Chiropractic Case History/Patient Information

Patient Name________________________ Date Filled Out____________

Completed by (circle) Patient/Self or Parent/Guardian or Other: ____________

Date of Birth____________ Age______ Social Security #____________________

Home Phone____________ Cell Phone____________ Prefer Messages left at: []Home [] Cell [] Work

Address:________________________City______________State______Zip__________

Email:____________________ Race__________ Marital Status: M S W D # of Children___

Occupation________________ Employer______________ Work Phone ____________

Employer's Address________________City______________State_____Zip__________

Spouse________________ Spouse's Date of Birth__________ Spouse's Occupation__________

Emergency Contact/Name of Nearest Relative____________________ Phone ____________

How were you referred to our office?____

Medical Doctor____________________ Facility______________ Phone Number__________

May we update your medical doctor regarding your care at this office? (circle one) Yes No

Purpose of this appointment:____

Date Symptoms Appeared:______________________ Is this due to: [] Auto [] Work [] Other

Have you ever had the same or a similar condition? [] Yes [] No

If Yes, When? And Describe:____

Days lost from work__________ Date of last physical examination____________________

What surgeries have you had (include approximate dates)____________________________

____

Have you had any injuries, significant falls, or auto accidents?(Include approximate dates):__________

____

Have you been treated for any health condition by a physician in the last year? [] Yes [] No

If yes, describe____

Please list Current Medications:

____

____

____

____

Doctor's Signature________________________________Date______________

Summary of Current Condition

Patient Name____Date______________

What is your major symptom?____

What does this prevent you from doing or enjoying?____

How did it originally occur?____

Has it become worse recently? [] Yes [] No []Same []Better []Gradually worse

If yes, When and How?____

How Frequent is the condition? []Constant [] Daily [] Intermittent [] Night only [] Other:____________

How long does it last? [] All Day []Few Hours [] Few Minutes [] Other:___________________________

Are there any other conditions or symptoms that may be related to your major symptom? []Yes []NO

If yes, describe:____

Is there anything you can do to relieve the problem? []Yes [] No If yes, what?__________________

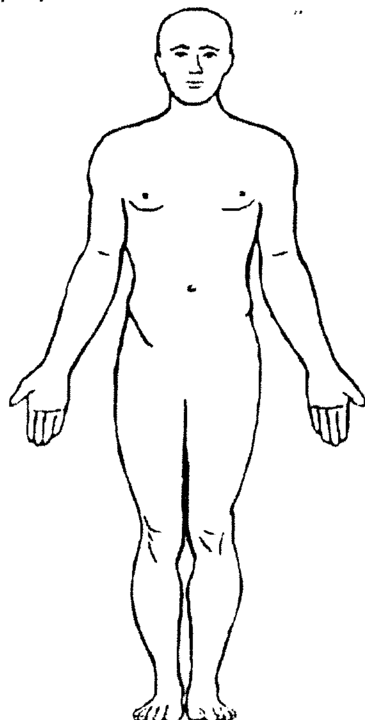
If no, what have you tried?____

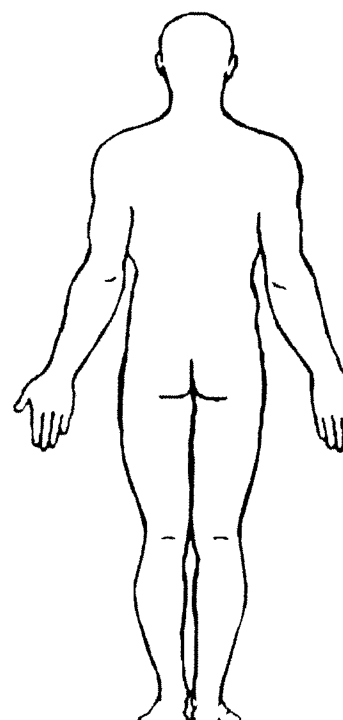
What makes the problem worse? (mark all that apply) [] Standing [] Sitting [] Lying [] Bending []Lifting
[] Twisting []Other:____

Additional Comments?____

Where and how do you hurt: []Dull []Sharp []Aching []Burning []Numbness []Tingling []Other:________

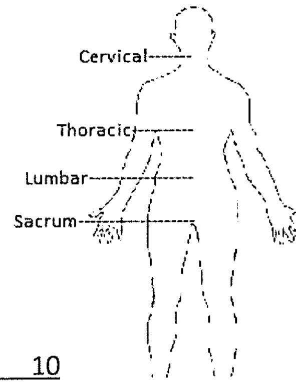
Mark where you feel your symptoms





Doctor's Signature____Date______________

Visual Analogue Pain Scale



Name________________________________ Date______________

Use the guide to right to evaluate EACH area you are experiencing discomfort.
Circle the number that best describes the question being asked.

Neck (Cervical spine)

Currently: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

At Its Worst: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

Upper/Middle back (Thoracic Spine)

Currently: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

At Its Worst: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

Low Back (Lumbar Spine)

Currently: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

At Its Worst: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

Hips/Pelvis

Currently: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

At Its Worst: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

Other (please label): ______________

Currently: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

At Its Worst: 0 1 2 3 4 5 6 7 8 9 10
NO PAIN MODERATE PAIN WORST POSSIBLE PAIN

Other Comments:

____

____

____

Doctor's Signature:______________________________ Date______________

Case History Evaluation

Name____Date____________________

GIVE APPROXIMATE START DATES for each condition you have experienced. **If it does not apply, leave blank**.

General Symptoms
Fever__________
Chills__________
Night Sweats_________
Fainting_____________
Convulsions__________
Numbness/pain in arms/legs/hands______
Allergies________
Wheezing________
Neuralgia________
Seizures________

Cardiovascular
Rapid Heart_________
Slow Heart__________
Low Blood pressure_________
High Blood pressure_________
Pain over heart__________
Previous heart trouble_________
Swelling at ankles_________
Poor Circulation/Circulatory problems____
Varicose Veins________
Strokes__________
Sneezing_________
Wheezing__________
Palpitations________
Artificial valves_________

Respiratory
Spitting Phlegm__________
Difficulty Breathing________

Genitourinary
Frequent Urination_________
Blood in Urine__________
Kidney Infection_________
Bedwetting_________
Inability to Control Urine_________
Prostate Trouble__________

Muscles & Joints
Twitching________
Stiff Neck________
Backache_________
Swollen Joints________
Tremors_________
Foot Trouble_________
Painful Tailbone_______
Pain between shoulders______
Hernia_________
Spinal Curvature_________

Eye/Ear/Nose/Throat
Crossed Eyes________
Pain in Eyes_________
Eye Dryness_________
Eye Redness_________
Cataract Glaucoma______
Deafness________
Earache________
Ear Noises________
Ear Discharges______
Nasal Obstruction______
Nasal Pain_________
Nasal Infections_________
Sore Throat________
Hoarseness_________
Mouth Sores_________
Hay Fever_________
Asthma_________
Frequent Colds________

Psychologic
Anxiety_________
Depression________
Memory Loss_________
Mood Swings_________

Gastrointestinal
Poor Digestion_________
Excessive Hunger________
Nausea__________
Vomiting Blood__________
Pain over stomach_______
Heartburn_________
Colon Trouble___________
Hemorrhoids________
Liver Trouble_________
Jaundice__________
Gallbladder Trouble_____
Ulcers/Colitis__________

Skin or Allergies
Skin Eruptions________
Excessive Itching_________
Bruising Easily__________
Excessive Dryness________
Boils_______
Sensitive Skin_________
Hives or Allergies______
Eczema________

Endocrine
Goiter__________
Sugar in Urine________
Heat Intolerance________
Cold Intolerance_________

For Women Only
Pregnant (Due:______________)
Painful Periods_________
Excessive Flow__________
Irregular Cycle_________
Hot Flashes________
Cramps/Backaches_____
Miscarriages________
Vaginal Discharge_______

Cancer? [] Yes [] No If Yes, where/type and approximate diagnosis date_______________________________________

Additional Comments:____

____

Doctor Signature:____Date__________________

Family & Social History Evaluation

Patient Name______________________________________Date_______________

Family History

Indicate whether family member is Father, Mother, Sister, Brother (If none, leave blank)

Tuberculosis___________ Mental Illness________ Diabetes_________

Asthma_______________ Heart Disease________ Stroke___________

Kidney Disease_________ Lung Disease_________ Arthritis__________

Liver Disease___________ Cancer (also list type)______________________________

Other:____

Social History

Do you drink alcoholic beverages? []Yes []NO How much? ______ per []Day []Week []Month

Do you use tobacco products? []Yes [] No Type: []Smoke []Smokeless/chew How much per day? ______

Do you consume caffeine? []Yes []No Type? []Pop/soda [] Coffee []Energy Drinks []Other?__________

How much caffeine do you consume on an average day?____

What are your hobbies?____

____

Do you take Vitamins/supplements? []Yes []No If yes, what do you take?_____________________________

____

Do you exercise? []Yes []No Type and Frequency of exercise?____

____

What percentage of your day (at home, job or otherwise) do you spend:

____Lifting _____Sitting _____Bending ______Standing _____Sleeping _____Working at a computer

Doctor's Signature____Date________________________

Informed Consents

Patient Name____Date_________________

Patient Health Information Consent Form: We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any healthcare operations, we must require you to read and sign this consent form sating that you understand and agree with how your records will be sued. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the Front Desk before signing this consent.

1) The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operation, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment
2) The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3) A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4) The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior t the written request to revoke consent but would apply to any care given after the request has been presented.
5) For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure your records are not readily available to those who do not need them.
6) Patient have the right to file a formal complaint with our privacy official about any possible violations
7) If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician as the right to refuse to give care

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. Patient/Guardian Initials_____

Benefits Authorization: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with physicians, healthcare providers and payors to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. **I have read and agree to the Benefits Authorization. Patient/Guardian Initials_____**

Informed Consent: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware of the nerve or brain damage, including stroke is reported to occur once in a million to once in ten million treatments. (Once in a million is the same chance as getting struck by lightening. Once in ten million is about the same as the chance of a normal dose or Tylenol or aspirin causing death. I authorize Sioux Falls Chiropractic doctors and staff to contact me regarding my care at this facility whether I am an active patient or inactive patient. **I have read and agree to the Informed Consent. Patient/Guardian Initials_____ Doctor discussed on:_________ Doctor's Initials:____**

I have read and agree to the above listed Consents and Authorizations. I understand that refusing to agree to any of the above Consents and Authorizations the chiropractic physician as the right to refuse to give care.

____

Patient/Guardian Signature **Patient Printed Name** **Date**

Doctor's Signature____Date____________________

Neck Index

Form N1-100

rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark 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 worst imaginable at the moment.

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 my 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.

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).

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 (e.g., 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.

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.

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.

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.

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 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.

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.

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.

Doctor Signature ______________________ Date __________

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

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name ______________________ **Date** ____________

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

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.

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.

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.
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 off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

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 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

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.

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.

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 (e.g., dancing, etc).
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 the pain.

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 more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 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.

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.

Doctor Signature ______________________ Date ____________

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

Back Index Score