

About You

Today's Date: _____/_____/_____

Name: _____

Email: _____

What do you prefer to be called: _____

Cell Phone: _____

Male Female

Home Phone: _____

Birthdate: ____/____/____ Age: _____

Preferred Contact: Home Cell

SS# _____

Phone call Text Email

Home Address: _____

City: _____ County: _____ State: _____ Zipcode: _____

Employer: _____ Occupation: _____ How long? _____

Employer's Address: _____ City: _____

State: _____ Zipcode: _____ Work #: _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name: _____

Referred by: _____

Insurance Info

Co. Name: _____

Address: _____

Phone #: _____

Insured's SSN: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Insured's Employer: _____

Relation: _____ Date of Birth: ____/____/____

Please inform front desk of 2nd Insurance source

Reason For Visit

Have you ever been treated by a Chiropractor before? Yes No

If so, please explain: _____

The reason for this visit is a result of (Please circle): work, sports, auto, trauma, or chronic

(Explain what happened): _____

Please describe the pain and its location: _____

When did this condition begin: ____/____/____

Is this condition getting worse: Yes No Constant Comes and goes

Is this condition interfering with your (Please circle): work, sleep or daily routine?

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition: Yes No

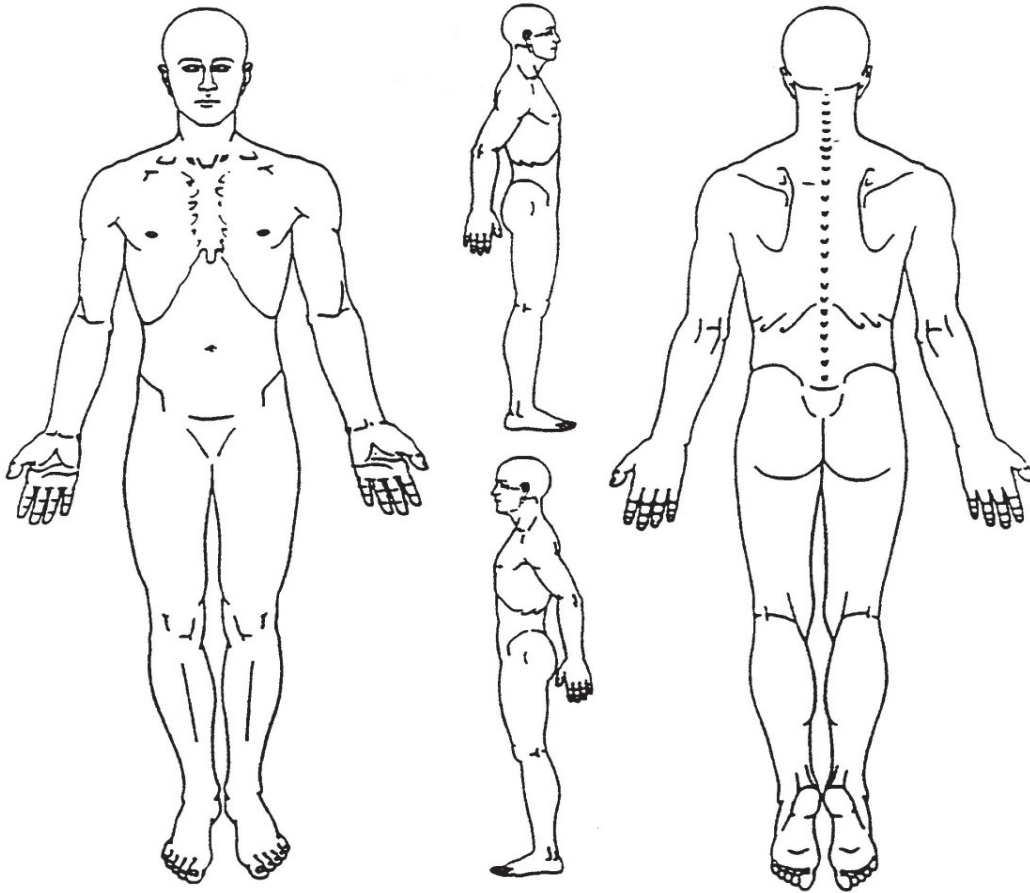
If so, please explain: _____

What is your current weight: _____ lbs., and height _____ Feet, _____ Inches

Where do you hurt?

Please mark **area(s)** of injury or discomfort as shown below.

Numbness Pins & Needles Burning Aching Stabbing
----- ○○○○○○ ^^^^^^^^ XXXXXX ●●●●●●



Describe your pain: _____

Emergency Contact: _____

Relation: _____

Home Phone: _____

Work Phone: _____

HEALTH HISTORY

List any medication you take: _____

List any supplements you take: _____

Have you ever had any of the following diseases/medical condition(s) ?

Y	N		Y	N		Y	N	
Y	N	Heart Attack/Stroke	Y	N	Heart Surg/Pacemaker	Y	N	Heart Murmur
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse	Y	N	Artificial Valves
Y	N	Alcohol/Drug Abuse	Y	N	Veneral Disease	Y	N	Hepatitis
Y	N	HIV+/AIDS	Y	N	Shingles	Y	N	Cancer
Y	N	Frequent Neck Pain	Y	N	Emphysema/Glaucoma	Y	N	Anemia
Y	N	High/Low Blood Pressure	Y	N	Psychiatric Problems	Y	N	Rheumatic Fever
Y	N	Severe/Frequent Headaches	Y	N	Kidney Problems	Y	N	Ulcers/Colitis
Y	N	Fainting/Seizures/Epilepsy	Y	N	Sinus Problems	Y	N	Asthma
Y	N	Diabetes/Tuberculosis	Y	N	Difficulty Breathing	Y	N	Chemotherapy
Y	N	Lower Back Problems	Y	N	Artificial Bones/Joints	Y	N	Arthritis

Please list any other serious medical condition(s) you have or ever had:

Please list anything you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Do you smoke? No Yes How much? _____ packs/week How long? _____ years

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

What is the age of your mattress? _____ years Is it comfortable? Yes No

For Women: Are you taking Birth Control? Yes No

Are you Pregnant: No Yes/How long? _____ Nursing? Yes No

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

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

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5-Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
 (Score x 2) / (Sections x 10) = %ADL

Section 6 – Concentration

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

Section 7—Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8 – Driving

- I drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Comments _____ %ADL

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- I can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

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

Section 4 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than one-half mile.
- Pain prevents me from walking more than one-quarter mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
 (Score x 2) / (Sections x 10) = %ADL

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 -- Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

Section 9 – Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain is bad but I manage journeys less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments _____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Statement of Acknowledgement of Financial Responsibility

Disclaimer:

I understand that I may be financially responsible for any charges incurred at this office, including co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review any/all documentation submitted by Buffalo Family Chiropractor, LLC for review for medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me if my care is not approved by the insurance company. If a treatment plan is not approved, this office will make me aware of the number of office visits allowed and the timeframe of the authorization. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

The office may seek payment from you for any services your health insurance plan determines to be not medically necessary.

I have read and understand my obligations for payment for care in the absence of insurance coverage.

Print Patient's Name

Signature (Patient, Parent, Guardian)

Date

Informed Consent to Chiropractic Treatment

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. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, 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 minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen 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 twenty 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 which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in 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 in 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 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.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

Printed Name

Signature

Date

WITNESS:

Printed Name

Signature

Date