History Sheet

Name:_____ **Date:**_____

1. What is your primary complaint? When & if known, how did it start?

   Since onset has it gotten any: ☐ Better ☐ Same ☐ Worse

   Do your symptoms refer anywhere?

   Have you had this issue before and if so, how often?

2. Timing changes: is it worse in the **AM** or **PM**? *Please circle.*

   If so, for how long? _____ min

3. Is the condition worse with any particular position or movement? *Please circle.*

-Sitting	-Changing Positions	-Twisting	-Up / Down Stairs
-Standing	-Bending	-Lifting	-Deep breath
-Walking	-Laying / Sleeping	-Reaching	-Cough / Sneeze / Bowel movement

   Other: _____

4. What makes it feel better? *(example: sitting, massage, ice, medications, etc.)*

5. What daily activities make it worse or have been affected by this problem?
   Please be specific: work, personal care, hobbies, exercise, home care, sleep, etc.

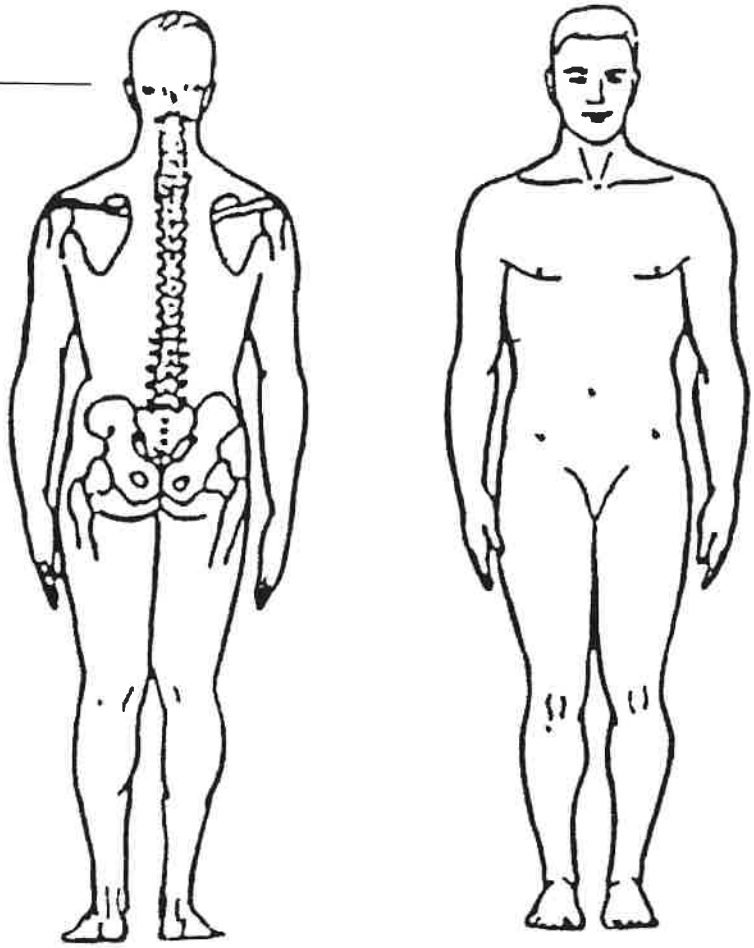
6. Any odd/unusual symptoms or changes in the last year? *(example: fatigue, weight loss, etc.)*

7. Please list any additional accidents or traumas. *(example: car, slips, falls, etc.)*

8. Have you ever had chiropractic care for this or other issues? Last approx. treatment?

9. Please list any other services, treatment, or surgeries you have had for this issue.

Name _____ Date _____



Please circle area(s) of pain.

If needed, please use the following symbols to describe the sensations you currently feel.

Numbness:	---	Tingling:	ooo	Burning:	xxx
	---		ooo		xxx

PAIN SCALE

Instructions: *Please circle the number which best describes the question asked.*
Note: *If you have more than one complaint, please indicate which score is for which complaint.*

What is your TYPICAL or AVERAGE pain?

1 2 3 4 5 6 7 8 9 10

What is your pain level at it's BEST? (How close to '0' does your pain get?)

1 2 3 4 5 6 7 8 9 10

What is your pain level at it's WORST? (How close to '10' does your pain get?)

1 2 3 4 5 6 7 8 9 10

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.

Office Use Only

Back Index Score ☐

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.

Office Use Only

Neck Index Score ☐

CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I(We) hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____,by **Dr. Deveau D.C.** and/or other licensed doctors of chiropractic who may be employed or engaged in practice in the **EAST WEST CHIROPRACTIC** Clinic.

I have had an opportunity to discuss with Dr. Deveau D.C., or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complication associated with chiropractic services is very low, anyone undergoing adjustment or manipulative procedures should know the possible hazards and complications which may be encountered or result. These include, but are not limited to fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its content and by signing below agree to the named procedures.

_____
Patient's Name

Witnesses:

_____
Patient's Signature

_____ _____
Relationship or authority
If not signed by Patient

Date:_____

DOCTOR'S NOTES

Patient counseled by the use of the following:

_____ Discussion
_____ Other (please specify)

_____

OFFICE POLICY

We believe that a clear definition of our office policies will allow both you, the patient, and us, the doctor, to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY
Multiple appointments will be scheduled for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts; and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. It is your obligation to make up a missed appointment within **7 days** of any cancellation.

This office reserves the right to charge for missed appointments and those cancelled without 24 hours notice. All Text and E-mail reminders are sent as a courtesy, patients are still responsible for keeping track of their appointment times.

When entering the office on any given visit, please go directly to the front desk and "sign-in." We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. If you have any questions regarding our office policy or your appointments, please do not hesitate to speak to the receptionist directly.

FINANCIAL POLICY

1. It is our office policy that all services rendered in this office are billed to your insurance company, if applicable. If for any reason your insurance company rejects you claims, you are personally responsible for all charges incurred.

2. All payments, including co-pays and deductibles, are expected at the time of service or at the end of each week. Patients' balances may not exceed $150 at any time.

3. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1 ½% per month.

4. **A charge of $20 will be incurred for all appointments that are missed or those not cancelled with 24 hour notice.**

5. **A charge of $40.00 will be incurred for all 60 minute massage appointments that are missed or those not cancelled with 24 hour notice.**

6. **A charge of $20.00 will be incurred for all 30 minute massage appointments that are missed or those not cancelled with 24 hour notice.**

PATIENT NAME_____

PATIENT'S SIGNATURE_____

DATE_____