

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI) _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____
Email: _____ Gender: M / F Marital Status: Married / Other / Single
Social Security #: _____ Date of Birth: _____
Student Status: Full Student / Part Student / Non-Student Employed Employer: _____
*Referred By: _____

Ethnicity: Hispanic or Latino / Other Preferred Language: _____
Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ Primary Care Physician: _____
Home: _____ Mobile: _____ Doctor's Phone: _____
Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other (please explain): _____

PRIMARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

SECONDARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

Who is responsible for payment? Self / Other - (Relationship) _____

Other than Self:

Full Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

19. How would you rate your overall health?
__Excellent __Very Good __Good __Fair __Poor

20. Are you allergic to any medications? ___Yes ___No
If yes, what is the reaction? _____

21. Please list all prescription medications you are currently taking.

22. Please list all over-the-counter medications or supplements you are currently taking.

23. Please list all surgical procedures you have had.

24. What activities do you do at work?
Sit: ___most of the day ___half of the day ___a little of the day
Stand: ___most of the day ___half of the day ___a little of the day
Computer work: ___most of the day ___half of the day ___a little of the day
On the phone: ___most of the day ___half of the day ___a little of the day
Drives: ___most of the day ___half of the day ___a little of the day
___performs manual labor most of the day ___reads about half of the day ___travels frequently a little of the day ___None

25. What activities to you do outside of work?
___Aerobics ___skiing ___basketball ___soccer ___baseball ___softball ___bicycling ___swimming
___football ___tennis ___golf ___triathlons ___hiking ___volleyball ___ice hockey ___walking
___inline skating ___weight lifting ___jogging ___working out ___marital arts ___yoga ___rock climbing
___other _____

26. Have you ever been hospitalized? ___Yes ___No ___Previously mentioned
If yes, why?

27. Have you ever been to a chiropractor before? ___Yes ___No. If yes, how long ago? _____
Results: ___great ___good ___fair ___poor

28. Have you had any significant trauma? ___Yes ___No. If yes, what kind? _____

29. Anything else pertinent to your visit today? _____

Patient or Patient's guardian signature: _____ Date: _____

PATIENT INTAKE FORM

Patient's Name: _____ Date: _____

1. Is today's problem caused by _____ Auto Accident _____ Workman's Compensation
2. How often do you experience your symptoms?
 _____ constantly (76-100% of the time) _____ occasionally (26-50% of the time)
 _____ frequently (51-75 % of the time) _____ intermittently (1-25% of the time)
3. How are your symptoms changing with time?
 _____ getting worse _____ staying the same _____ getting better
4. How much has the problem interfered with your work?
 _____ not at all _____ a little bit _____ moderately _____ quite of bit _____ extremely
5. How much has the problem interfered with your social activities?
 _____ not at all _____ a little bit _____ moderately _____ quite of bit _____ extremely
6. Who else have you seen for your problem?
 _____ chiropractor _____ massage therapist _____ orthopedist _____ ER Physician _____ Neurologist
 _____ Physical Therapist _____ Primary Care Physician _____ Other: _____
7. How long how you had this problem? _____
8. How do you think your problem began? _____
9. Do you consider this problem to be severe? _____ Yes _____ Yes, at times _____ No
10. What aggravates your problems? _____
11. What alleviates your pain? _____
12. What concerns you most about your problem? _____
13. What does it prevent you from doing? _____
14. What is your: Height _____ Weight _____ Date of birth _____
15. Occupation: _____ Trader _____ Laborer _____ Professional/Executive _____ Homemaker _____ student
 _____ white collar _____ truck driver _____ retired _____ unemployed _____ other _____
16. What type of exercise do you do? _____ strenuous _____ moderate _____ light _____ none
17. Indicate if you have any immediate family members w/any of the following. (M)other, (F)ather or (S)ibling
 _____ Rheumatoid Arthritis _____ Diabetes _____ Lupus _____ Heart Problems _____ Cancer _____ ALS
18. 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

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip Pain
- Upper Leg Pain
- Knee Pain
- Ankle/Foot Pain
- Jaw Pain
- Joint Pain/Stiffness
- Arthritis
- Rheumatoid Arthritis
- Cancer
- Tumor
- Asthma
- Chronic Sinusitis
- Other: _____

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Angina
- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder
- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

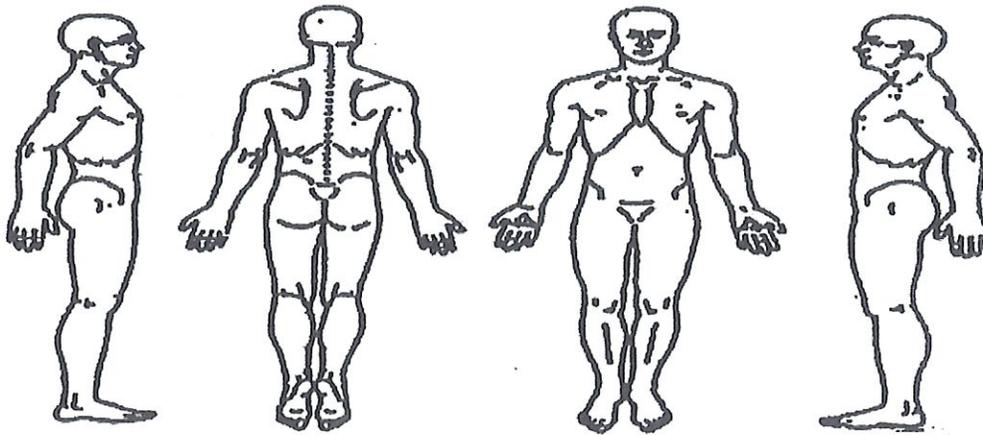
Past Present

- Diabetes
 - Excessive Thirst
 - Frequent Urination
 - Smoking/Tobacco Use
 - Drug/Alcohol Dependence
 - Allergies
 - Depression
 - Systemic Lupus
 - Epilepsy
 - Dermatitis/Eczema/Rash
 - HIV/AIDS
- For Females Only**
- Birth Control Pills
 - Hormonal Replacement
 - Pregnancy

A: Identify your areas of discomfort by marking the affected body parts in the illustration in order of complaint with a number. i.e.: 1 lower back; 2 neck; 3 shoulder; etc.

B: Indicate the area name along with your specific symptoms associated with each selected area.

C: Rate your discomfort associated with each selected with 1 (least pain) to 10 (worst pain).



Sharp Dull Diffuse Achy Burning Shooting Stiff Numb Tingly Sharp w/motion Shooting w/motion Stabbing w/motion Electric like w/motion other

Example

L	R	Lower back	X			X			X											
---	---	------------	---	--	--	---	--	--	---	--	--	--	--	--	--	--	--	--	--	--

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	(X) 7	8	9	10
---	---	---	---	---	---	---	-------	---	---	----

1.

L	R																			
---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

2.

L	R																			
---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

3.

L	R																			
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0= No discomfort 10= severe discomfort

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

4.

L	R																			
---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

0= No discomfort 10= severe discomfort

0	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.

Back
Index
Score

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

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

- 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 causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, i.e. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

SECTION 4 - WORK

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

SECTION 5 - HEADACHES

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

SECTION 6 - CONCENTRATION

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

SECTION 7 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 - DRIVING

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

SECTION 9 - READING

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

SECTION 10 - RECREATION

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

PATIENT NAME _____

DATE _____

SCORE _____ [50]

BENCHMARK -5 = _____

DR. DENNIS MYERS
CARE CHIROPRACTIC & ACUPUNCTURE
1503 GRAHAM AVE
HENDERSON, NC 27536
252-438-2273

INFORMED CONSENT
TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Dennis Myers and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Dennis Myers and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Name

Print Name of Patient

Print Name of Representative

Signature of Patient

Signature of Representative

This form should be maintained in the patient's health record.

Patient: _____

AUTHORIZATIONS AND RELEASES

Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child and grant my consent for the treatment of the child as provided for herein. I acknowledge that I may refuse treatment at any time.

Initials: _____

Consent to Perform and Interpret X-rays

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate. I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor.

Initials: _____

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit:

hhs.gov-Understanding Health Information Privacy

The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit release of all PHI to the minimum necessary to receive payment. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services. This office is committed to protecting your PHI and meeting the HIPAA obligations: Staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. Patients have the right to file a formal complaint with our privacy official about any suspected violations. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initials: _____

Financial Obligations and Appointment Policy

Financial Obligations: I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefits exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage. You may direct any questions regarding this financial obligation to the clinic manager or physician.

Appointment Policy: If the patient is unable to keep his or her appointment then the patient must call 24 hours prior to the scheduled appointment, failure to do so can result in a \$50 charge to the patient. The patient is allowed to miss 3 visits with no notice, after the three missed visits without prior notification the patient will be discharged from care due to non-compliance.

Initials: _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus. **DATE OF LAST MENSTRAL PERIOD (LMP):** _____

Initials: _____

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable. I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carries, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initials: _____

Insurance/Medicare Payment-Signature on File

I certify that the information given by me in applying for Insurance and/or Medicare payment is true and correct. I authorize this office and/or doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits to this clinic and/doctor of record on my behalf for any services and material furnished.

Initials: _____

Females: Consent to X-Ray during Pregnancy

This is to certify that, I am or may be pregnant and that the doctor or certified staff has my permission to perform diagnostic x-rays involving any cervical spine (neck) or extremities (arms or legs), on the condition that lead shielding be use over the trunk of my body. I have been advised that certain x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Initials: _____

PATIENT'S SIGNATURE: _____ **DATE:** _____