Chiropractic Case History/Patient Information

Date _____

Name _____ Social Security #_____Home Phone _____

Address _____City _____ State _____ Zip _____

E-mail Address _____ Fax # _____ Cell Phone _____

Best place to leave message: ☐ Home ☐ Work ☐ Cell ☐ Other _____

Age _____ Birth Date _____ Race _____ Marital: M S W D How many children?_____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Spouse's Birth Date_____

Name of Nearest Relative _____ Address _____Phone _____

How were you referred to our office? _____

Family Medical Doctor _____ Doctor's Address_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Purpose of this appointment _____ **Is this due to: Auto___ Work____ Other___**

Date symptoms appeared or accident happened _____

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 Dates) _____

_____

Serious Illnesses (Include Dates) _____

_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

_____

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

If yes, describe _____

What medications or drugs are you taking? _____

_____

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ☐ Yes ☐ No _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes _____ No _____ Uncertain _____

AUTHORIZATION AND RELEASE: 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 personal physicians and other healthcare providers and payors and to secure the payment of benefits. I authorize the release of my medical records and information to other healthcare providers, which this office may utilize or be in contact with such as PCP. 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. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Doctor's Signature:_____ Date: _____

SUMMARY

Patient Name_____ Date_____

1. What is your major symptom? _____
2. Whatdoes this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____

   How did it originally occur?_____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes _____ No _____. If yes, describe: _____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

   _____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____

   _____. If no, what have you tried to do that has not helped? _____

   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____

   _____
10. **WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?**

    Yes _____ No _____ Uncertain _____
11. Remarks: _____

    _____

NO SYMPTOMS _____ EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature _____ Date _____

Name:_____ Date:_____

HEALTH HISTORY- Please circle Yes or No. Please do not leave any questions blank.

Y N Heart Attack/ Stroke	Y N Heart Surgery/ Pacemaker	Y N Artificial Valves
Y N Broken or Fractured Bones	Y N Osteoarthritis	Y N Eating Disorder
Y N Circulatory Problems	Y N Epilepsy	Y N Diabetes
Y N Rheumatoid Arthritis	Y N Seizures/Convulsions	Y N HIV Positive / AIDS
Y N Cancer	Y N Alcohol/ Drug Abuse	Y N Gall Bladder Problems
Y N Excessive Bleeding	Y N Depression	Y N Chemotherapy/Radiation
Y N High/Low Blood Pressure	Y N Ulcers/Colitis	Y N Severe Headaches

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting_____ Sitting_____ Bending_____ Standing_____ Working at a computer_____Sleeping____

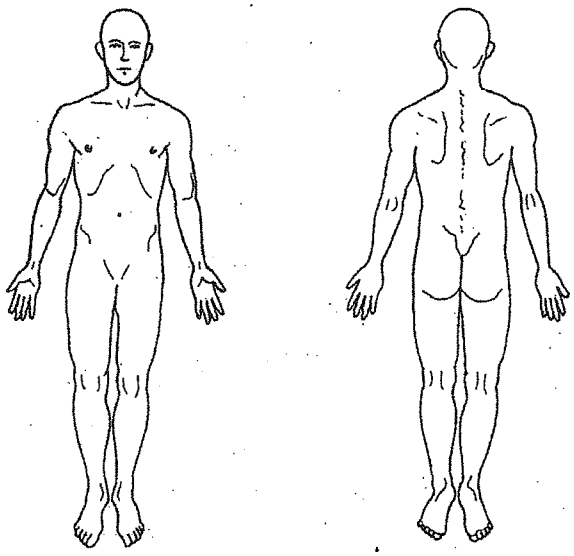
FAMILY HISTORY: **DISEASES** (indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis____	Cancer____	Mental Illness____	Diabetes ____	Asthma____
Heart Disease ____	Stroke ____	Kidney Disease____	Lung Disease____	Arthritis_____
Liver Disease ____	Other _____			

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



Doctor's Signature:_____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 will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

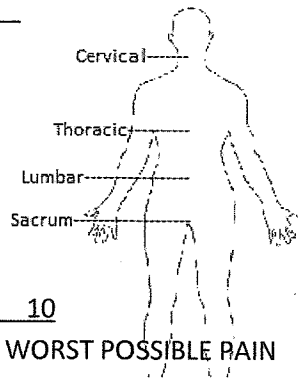
1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI 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 effect the use of those records for the care given prior to 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 that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has 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.

Name of Patient Signature of Patient Date

Doctor's Signature: _____ Date: _____

Name_____Date_____



Visual Analogue Pain Scale

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

Tailbone (Sacrum)

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 Comments:

_____

_____

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.

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).

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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

CASE HISTORY (RE-EVALUATION)

Name_____Date_____

Enter "C" for a symptom you are experiencing currently, and "P" for a symptom you have experienced in the past

GENERAL SYMPTOMS
__Fever
__Chills
__Night Sweats
__Fainting
__Convulsions
__Numbness or pain in arms/legs/hands
__Allergies
__Wheezing
__Neuralgia
__Seizures

CARDIOVASCULAR
__Rapid Heart
__Slow Heart
__Low Blood Pressure
__Pain over Heart
__Previous Heart Trouble
__Swelling Ankles
__Poor Circulation
__Varicose Veins
__Strokes
__Sneezing
__Wheezing
__Palpitations

RESPIRATORY
__Spitting Phlegm
__Difficulty breathing

GENITOURINARY
__Frequent Urination
__Painful 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

PSYSCHOLOGIC
__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

SKIN OR ALLERGIES
__Skin Eruptions
__Itching
__Bruising easily
__Dryness
__Boils
__Sensitive Skin
__Hives or Allergies
__Eczema

FOR WOMEN ONLY
__Painful Periods
__Excessive Flow
__Irregular Cycle
__Hot Flashes
__Cramps or Backaches
__Miscarriages
__Vaginal Discharge

ENDOCRINE
__Goiter
__Sugar in Urine
__Heat Tolerance
__Cold Intolerance

Informed Consent: Although stroked 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 lightning. Once in ten million is about the same chance as a normal dose of 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.

Signature: _____Date:_____

Doctor's Signature: _____Date:_____

Current Health Status

In an effort to comply with recent health law changes, please provide us with the following information:

Name_____ [] Male [] Female

Height_____ **Weight**_____

Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino

Race: [] American Indian or Alaskan Native [] Black or African American

[] White [] Asian [] Native Hawaiian or Other Pacific Islander

[] No Current Prescription Medication

Current Prescribed Medications:	**Dosage:**

Allergies to medications:

Tobacco Status: *Start Date*_____ *Cessation Date*_____

[] Non-Smoker [] Light Smoker [] Moderate Smoker [] Heavy Smoker

[] Chew [] Former Smoker

Blood Pressure:_____ **Pulse:**_____