Full Name_____ **Gender: M F**

Address_____**City**_____**State**_____**Zip**_____

Home Phone_____ **Cell Phone**_____ **Age** _____ **Birth Date** _____

Marital Status (Circle One): S M W D No. of Children_____

Preferred Language _____ **Ethnicity (Check one) □ Hispanic or Latino □ Non Hispanic or Latino**

Race (Check one) □ African American □ American Indian □ Asian □ Black □ Native Hawaiian □ Pacific Islander □ White

Your Employer_____ **Your Occupation**_____ **Years on Job**_____

Employer Address_____**City**_____**State**_____**Zip**_____

Work Phone_____

Do you have health insurance where you work? Yes____ No____ Plan/Group_____

Insurance Company_____

Name of Spouse, Parent or Guardian _____ Age _____ Birth Date _____

Spouse's Employer_____ Work Phone_____

Employer Address_____City_____State_____Zip_____

Does your spouse have insurance at work? Yes____ No____ Plan/Group#_____

Insurance Company_____

How did you find our office? _____

Describe the major complaint that brought you to our office:_____

_____

Is your condition due to an accident? □ Yes □ No Date of Accident:_____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and herby release him/her of any consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowed to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to assignee. I agree that a photo static copy of this agreement shall serve as the original.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

We file your primary insurance at no charge to you. *Filing for policies in addition to your primary coverage is completed for a fee and as time permits.*

Payments Options (please Indicate): ___ Cash ____Check ____MasterCard ____Visa ____Discover

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present.

An understanding of your health history will help us to determine appropriate care.

NAME _____ DATE _____

HEIGHT _____ WEIGHT _____

Review of Systems

1. Do you have skin, hair or nail problems? ❑ Yes ❑ No _____
2. Do you have mouth and/or throat problems? ❑ Yes ❑ No _____
3. Do you have nose and/or sinus problems? ❑ Yes ❑ No _____
4. Do you have ear problems? ❑ Yes ❑ No _____
5. Do you have eye problems? ❑ Yes ❑ No _____
6. Do you have chest or lung (breathing) problems? ❑ Yes ❑ No _____
7. Do you smoke? ❑ Yes ❑ No Cigarettes per day _____ How long? _____
8. Do you have heart and/or blood vessel problems? ❑ Yes ❑ No _____
9. Do you have blood or lymph node problems? ❑ Yes ❑ No _____
10. Do you have digestive problems? ❑ Yes ❑ No _____
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? ❑ Yes ❑ No _____
12. Females, have you had menstrual problems? ❑ Yes ❑ No _____
13. Do you have any nervous system diseases and/or mental health problems? ❑ Yes ❑ No

_____

14. Do you have any gland and/or hormone problems? ❑ Yes ❑ No _____
15. Do you have allergy or immunity problems? ❑ Yes ❑ No _____
16. Do you have any muscle, tendon or ligament problems? ❑ Yes ❑ No _____
17. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? ❑ Yes ❑ No _____

Past History

18. List any diseases that you have had in the past, including childhood diseases:

_____

19. Tell us if you have ever been diagnosed as having a particular condition, such as diabetes, cancer, AIDS, etc.:

_____

20. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, dislocations, broken or cracked bones? ❑ Yes ❑ No _____

_____

21. List any surgeries you have had (appendix, tonsils, ear tubes, wisdom teeth, etc):

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

_____ Date _____ _____ Date _____

22. Have you ever been hospitalized for any reason other than surgery? ❑ Yes ❑ No
23. **Medications**: Please list all medications, including dosages (prescription & non-prescription) you are currently taking or take on an occasional basis: _____

_____

_____

24. Any medication allergies: ❑ Yes ❑ No _____
25. Your diet is: ❑ Balanced ❑ Fair ❑ Poor ❑ Excessive ❑ Restricted

CASE HISTORY

(Continued)

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? ❑ Yes ❑ No _____

Social History

27. In what position do you usually sleep, and how well? _____
28. Do you exercise on a regular basis? ❑ Yes ❑ No How? _____
29. How do you spend your spare time (hobbies, etc.)? _____
30. Do you use: ❑ Caffeine ❑ Tobacco ❑ Nicotine ❑ Recreational Drugs ❑ Alcohol
31. Please describe your work

    Physical Demands: ❑ Heavy ❑ Moderate ❑ Mild ❑ Sedentary

    Stress Level: ❑ High ❑ Medium ❑ Low

Additional Questions

32. Do you have problems with recurring headaches? ❑ Yes ❑ No _____
33. Are you losing weight without trying? ❑ Yes ❑ No
34. Does your pain wake you up at night? ❑ Yes ❑ No
35. Have you had a sore that doesn't heal? ❑ Yes ❑ No _____
36. Have you recently had any unusual bleeding or discharge? ❑ Yes ❑ No _____
37. Do you have a thickening/lump in the breast or elsewhere? ❑ Yes ❑ No _____
38. Do you have indigestion or difficulty swallowing? ❑ Yes ❑ No _____
39. Have you had an obvious change in a wart or mole? ❑ Yes ❑ No _____
40. Do you have a nagging cough or hoarseness? ❑ Yes ❑ No _____
41. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history that was not requested, please fill it in below.

_____

_____

42. Who is your:

    Medical Doctor:

    _____

    OB/GYN:

    _____

    Dentist:

    _____

Patient Health Survey

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing, but not fainting)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

Do you currently have, or could you be, any of the following?

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy	Y	N
Male Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs/day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

In the past 14 days, have you experienced any of the following?

Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain during bowel movements	Y	N
Head trauma	Y	N
Abnormal period	Y	N

Neck Pain and Disability Index

Patient Name _____ **Date** _____

Please rate the severity of your pain by circling a number below:

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

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. In each section please circle ONE number which most closely describes your problem.

Pain Intensity
0 No pain at the moment
1 Mild pain at the moment
2 Moderate pain at the moment
3 Fairly severe pain at the moment
4 Very severe pain at the moment
5 Worst imaginable pain at the moment

Personal Care
0 Personal care is normal without extra pain
1 Personal care is normal with extra pain
2 Personal care is painful/slow and careful
3 Manage most of personal care with some help
4 Needs help every day in most aspects of care
5 Difficulty dressing and washing/stays in bed

Lifting
0 Lifts heavy weights with no pain
1 Lifts heavy weights with pain
2 Can lift heavy weights from a table
3 Can lift light weights from a table
4 Can lift only very light weights
5 Cannot lift or carry anything

Reading
0 No pain while reading
1 Slight pain while reading
2 Moderate pain while reading
3 Moderate pain prevents reading
4 Severe pain prevents reading
5 Cannot read at all

Headaches
0 No headaches
1 Slight, infrequent headaches
2 Moderate, infrequent headaches
3 Moderate, frequent headaches
4 Severe, frequent headaches
5 Constant headaches

Concentration
0 Can concentrate without difficulty
1 Can concentrate with slight difficulty
2 Can concentrate with fair difficulty
3 Can concentrate with a lot of difficulty
4 Can concentrate with extreme difficulty
5 Cannot concentrate at all

Work
0 Work is unrestricted
1 Can do usual work but no more
2 Can do most usual work but no more
3 Cannot do usual work
4 Can hardly do any work
5 Cannot do any work

Driving
0 Can drive without pain
1 Driving causes slight neck pain
2 Driving causes moderate neck pain
3 Cannot drive long due to moderate pain
4 Can hardly drive due to severe pain
5 Pain prevents driving

Sleeping
0 No difficulties sleeping
1 Sleep is mildly disturbed
2 1-2 hours loss of sleep
3 2-3 hours loss of sleep
4 3-5 hours loss of sleep
5 5-7 hours loss of sleep

Recreation
0 Recreation is not affected
1 Some neck pain, but does not affect activity
2 Some activity is affected by pain
3 Most activity is affected by pain
4 Activity severely restricted by pain
5 Cannot do any activity

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Office Use Only
Neck Index Score _____

Back Pain and Disability Index

Patient Name _____ **Date** _____

Please rate the severity of your pain by circling a number below:

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

This questionnaire has been designed to give the doctor information as to how your back pain has affected your everyday life. In each section please circle ONE number which 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
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 severe
5 The pain is severe and does not vary much

Personal Care
0 Does not change habits to avoid pain
1 Does not change habits/some pain
2 Does not change habits/Increases pain
3 Changes habits/Increases pain
4 Unable to do some personal care without help
5 Unable to wash or dress without help

Lifting
0 Lift heavy weights with no pain
1 Lift heavy weights with pain
2 Can not lift heavy weights off the floor
3 Can lift heavy weights from a table
4 Can lift light to medium weights from a table
5 Can only lift very light weights

Walking
0 Pain does not prevent walking
1 I cannot walk more than 1 mile
2 I cannot walk more than 1/2 mile
3 I cannot walk more than 1/4 mile
4 Can walk only with crutches
5 Bedridden and must crawl to the toilet

Sitting
0 Can sit in any chair as long as desired
1 Can only sit in my favorite chair as long as desired
2 Can sit no more than 1 hour
3 Can sit no more than 1/2 hour
4 Can sit no more than 10 minutes
5 Can not sit at all due to pain

Standing
0 Can stand for an unlimited time without pain
1 Some pain while standing does not increase with time
2 Cannot stand for more than 1 hour
3 Cannot stand for more than ½ hour
4 Cannot stand for more than 10 minutes
5 Cannot stand at all

Sleeping
0 No pain in bed
1 Get pain in bed but sleeps well
2 Normal sleep reduced by 1/4
3 Normal night's sleep reduced by 1/2
4 Normal night's sleep reduced by 3/4
5 Can not sleep at all due to pain

Traveling
0 Travel without pain
1 Travel causes some pain, but not made worse
2 Causes extra pain, no change in form
3 Causes pain, uses/alternate travel
4 Pain restricts all forms of travel
5 Pain restricts travel except lying down

Social Life
0 Normal and causes no pain
1 Normal but causes extra pain
2 Limits energetic interests
3 Pain limits/doesn't go out as often
4 Pain restricted social life to home
5 Pain restricts all social life

Changing degree of pain
0 Pain is rapidly improving
1 Pain fluctuates but is improving
2 Improvement is slow
3 Pain level is unchanged
4 Pain is gradually worsening
5 Pain is rapidly worsening

Office Use Only
Back Index Score _____

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100