STRONG SPINE CHIROPRACTIC

Patient information

Please complete and sign at bottom

Patient Legal Name	Date of Birth	Social Security #	Sex M F

Preferred Name (if different)	If under 18, parent/guardian	Race/Ethnicity

Street Address (if student, permanent address)	City and State	Zip Code

Home Phone	Cell Phone	Email

Marital Status (circle) Single Married Separated Divorced Widowed	Spouse's Name	Spouse's Phone	Permission to release your info? Yes No

Employer (indicate if retired)	Occupation (indicate if student)	Work Phone & EXT	Currently Working? Yes No

Emergency Contact	Emergency Contact Phone	Emergency Contact Relationship	Permission to release your info? Yes No

Preferred Method of Contact (circle) Home Cell Email Work	How did you hear about us?

Primary Care Physician (First Name, Last Name)	Facility/Address	Phone

Referring Physician, if applicable (First Name, Last Name)	Facility/Address	Phone

IF YOU ARE UTILIZING HEALTH INSURANCE FOR THIS VISIT, PLEASE PROVIDE ALL INFORMATION REQUESTED BELOW.

Primary Health Insurance Company	Name & DOB of Policyholder	Relationship to Policyholder	Identification #	Group #

Secondary Health Insurance Company	Name & DOB of Policyholder	Relationship to Policyholder	Identification #	Group #

PLEASE INDICATE IF YOU ARE HERE DUE TO A: MOTOR VEHICLE ACCIDENT ☐ WORK-RELATED INJURY ☐

LIST ALL CURRENT MEDICATIONS AND/OR SUPPLEMENTS. ***Attach a separate list if needed.***

Name	Dosage	Frequency	Reason for use

Signature: _____ Date: _____

Patient medical history
Please complete and sign at bottom

STRONG SPINE CHIROPRACTIC

Patient Name: _____ Age: _____ Height: _____ Weight: _____

REASON FOR VISIT

Chief Complaint: _____

_____

_____

What brought on this current condition? _____

_____

When did your condition start? _____

_____

Have you seen another physician for this condition? Yes No

If yes, where, when, and whom? _____

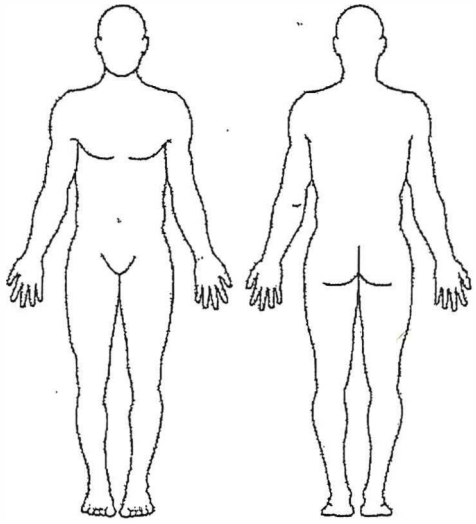
_____

Numeric Pain Rating Scale *(circle one)*:

(None) 0 1 2 3 4 5 6 7 8 9 10 *(Worst)*

PAIN DIAGRAM – *label the diagram where your symptoms are.*

Aching	A
Burning	B
Dull	D
Numbness	N
Tingling.	T
Stabbing	S



What makes your pain better? _____

What makes your pain worse? _____

Do any of the following activities affect your condition?

Better	Worse	No change	
☐	☐	☐	Sitting
☐	☐	☐	Standing
☐	☐	☐	Walking
☐	☐	☐	Lying down
☐	☐	☐	Bending
☐	☐	☐	Lifting
☐	☐	☐	Straining/coughing/sneezing

Which of the following treatments have you tried?

Yes	No	
☐	☐	Chiropractic (when? _____)
☐	☐	Physical therapy (when? _____)
☐	☐	Traction/Spinal Decompression (when? _____)
☐	☐	Injections (when? _____)
☐	☐	Orthopedic consult (when? _____)
☐	☐	Neurosurgical consult (when? _____)
☐	☐	Primary Care (when? _____)

Indicate if you tried any of the following forms of pharmaceutical pain management for this condition:

☐ OTCs/Anti-inflammatory ☐ Steroids ☐ Muscle Relaxants ☐ Narcotics ☐ Medicinal marijuana ☐ Other _____

Have you had any x-rays, MRIs, CTs, and/or other forms of diagnostic imaging? *Please list type of imaging, when and where they were taken.*

_____

List any previous surgeries including the date(s): _____

_____

_____

List any previous accidents and/or traumas that may have resulted in significant injury: _____

_____

List any previous and/or active Workers Compensation or No-Fault claim injuries: _____

_____

Signature: _____ Date: _____

Patient medical history
Please complete and sign at bottom

STRONG SPINE CHIROPRACTIC

Review of Systems:
Circle any of the following symptoms you may have experienced recently. If none apply, circle "None."

General	Weight loss Fatigue Unsteadiness Fever Chills Night sweats	None
HEENT	Vision changes Hearing loss Ringing in ears Nose bleeds	None
Neck	Pain/difficulty swallowing Sore throat Lumps/masses in neck Hoarseness	None
Respiratory	Shortness of breath Difficulty breathing Wheezing Dry cough Productive cough Asthmatic attacks	None
Cardiovascular	Palpitations Chest pain Swelling in legs Abnormal blood pressure Irregular heart rate	None
Gastrointestinal	Nausea/vomiting Indigestion Change in bowel habits Blood in stool Constipation Abdominal pain	None
Genitourinary	Difficult/painful urination Frequent urination Blood in urine Incontinence Discharge Sexual dysfunction	None
Vascular	Pain in calves when walking Blood clots Abnormal blood pressure Abnormal heart rate	None
Musculoskeletal	Pain/stiffness in bones or joints Muscle spasms Muscle weakness Altered gait/posture Scoliosis	None
Neurologic	Numbness/weakness Tingling Tremors Seizures Blackouts Headaches Migraines Dizziness/Vertigo	None
Hematologic	Easy bruising Easy bleeding Long wound healing time Fatigue Malaise	None
Endocrine	Heat/Cold intolerance Excessive thirst Mood swings Unintentional weight fluctuation Fatigue	None
Dermatologic	Skin/hair/nail changes Rashes Sores Moles Warts	None
Psychiatric	Depression Anxiety Thoughts of suicide	None
Reproductive	Absent or irregular menstrual cycle Profuse menstrual cycle Endometriosis PMS	None

List any allergies you have, and your reaction(s) if known._____

_____

For Females: Are you on any form of birth control? ☐Yes ☐No If yes, what are you on?_____

Are you, or could you be pregnant? ☐Yes ☐No If yes, how far along? _____. If no, last period? _____

Personal Health History:

Yes	No		Yes	No	
☐	☐	Aneurysm_____	☐	☐	High Cholesterol
☐	☐	Atrial Fibrillation	☐	☐	Hypertension
☐	☐	Cancer_____	☐	☐	Lung disease/asthma
☐	☐	Diabetes	☐	☐	Pacemaker
☐	☐	Heart Attack	☐	☐	Osteoarthritis/Rheumatoid
☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	Heart Surgery	☐	☐	Ulcer/GI bleed
☐	☐	Hepatitis	☐	☐	Other_____

Immediate Family Health History:

	Father	Mother	Brother	Sister	Son	Daughter
Diabetes	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐	☐	☐

Other Condition(s) _____

Social Health History:

Tobacco: ☐Past. ☐Present. Type:_____ ☐Everyday. ☐Some days. Pack/day:_____ # Years:_____ Interest in quitting? Yes ☐ No ☐

Alcohol: ☐Yes ☐No If yes, how frequent? ☐Daily ☐Weekly ☐Socially Type:_____

Recreational Drug(s): ☐Yes ☐No If yes, how frequent? ☐Daily ☐Weekly ☐Socially Type: _____

Exercise: ☐Yes ☐No Describe your typical diet: ☐Poor ☐Fair ☐Good ☐Excellent

Signature: _____ Date: _____

Authorization and HIPAA Compliance Patient Consent Form

I have reviewed the information provided for the chiropractor and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and helpful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor. I authorize my insurance company, lawyer, or representative to pay the chiropractor or chiropractic group all benefits for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: • Protected health information may be disclosed or used for treatment, payment, or healthcare operations. • The practice reserves the right to change the privacy policy as allowed by law. • The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. • The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. • The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:_____

This consent was signed by (PRINT NAME HERE): _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

- **Skin irritation or burn** – Skin irritation or a bum may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A bum may leave a permanent scar.

- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____

Name (Please Print)

_____ Date: _____

Signature of patient (or legal guardian)

_____ Date:_____

Signature of Chiropractor

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY-LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT-DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 5 – HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50] BENCHMARK -5 = _____

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: _____ File #_____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4-WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5-SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

SECTION 6-STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8-SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9-TRAVELLING

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.