CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____ Race _____

Birthdate _____ Ethnicity _____

Preferred Language _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Communication Preference ☐ Phone ☐ Email

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

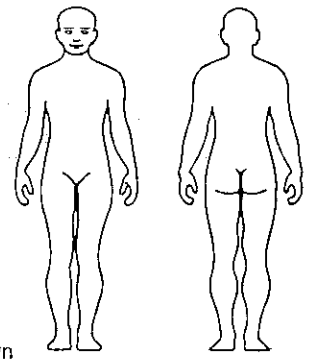
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

– OVER –

6 HEALTH HISTORY

Height_____ Weight_____

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other_____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam_____ Chest X-Ray_____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐Yes ☐No	Diabetes ☐Yes ☐No	Liver Disease ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Alcoholism ☐Yes ☐No	Emphysema ☐Yes ☐No	Measles ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
Allergy Shots ☐Yes ☐No	Epilepsy ☐Yes ☐No	Migraine Headaches ☐Yes ☐No	Sexually Transmitted Disease ☐Yes ☐No
Anemia ☐Yes ☐No	Fractures ☐Yes ☐No	Miscarriage ☐Yes ☐No	Stroke ☐Yes ☐No
Anorexia ☐Yes ☐No	Glaucoma ☐Yes ☐No	Mononucleosis ☐Yes ☐No	Suicide Attempt ☐Yes ☐No
Appendicitis ☐Yes ☐No	Goiter ☐Yes ☐No	Multiple Sclerosis ☐Yes ☐No	Thyroid Problems ☐Yes ☐No
Arthritis ☐Yes ☐No	Gonorrhea ☐Yes ☐No	Mumps ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Asthma ☐Yes ☐No	Gout ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Bleeding Disorders ☐Yes ☐No	Heart Disease ☐Yes ☐No	Pacemaker ☐Yes ☐No	Tumors, Growths ☐Yes ☐No
Breast Lump ☐Yes ☐No	Hepatitis ☐Yes ☐No	Parkinson's Disease ☐Yes ☐No	Typhoid Fever ☐Yes ☐No
Bronchitis ☐Yes ☐No	Hernia ☐Yes ☐No	Pinched Nerve ☐Yes ☐No	Ulcers ☐Yes ☐No
Bulimia ☐Yes ☐No	Herniated Disk ☐Yes ☐No	Pneumonia ☐Yes ☐No	Vaginal Infections ☐Yes ☐No
Cancer ☐Yes ☐No	Herpes ☐Yes ☐No	Polio ☐Yes ☐No	Whooping Cough ☐Yes ☐No
Cataracts ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Prostate Problem ☐Yes ☐No	Other _____
Chemical Dependency ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Prosthesis ☐Yes ☐No	
Chicken Pox ☐Yes ☐No	Kidney Disease ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	
		Rheumatoid Arthritis ☐Yes ☐No	

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Former Smoker ☐ Never Smoked
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

Sylva Chiropractic Center
1635 E Main St, Sylva, NC, 28779-
(828) 586-2483

Informed Consent -- Chiropractic Care

Patient's Name:

Date of Care Plan: (see attached Care Plan)

Instructions: This document relates to your Informed Consent for care. Please read carefully before signing.

General. I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. To the best of my knowledge. I am not pregnant.

Sylva Chiropractic Center
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Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended Care.

Patient's Name:

Patient's Signature: _____

Date of Signature: ___/___/___

Name of Parent / Guardian / Authorized Representative: Click here to enter text.

Signature: _____

Date of Signature: ___/___/___

Neck Pain Disability Index Questionnaire

Patient name _____ File # _____ Date _____
Initial Exam _____ Re-activation _____ Re-evaluation Exam _____
Vitals: Height _____ Weight _____ Blood Pressure _____ Pulse _____

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the number 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 most closely describes your problem right now. Add the score of each category and place total at bottom.

PAIN INTENSITY

1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

PERSONAL CARE

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

LIFTING

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it gives me extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, e.g., on a table.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

READING

1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want with moderate pain in my neck.
4. I cannot read as much as I want because of moderate pain in my neck.
5. I cannot read as much as I want because of severe pain in my neck.
6. I cannot read at all.

HEADACHES

1. I have no headaches at all.
2. I have slight headaches which come infrequently.
3. I have moderate headaches which come infrequently.
4. I have moderate headaches which come frequently.
5. I have severe headaches which come frequently.
6. I have headaches almost all the time.

Doctor's Signature _____

Patient name _____ Date _____

CONCENTRATION

1. I can concentrate fully when I want to with no difficulty.
2. I can concentrate fully when I want to with slight difficulty.
3. I have a fair degree of difficulty in concentrating when I want to
4. I have a lot of difficulty in concentrating when I want to.
5. I have a great deal of difficulty in concentrating when I want to.
6. I cannot concentrate at all.

WORK

1. I can do as much work as I want to.
2. I can only do my usual work, but no more.
3. I can do most of my usual work, but no more.
4. I cannot do my usual work.
5. I can hardly do any work at all.
6. I cannot do any work at all.

DRIVING

1. I can drive my car without any neck pain.
2. I can drive my car as long as I want with slight pain in my neck.
3. I can drive my car as long as I want with moderate pain in my neck.
4. I cannot drive my car as long as I want because of moderate pain in my neck.
5. I can hardly drive at all because of severe pain in my neck.
6. I cannot drive my car at all.

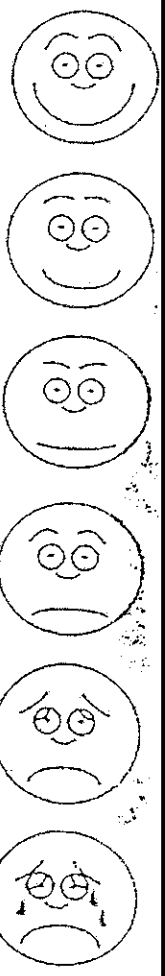
SLEEPING

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

RECREATION

1. I am able to engage in all of my recreation activities, with no neck pain at all.
2. I am able to engage in all of my recreation activities, with some pain in my neck.
3. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
4. I am able to engage in a few of my usual recreational activities because of pain in my neck.
5. I can hardly do any recreational activities because of pain in my neck.
6. I cannot do any recreational activities at all due to pain in my neck.

	Scale
No pain	0
	1
Mild, annoying pain	2
	3
Nagging, uncomfortable, troublesome pain	4
	5
Distressing, miserable pain	6
	7
Intense, dreadful, horrible pain	8
	9
Worst possible, unbearable, excruciating pain	10



Total Score _____

Doctor's Signature _____ Date _____

Oswestry Low Back Pain Disability Questionnaire

Patient name _____ File # _____ Date _____
Initial Exam _____ Re-activation _____ Re-evaluation Exam _____
Vitals: Height _____ Weight _____ Blood Pressure _____ Pulse _____

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the number 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 most closely describes your problem right now. Add the score of each category and place total at bottom.

PAIN INTENSITY

1. The pain comes and goes and is very mild.
2. The pain is mild and does not vary much.
3. The pain comes and goes and is moderate.
4. The pain is moderate and does not vary much.
5. The pain comes and goes and is severe.
6. The pain is severe and does not vary much.

PERSONAL CARE

1. I would not have to change my way of washing or dressing in order to avoid pain.
2. I do not normally change my way of washing or dressing even though it causes some pain.
3. Washing and dressing increases the pain, but I manage not to change my way of doing it.
4. Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
5. Because of the pain, I am unable to do some washing and dressing without help.
6. Because of the pain, I am unable to do any washing or dressing without help.

LIFTING

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
5. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
6. I can only lift very light weights, at the most.

WALKING

1. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than a mile.
3. Pain prevents me from walking more than ½ mile.
4. Pain prevents me from walking more than ¼ mile.
5. I can only walk while using a cane or crutches
6. I am in bed most of the time and have to crawl to the toilet.

Doctor's Signature _____

Patient name _____

Scale

SITTING

1. I can sit in any chair as long as I like without pain.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than one hour.
4. Pain prevents me from sitting more than ½ hour.
5. Pain prevents me from sitting more than ten minutes.
6. Pain prevents me from sitting at all.

No pain 0

1

Mild, annoying pain 2

3

Nagging, uncomfortable, troublesome pain 4

5

Distressing, miserable pain 6

7

Intense, dreadful, horrible pain 8

9

Worst possible, unbearable, excruciating pain 10

STANDING

1. I can stand as long as I want without pain.
2. I have some pain while standing, but it does not increase with time.
3. I cannot stand for longer than one hour without increasing pain.
4. I cannot stand for longer than ½ hour without increasing pain.
5. I cannot stand for longer than ten minutes without increasing pain.
6. I avoid standing, because it increases the pain immediately.

SLEEPING

1. I get no pain in bed.
2. I get pain in bed, but it does not prevent me from sleeping well.
3. Because of pain, my normal night's sleep is reduced by less than one-quarter.
4. Because of pain, my normal night's sleep is reduced by less than one-half.
5. Because of pain, my normal night's sleep is reduced by less than three-quarters
6. Pain prevents me from sleeping at all.

SOCIAL LIFE

1. My social life is normal and gives me no pain.
2. My social life is normal, but increases the degree of my pain.
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
4. Pain has restricted my social life and I do not go out very often.
5. Pain has restricted my social life to my home.
6. I have hardly any social life because of the pain.

TRAVELING

1. I get no pain while traveling.
2. I get some pain while traveling, but none of my usual forms of travel make it any worse.
3. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
4. I get extra pain while traveling which compels me to seek alternative forms of travel.
5. Pain restricts all forms of travel.
6. Pain prevents all forms of travel except when lying down.

CHANGING DEGREE OF PAIN

1. My pain is rapidly getting better.
2. My pain fluctuates, but overall is definitely getting better.
3. My pain seems to be getting better, but improvement is slow at present.
4. My pain is neither getting better nor worse.
5. My pain is gradually worsening.
6. My pain is rapidly worsening.

TOTAL SCORE _____

Doctor's Signature _____

Date _____

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