Today's Date: ______________

Patient Health Record

Name: ______________________________ Guardian's Name (if minor): ______________________

Address: ______________________________ City: ______________ State: _______ Zip: __________

Birth Date: ________________ Age: ________ Ethnicity: ________________ Gender: ☐M ☐ F

Cell Phone: ______________________________ Home Phone: ______________________________

Work Phone: ______________________________ E-mail: ______________________________

Occupation: ______________________________ Employer: ______________________________

Primary Care Physician: ______________________ City: ______________ Marital Status: ☐ M ☐ S ☐ W ☐ D

Emergency Contact: ________________ Relationship: ________________ Phone #: ________________

Are you insured? ☐ Y ☐ N Insurance Company: ________________ ID#: ________________ Group #: __________

Cardholder's Name: ______________________________ Cardholder's Date of Birth: ________________

Social Security #: ______________________ Is this visit the result of a work or auto injury? ☐ Y ☐ N

Reason for This Visit

Describe the purpose of this visit: ____

____

How did this condition begin? ____

____

When did this condition begin? ____

____

Is this condition: ☐Getting worse ☐Not changing ☐Getting better Is this condition: ☐Constant ☐ Comes and Goes

What makes it **better**? (rest, ice, heat, positioning, etc.) ______________________________

What makes it **worse**? (circle all that apply)

Sitting	Changing positions	Laying/Sleeping	Going up/downstairs
Standing	Twisting	Reaching	Deep breaths
Walking	Lifting	Bending	Cough/Sneeze/Bowel movements

Other: ____

Does the pain: ☐Stay in one spot ☐Travel to other areas If it travels, where? ______________________

Describe the pain: Ache/sharp/shooting/burning/pins and needles/numbness Other: ______________________

Is your pain worse in the AM or PM (circle one)? Or no difference?

Please rate the severity of your pain when it's at its **best** (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Please rate the severity of your pain when it's at its **worst** (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Please rate the **average** severity of your pain (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Has this condition occurred before? If yes, how often?: ______________________________

Have you ever seen other doctors/massage/acupuncture, etc. for this condition? ☐ Y ☐N Name(s): ______________

Types of Treatment: ____

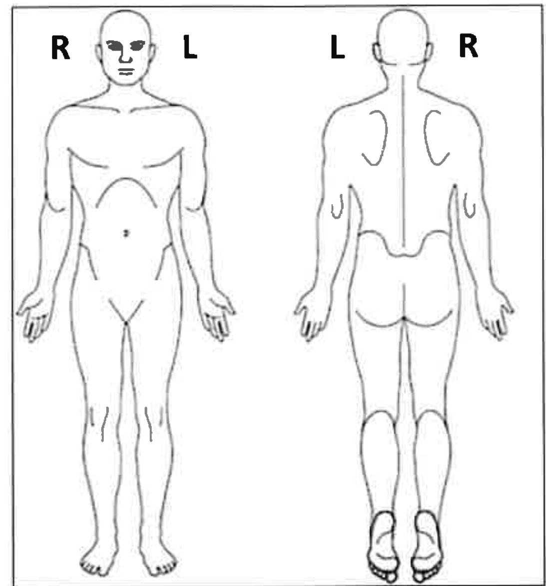
Did it help? ☐ Yes ☐ No ☐ Temporary Relief

Other injuries: (i.e. car accidents, falls, etc.) ______________________________

____

Any other odd/unusual changes in the last few months: (i.e. unexplained weight loss/gain, fatigue, changes in bowel/bladder function, etc.) ____

Please mark the location of your pain on the drawing (right) →



Experience with Chiropractic

Who referred you to this office? ____________________

Have you ever received chiropractic care before? ☐ Y ☐ N

Where? ____________________

Reason for care? ____________________

____

Date of last treatment (approx.)? ____________________

What types of treatment did you receive? ____________________

____

Current Medications and Supplements

Please circle all that apply

High Blood Pressure	Prescription Pain Medication	Insulin	Muscle Relaxers
High Cholesterol	Thyroid Medication	Blood Thinners	Anti-depressant
Anti-anxiety	Anti-biotics	Allergy	Medical Marijuana
OTC NSAIDs (Tylenol, Motrin, etc.)		Steroids/Anti-inflammatory	
Multivitamin	Probiotic	Omegas	Fiber
Vitamin C	Vitamin D	Calcium	Turmeric

Other: ____________________

____

Health History

Please circle each of the diseases or conditions you have now or have had in the past:

High/Low Blood Pressure	High Cholesterol	Heart Disease	Heart Attack
Headache/Migraines	Dizziness	Stroke	Epilepsy
Thyroid Problems	Anxiety	Depression	Arthritis
Diabetes	Hepatitis	Liver Disease	Joint Replacement
HIV/AIDS	Osteoporosis	Multiple Sclerosis	Rheumatoid Arthritis
Cancer/Chemotherapy	Anemia	Bleeding Disorders	Emphysema
Gout	Kidney Disease	Pacemaker	Parkinson's Disease

Other: ____________________ Medical Implants: ____________________

Past Surgeries and Dates: ____________________

____

Smoking: ___ packs/day ___ Former ___ Never Alcohol: ____ drinks/week

Coffee/Caffeine: ___ cups/day Water: ___ oz/day

Do you exercise? If yes, what type and how often? ____________________

*****For Women:*** *Last Menstrual Cycle:* ____________________

Are you taking birth control? ______ *Are you pregnant?* ______ *If yes, when are you due?* ________________

Name: ____________________ *Today's Date:* ______________

Our Privacy Policy

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health conditions.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. (164.520)

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to certain individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions.

Your Right to Revoke Your Authorization: You may revoke your consent to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I authorize you to use and disclose my information in the manner described above, to my primary care physician, and to:

Name: ______________________ Relationship: ______________________

I have read your consent policy and agree to its terms. Initials: ______________

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to adjust/manipulate your joints. You may hear a "pop" or "click" like when a knuckle is "cracked", and you may feel movement in the joint. Various ancillary procedures, such as hot or cold packs, electric stimulation, therapeutic ultrasound, and traction as well as exercise instruction and other modalities may also be used. There are inherent risks in all treatment derived by any health care provider ranging from taking a single aspirin to a complicated brain surgery. Chiropractic care is no exception. Although we take every precaution, there is a very low incidence of complication associated with chiropractic services, and anyone undergoing adjustment or manipulative therapy procedures should know the possible hazards and complications which may be encountered. These include, but are not limited to fractures, disc injuries, stroke, dislocations, sprains, and those related to physical aberrations unknown or reasonably undetectable by the doctor.

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 judgement; 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 judgement during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

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 include chronic pain cycles. It is quite probable the delay of treatment will complicate the condition and make further rehabilitation more difficult or impossible. Concerns or questions: Please ask your doctor to explain any concerns about treatment you may have.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on my dependent/charge, by the licensed Doctor of Chiropractic (D.C.) employed or engaged in practice at **East West Chiropractic**.

I have read the above consent to chiropractic care. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. Initials: ______________

Emails and Appointment Reminders

We may need to use your name, address, phone number and your clinical records to contact you with appointment reminders (text and email), information about treatment alternatives, or other health related information that may be of interest to you. This information may also be used for the purpose of sending birthday/holiday cards and messages, occasional newsletters, etc. If this contact is made by phone and you do not answer, a message will be left on your answering machine. By signing this, you are giving us authorization to contact you with these reminders and information. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, and other health related information or marketing at any time. Telephone calls, text messages, and emails may be monitored for quality control.

I authorize you to use and disclose my health information in the manner described above. Initials: ______________

I understand that all services are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I clearly understand 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 service rendered to me will be immediately due and payable. I authorize the use of signature on my insurance submissions.

Name (Print): ______________________ **Signature:** ______________________ **Date:**

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.

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.

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.

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.

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.

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.

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.

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.

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.

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