

Patient Personal/Confidential Data

No. _____ Date _____

Patient: _____ Age _____ Date of Birth: _____ Social Security No. _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ E-mail: _____

Employer: _____ Address: _____

Married _____ Single _____ Other _____ Name of Spouse _____ No. of Children _____

Nearest relative not living with you? _____ Phone: _____

Who is responsible for payment? Self Spouse Other _____

Patient's Insurance

Spouse's Insurance

Name of Company: _____ Name of Company _____

Address: _____ Address: _____

ID & Group No.: _____ ID & Group No.: _____

Phone No.: _____ Phone No.: _____

Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ AM/PM Location: _____

How did the accident occur? Auto On the job Other: _____

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Physician: _____ Signature Patient: _____

Consent of Professional Services and release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charges, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer. For additional HIPAA information or privacy practices information please ask at the front desk. Copies can be made available to take home.

Patient Signature: _____

(IF A MINOR) Guardian's Signature: _____

Health Questionnaire

Please check mark each of the conditions below that you are currently experiencing.

Date: _____

Patient: _____ No. _____

MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painfull joints
- Stiff joints
- Sore Muscles
- Weak muscles
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES NO

GASTRO-INTETIONAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallowing
- Excessice thirst
- Nausea
- Vomitting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles Jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alchohol Abuse
- Coffee or Tea
- Drug Abuse
- Other _____

CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Chouging blood
- Rapid heartbeat
- Blood pressure problems
- Lung problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing through nose
- Sore gums
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw pain

SYMPTOM LOCALIZATION

P ___ Pain T ___ Tender

N ___ Numb H ___ Hypoesthesia

S ___ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature _____

-----DO NOT WRITE BELOW THIS LINE-----

Patient Accepted? Yes No

Doctor's Signature _____

Revised Oswestry Low Back Pain Disability Questionnaire

Name _____

Date _____

Please mark the ONE choice from EACH group that best describes you.

PAIN INTENSITY

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is severe.
- F. The pain is severe and does not vary much.

PERSONAL CARE

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

LIFTING

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

WALKING

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than one mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than 1/4 mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SITTING

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than ½ hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

STANDING

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than ten minutes without increasing pain.
- F. I avoid standing, because it increases the pain straight away.

SLEEPING

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SOCIAL LIFE

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

TRAVELING

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

CHANGING DEGREE OF PAIN

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Patient Signature _____

Date _____

Neck Pain Disability Questionnaire

Name _____

Date _____

Please mark the ONE choice from EACH group that best describes you.

PAIN INTENSITY

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is worst imaginable at the moment.

PERSONAL CARE

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

LIFTING

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table..
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can only lift very light weights.
- F. I cannot lift or carry anything at all.

READING

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want to with slight pain in my neck.
- C. I can read as much as I want to with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

HEADACHES

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

CONCENTRATION

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty concentrating when I want to.
- F. I cannot concentrate at all.

WORK

- A. I can do as much work as I want to
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

DRIVING

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot drive my car at all.

SLEEPING

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

RECREATION

- A. I am able to engage in all of my recreational activities, with no neck pain at all.
- B. I am able to engage in all of my recreational activities, with some neck pain at all.
- C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

Patient Signature _____ Date _____

Family Health Chiropractic
519 E. Robinson Street, Norman, OK 73071

Informed consent to chiropractic examination and treatment

Full Name: _____ Birth date: ____/____/____ Age: _____

History, Examination and Treatment: Family Health Chiropractic follows referenced guidelines. Variable levels of history taking and examinations are required depending on the case. Evaluation – Management codes and relevant charges will be applied depending on the case.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop” such as the noise when a knuckle is “cracked” and you may feel movement of the joint (s). Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, traction and stretches may be utilized. Exercises may also be used and medical clearance may be obtained prior to engaging in such exercise participation.

Possible risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints or injury to the intervertebral disks, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in ten million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”. Other treatment options that could be considered may include: **Over the counter analgesics:** the risk of these medications include irritation to the stomach, liver, and kidneys and other side effects on a significant number of cases. **Medical care:** typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence on a significant number of cases. **Hospitalization:** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases. **Surgery:** in conjunction with medical care adds to the risks of adverse reaction to anesthesia as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the above information, have fully evaluated the risks and benefits of being treated and hereby give my full consent to undergo examination and treatment at this facility.

If today s care is for a minor child, a parent or legal guardian must sign this consent before treatment

Signature: _____ Date: ____/____/____