Today's Date:_____/_____/_____

About You

Name:_____

What do you prefer to be called: _____

□ Male □ Female

Birth date: _____/_____/_____ Age:_____

SS#_____

Home Address: _____

City:_____

State:_____Zip code:_____

Occupation:_____

How long?_____

Employer: _____

Employer's Address:_____

City:_____

State:_____Zip code:_____

Email: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Preferred Contact: □ Home □ Cell □ Work

Preferred Type: □ Call □ Text □ Email

Marital Status: □ Single □ Married

□ Divorced □ Separated □ Widowed

Spouse's Name:_____

Referred by:

_____

Insurance Info

Insurance Company:

_____

Phone#:

_____

Policy Number: _____

Insured's Employer:

_____

Address: _____

Insured's SSN: _____

Insured's Name:

_____

Relation:

_____

Insured's 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

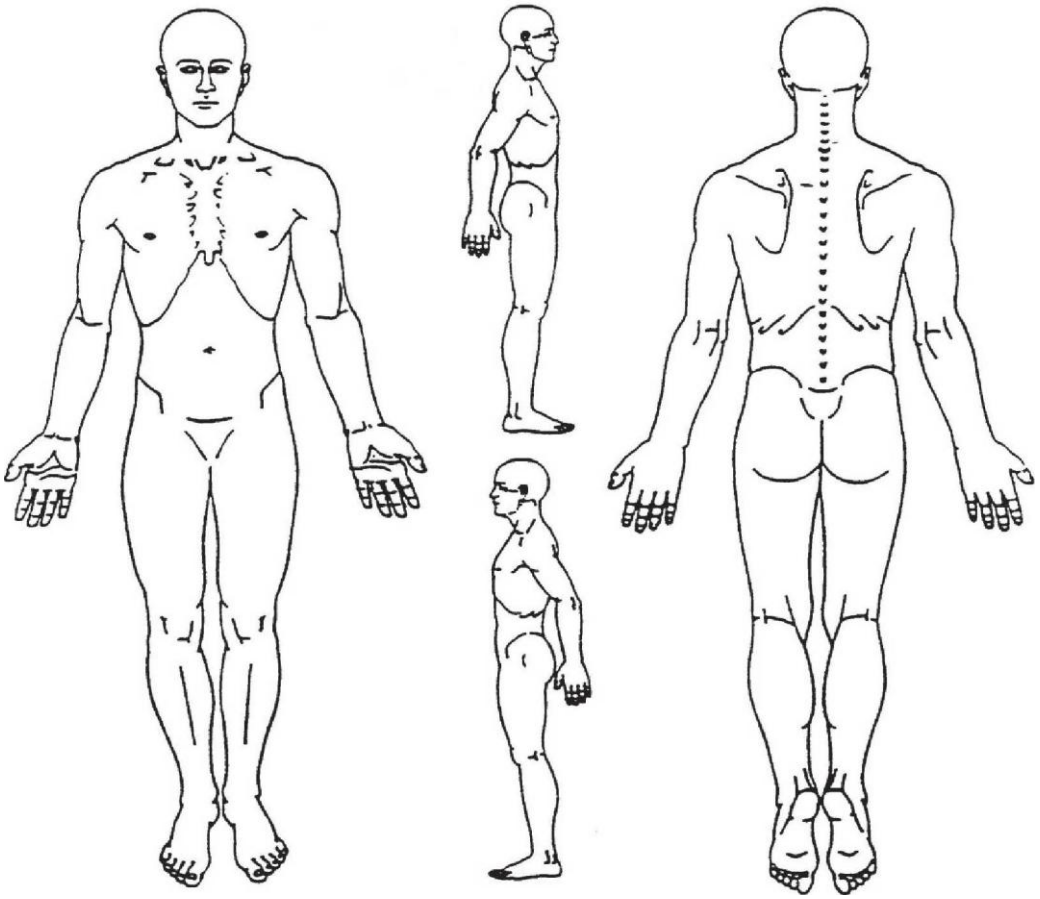
If so, please explain:_____

What is your current weight: _____lbs
What is your current 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:

_____

_____

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	Venereal 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 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 For how many years? _____

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

What is the age of your mattress?_____Years Is it comfortable? □ Yes

For Women: Are you taking Birth Control? □ Yes □ No

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

Neck Disability Index Questionnaire (NDI)

Name: **Date:**

*This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but* **Please just circle the one choice which closely describes your problem right now.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

DISABILITY INDEX SCORE: **%** _____

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

Source: Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. J Manipulative Physiol Ther 1991;14(7):409-15.

Revised Oswestry Disability Index (ODI)

Name: **Date:**

*This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but* **Please just circle the one choice which closely describes your problem right now.**

SECTION 1 – Pain Intensity

A. The pain comes and goes and is very mild
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing or dressing without help.
F. Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights off of the floor.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
F. I can only lift very light weights at the most.

SECTION 4 – Walking

A. I have no pain walking.
B. I have some pain walking, but I can still walk my required normal distances.
C. Pain prevents me from walking long distances.
D. Pain prevents me from walking intermediate distances.
E. Pain prevents me from walking even short distances.
F. Pain prevents me from walking at all.

SECTION 5 – Sitting

A. Sitting does not cause me any pain.
B. I can sit as long as I need provided I have my choice of sitting surfaces.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than 10 minutes
F. Pain prevents me from sitting at all.

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for more than one hour without increasing pain.
D. I cannot stand for more than ½ hour without increasing pain.
E. I cannot stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases my pain right away.

SECTION 7 – Sleeping

A. I have no pain in bed.
B. I have pain in bed but it does not prevent me from sleeping well.
C. Because of pain I only sleep ¾ of normal time.
D. Because of pain I only sleep ½ of normal time.
E. Because of pain I only sleep ¼ of normal time.
F. Pain prevents me from sleeping at all.

SECTION 8 –Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of pain.
C. Pain prevents me from participating in more energetic activities, eg sports, dancing.
D. Pain prevents me from going out very often.
E. Pain has restricted my social life to home.
F. I hardly have any social life because of pain.

SECTION 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get some pain while traveling, but it does not cause me to seek alternative forms of travel.
D. I get extra pain from travel that causes me to seek alternative forms of travel.
E. Pain restricts me from all forms of travel.
F. Pain restricts me from all forms of travel, except that done lying down.

SECTION 10 – Employment / Homemaking

A. My normal job/homemaking activities do not cause me pain.
B. My normal job/homemaking activities cause me extra pain, but I can still perform all that is required of me.
C. I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities eg, lifting, vacuuming.
D. Pain prevents me from doing anything but light duties.
E. Pain prevents me from doing even light duties.
F. Pain prevents me from performing any job or homemaking chore.

DISABILITY INDEX SCORE: _____%

Source: Fairbank JC, Couper J, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. Physiotherapy 1980;66(8):271-3.

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 Herrington Family Chiropractic, PLLC 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 or therapeutic ultrasound 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.

PATIENT:

_____

Printed Name Signature Date

WITNESS:

_____

Printed Name Signature Date