Chiropractic Case History/Patient Information

Date:_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail Address:_____Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D Gender: M F

Occupation:_____ Employer:_____Office Phone:_____

Spouse:_____ Birth Date:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

Name of Nearest Relative:_____ Address:_____Phone:_____

Family Medical Doctor:_____

May we have your permission to update your medical doctor regarding your care at this office?_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____ Is this due to: Auto____ Work____ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

List all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

Have you ever seen a chiropractor before?_____ If yes, Name of Dr.:_____ Location: _____

Date of last visit: _____ (approx)

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have allergies of any kind?

Family Diseases (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

___ Tuberculosis ___ Cancer ___ Mental Illness ___ Diabetes ___ Asthma
___ Stroke ___ Kidney Disease ___Lung Disease ___ Arthritis ___Liver Disease
___ Heart Disease ___ Other: _____

PAST MEDICAL HISTORY

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? π Yes π No
If yes, please describe: _____

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 consume caffeine?____ If so, how much per day:_____
What are your hobbies?_____
What % of time during the day (at home or at your job) do you spend: lifting_____ sitting_____ bending_____at the computer_____
What type of regular exercise do you perform? O None O Light O Moderate O Strenuous

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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 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. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Patient Health Questionnaire – PHQ

Patient Name_____ **Date** ____/____/____

1. Describe your symptoms _____

_____

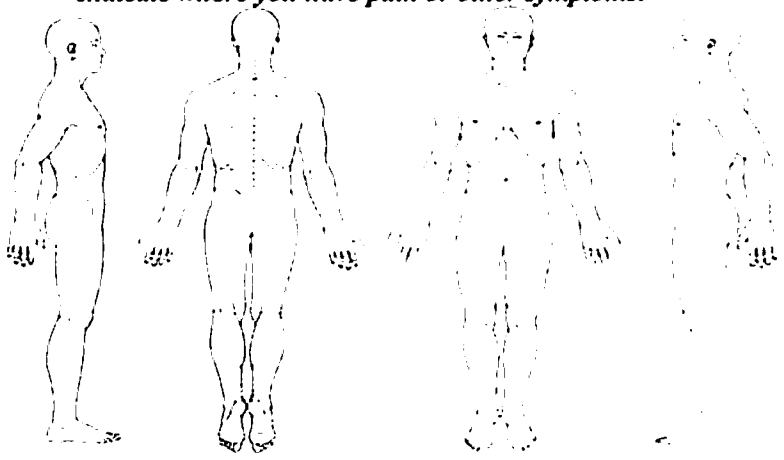
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting better
② Not changing
③ Getting worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms: None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. For each of the conditions listed below, place a check in the past column if you have had the condition in the past and place a check in the present column if you have the condition presently. Circle L for Left and R for Right where applicable.

Past	Present		Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure	O	O	Diabetes
O	O	Neck Pain	O	O	Heart Attack	O	O	Excessive Thirst
O	O	Upper Back Pain	O	O	Chest Pains	O	O	Freq. Urination
O	O	Mid Back Pain	O	O	Stroke	O	O	Ruptures
O	O	Low Back Pain	O	O	Angina	O	O	Coughing Blood
			O	O	Kidney Stones	O	O	Eating Disorder
O	O	Shoulder Pain L R	O	O	Kidney Disorders	O	O	Pace Maker
O	O	Elbow/Upper Arm Pain L R	O	O	Bladder Infection	O	O	Allergies
O	O	Wrist Pain L R	O	O	Painful Urination	O	O	Depression
O	O	Hand Pain L R	O	O	Loss of Bladder Control	O	O	Systemic Lupus
			O	O	Prostate Problems	O	O	Epilepsy
O	O	Hip/Upper Leg Pain L R	O	O	Abnormal Weight Gain/Loss	O	O	Dermatitis/Rash
O	O	Knee/Lower Leg Pain L R	O	O	Loss of Appetite	O	O	HIV/AIDS
O	O	Ankle/Foot Pain L R	O	O	Abdominal Pain	O	O	Drug/Alcohol Dependence
O	O	Ulcer	O	O	Osteoarthritis	O	O	Smoking/Use Tobacco Prod.
O	O	Jaw Pain L R	O	O	Hepatitis			
			O	O	Liver/Gall Bladder Disorder			
O	O	Joint Swelling/Stiffness	O	O	Cancer			
O	O	Arthritis	O	O	Tumor	**Females Only**		
O	O	Rheumatoid Arthritis	O	O	Asthma	O	O	Hormonal Rep.
			O	O	Chronic Sinusitis	O	O	Pregnancy
O	O	General Fatigue	O	O	Broken/Fractured Bones	O	O	Birth Control
O	O	Muscular Incoordination	O	O	Circulatory Problems			
O	O	Visual Disturbances	O	O	Seizures/Convulsions	**Other Health Problems**		
O	O	Dizziness	O	O	A Congenital Disease	O	O	
O	O	Numbness/Tingling	O	O	Excessive Bleeding	O	O	

Patient Signature_____ **Date** ____/____/____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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.

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

Neck Index Score _____

PERSONAL INJURY QUESTIONNAIRE

NAME: _____ **Date of Accident:**_____

Where did accident happen? _____

Describe the accident in your own words:

What was your position in the car?

☐ Driver: if Driver were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both

☐ Passenger: If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

What was the driver's name: _____

- Did your vehicle strike another vehicle ☐ Yes ☐ No
- Was your vehicle struck by another vehicle ☐ Yes ☐ No
- Angles of impact... First Collision: ☐ Front ☐ Back ☐ Left ☐ Right
  Second Collision: ☐ Front ☐ Back ☐ Left ☐ Right
- Were you wearing a seat belt? ☐ Yes ☐ No
- Did you brace for impact? ☐ Yes ☐ No ... ☐ I braced with my hands ☐ I braced with my feet
- Which way were you facing at the time of impact... ☐ straight ahead ☐ Left ☐ Right
-

Did any part of your body strike the inside of your vehicle? Please indicate which part of your body hit each of the following, if applicable:

☐ Steering Wheel _____ ☐ Dashboard _____ ☐ Windshield _____

☐ Left Side Door _____ ☐ Right Side Door_____

☐ Left Side Window _____ ☐ Right Window _____

☐ Roof_____ ☐ Other _____

Did the seat back bend / break ? ☐ Yes ☐ No

Immediately following the accident, how did you feel? ☐ dizzy/dazed ☐ disoriented ☐ unconscious
☐ nervous ☐ nauseous ☐ upset ☐ weak ☐ Other _____

Did you go to hospital ☐ **Yes** ☐ **No** Were you admitted to the hospital? ☐ Yes ☐ No if yes how long? _____

If you went to hospital, when? ☐ At time of accident ☐ Next day

How did you get to hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation

Name of Hospital:_____

Attended by Dr. _____

What treatment was given:

- ☐ none
- ☐ given stitches
- ☐ given pain medication
- ☐ given instructions regarding sprains and strains
- ☐ instructed to call a Orthopedic Surgeon
- ☐ referred to this office for treatment
- ☐ placed in a cervical collar
- ☐ Bandaged
- ☐ x-rayed
- ☐ Physical Therapy
- ☐ instructed to call a private physician
- ☐ given instructions regarding concussions
- ☐ Other _____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctors Name

CHIEF Complaints or Symptoms: **Name:** **Date:**

☐**Neck pain** ☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand
check off the areas that the pain runs into from the neck ☐right shoulder ☐right arm ☐right forearm ☐right hand

☐headache
☐Migraine Headache
☐upper back pain

Ringing in Ears ☐Yes ☐No ☐Left ☐Right ☐Both Ears

Blurry Vision ☐Yes ☐No ☐Left ☐Right ☐Both Eyes
Wrist Pain ☐Yes ☐No ☐Left ☐Right ☐Both Wrists
Jaw Pain ☐Yes ☐No ☐Left ☐Right ☐Both Sides

☐Dizziness ☐nervousness ☐fatigue ☐anxiety
☐depression ☐excessive irritability ☐fear of driving in a car ☐a loss of concentration
☐jaw clenching ☐grinding of teeth at night ☐nightmares ☐difficulty with sleeping at night

☐**Low Back Pain** ☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee
select the areas of radiation, if any... ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain ☐Left ☐Right ☐Bilateral
Knee Pain ☐Left ☐Right ☐Bilateral
Foot Pain ☐Left ☐Right ☐Bilateral

Numbness:

☐ Left Hand ☐Left Upper Arm ☐Right Hand ☐Right Upper Arm
☐ Left Foot ☐Left Leg ☐Right Foot ☐Right Leg

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? ☐Yes ☐No
If yes please give dates: _____
Type of employment:
_____
Have you had previous injuries or accidents? ☐Yes ☐ No
Description of previous Accident: _____
Description of previous injuries: _____
Is there any residual pain from the previous injury? ☐Yes ☐No
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____