

## PATIENT INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender:  Female  Male Marital Status: M S D W

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Primary Health Care Practitioner and/or Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Insurance Company: \_\_\_\_\_

Is this condition due to injury or sickness arising out of employment? \_\_\_\_\_

Is this condition due to injury or sickness arising out of an auto or other accident? \_\_\_\_\_

### Note:

The front desk may have you sign a Patient Authorization to Release information form as we would want you to request information from other providers that have participated in your care. This will help insure that we have all information concerning your condition.

**Please read thoroughly, initial at each section and sign at the bottom. Thank You**

**Authorization to Release Information**

\_\_\_\_\_ I authorize this Southern Pines Chiropractic, P.A. to release all information related to care I receive to my HMO, insurance company, third party payor or their designee. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

**Information about Possible Risk of Chiropractic Treatment**

\_\_\_\_\_ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

Two different types of adjustment techniques are used in this office. Primarily, for a large majority of our patients, our office is currently utilizing state-of-the-art technology; therefore safety is not a concern. After 10 years and over 25,000,000 treatments there have been no reports of stroke or any other CVA related negative outcomes.

Doctors of Chiropractic using manual therapy treatment for patients with headaches and neck complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be 1 per 400,000 treatment to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this form of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

In addition to spinal manipulation, treatment can also involve other forms of therapy including: ultrasound electrical stimulation, traction, hot and cold packs, hydrotherapy, infrared heat, low level laser, trigger point, massage, exercise, topical pain relieving gel and nutritional supplements.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

**Assignment of Benefits**

\_\_\_\_\_ I assign all benefits payable to me for my care to Southern Pines Chiropractic, P.A. I understand that this health care facility will be paid directly by the insurance company or other payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

**Guarantee of Payment**

\_\_\_\_\_ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

**Consent for Treatment**

\_\_\_\_\_ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

**Authorization to Treat a Minor**

\_\_\_\_\_ I hereby request my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to all other doctor in this clinic and is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Southern Pines Chiropractic, P.A.

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# Patient Health Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. When did your symptoms start: \_\_\_\_\_

Describe your symptoms and how they began: \_\_\_\_\_

2. How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Complaints		Mild, forgotten with activity		Interferes with activity		Prevents full activity		Intense, preoccupied with seeking relief		Severe

3. What activities make your symptoms worse? \_\_\_\_\_

4. What activities make your symptoms better? \_\_\_\_\_

5. Who have you seen for your symptoms? No One Medical Doctor Other  
Other Chiropractor Physical Therapist

a. When and what treatment? \_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed? X-rays Date: \_\_\_\_\_ CT Scan Date: \_\_\_\_\_  
MRI Date: \_\_\_\_\_ Other Date: \_\_\_\_\_

6. Have you had similar symptoms in the past? Yes No

7. What is your occupation? \_\_\_\_\_

a. If you are not retired, a homemaker or student what is your current work status? Full Time Self Employed  
Part Time Unemployed  
Off Work Other

8. What do you hope to get from your visit /treatment? Circle all that apply.  
Reduce Symptoms Explanation of condition/treatment How to prevent this from occurring again  
Resume/increase activity Learn how to take care of this on my own Other

9. How often do you experience your symptoms?

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

10. What describes the nature of your symptoms?

- |           |          |
|-----------|----------|
| Sharp     | Shooting |
| Dull Ache | Burning  |
| Numb      | Tingling |

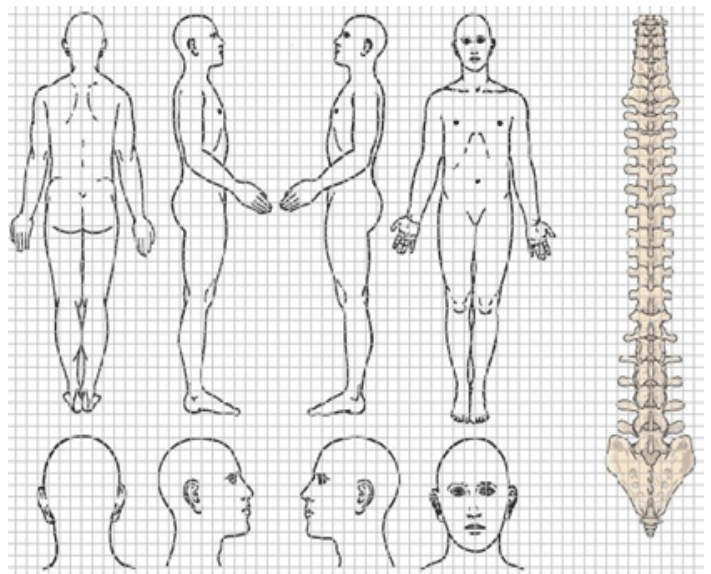
11. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

12. How bad are your symptoms at their:

- a. Worst: 0 1 2 3 4 5 6 7 8 9 10  
 b. Best: 0 1 2 3 4 5 6 7 8 9 10

13. Indicate where you have pain or other symptoms:



**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

What type of regular exercise do you perform?(circle one) None    Light    Moderate    Strenuous

What is your height and weigh? Height \_\_\_\_\_ Feet \_\_\_\_\_ Inches    Weight \_\_\_\_\_ lbs.

**For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.**

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid back pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones			
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper arm pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Wrist pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostrate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss			
<input type="checkbox"/>	<input type="checkbox"/>	Joint swelling/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			<b>Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor			
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			<b>Other Health Problems/Issues</b>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Indicate if an immediate family member has had any of the following:**

Rheumatoid Arthritis     Heart Problems     Diabetes     Cancer     Lupus     \_\_\_\_\_

**List all prescriptions, over-the-counter medications, & nutritional/herbal supplements you are taking:**

\_\_\_\_\_  
\_\_\_\_\_

**List all the surgical procedures you have had and times you have been hospitalized:**

\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Doctor's Additional Comments: \_\_\_\_\_

**Doctor Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# Neck Index

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

This questionnaire will give your provider information about how your neck condition affects your every day life. Please answer every section by circling the one statement that applies to you. If two or more statements in one section apply, please circle 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 hour 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 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 dresses, I wash with difficulty and I 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 of the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- 3 Pain prevents me from lifting heavy objects off of 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 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 with some infrequency.
- 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 of the time.

Neck Index Score \_\_\_\_\_

# Back Index

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

This questionnaire will give your provider information about how your back condition affects your every day life. Please answer every section by circling the one statement that applies to you. If two or more statements in one section apply, please circle 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 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 ½ an 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 ½ 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 ½ mile without increasing pain.
- 4 I cannot walk more than ¼ 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 pain.
- 1 I can lift heavy weights but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights off of the floor.
- 3 Pain prevents me from lifting heavy weights off of 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 of 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 alternative forms of travel.
- 3 I get extra pain while traveling which causes me to seek alternative 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.

Back Index Score \_\_\_\_\_