Family Chiropractic Center

Registration and History

Whom may we thank for referring you to us? _____

Is this visit due to an accident? YES NO

1. Patient Information

Patient Name: _____
Last First Middle Initial

Billing Address: _____
Number/Street City State Zip

Birthdate: _____ Email: _____
SS#: _____ Sex: Male / Female

Employer or School: _____ Occupation: _____
Employer/School Address: _____ Phone: _____

Spouse's Name: _____ Birthdate: _____
Spouse's Employer: _____ Phone: _____

2. Phone Numbers

Cell Phone (____) _____ Home/Work Phone (____) _____
Best time and place to reach you? _____

IN CASE OF EMERGENCY, CONTACT
Name: _____ Relationship: _____
Cell Phone (____) _____ Home/Work Phone (____) _____

3. Insurance Information (Initial pertaining section)

_____ Insurance: I certify that I, and or my dependent(s), have insurance coverage. If your insurance covers Chiropractic care, we will bill your insurance directly. We will require a copy of your insurance card on or before your second visit. Family Chiropractic Center may use your health care information and may disclose such information to your 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. 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.

_____ Cash: Fee are to be paid at the time services are rendered, unless special arrangements have been made. Fee's will be approved and decided on by the doctor.

_____ Auto Injury: You need to supply us with the accident report, your car insurance, health insurance and liable parties' insurance; attorney if applicable. We will bill your insurance directly after verifying coverage. I authorize Family Chiropractic Center to file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq. I understand and acknowledge that in the event a medical lien if filed, and that if the lien is paid or settled, I will be provided with an original, written Satisfaction of Lien and I am responsible for filing the Satisfaction of Lien with the County Auditor and for paying the filing fee costs associated with filing any such Satisfaction of Lien.

_____ Work Injury: You will need to report your accident to your employer, bring in necessary insurance information and sign the Report of Accident by your second visit.

_____ Medicare: Per established Medicare guidelines please bring us your Medicare information on or before your second visit. We will bill your Medicare directly. Medicare only pays for covered items and services when Medicare rules are met. If Medicare does not pay for all of your health care item costs, you might have to pay for them yourself.

If you are uncertain about your Chiropractic medical coverage, please contact your insurance company. We will try our best to help you in any way we can.

4. Health History

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 _____

Check only those conditions which are applicable:

- o AIDS/HIV
- o Alcoholism
- o Allergy Shots
- o Anemia
- o Anorexia
- o Appendicitis
- o Arthritis
- o Asthma
- o Bleeding Disorders
- o Breast Lump
- o Bronchitis
- o Bulimia
- o Cancer
- o Cataracts
- o Chemical Dependency
- o Chicken Pox
- o Depression
- o Diabetes
- o Emphysema
- o Epilepsy
- o Fractures
- o Glaucoma
- o Goiter
- o Gonorrhea
- o Gout
- o Heart Disease
- o Hepatitis
- o Hernia
- o Herniated Disc
- o Herpes
- o High Cholesterol
- o Kidney Disease
- o Liver Disease
- o Measles
- o Migraine Headaches
- o Miscarriage
- o Mononucleosis
- o Multiple Sclerosis
- o Mumps
- o Osteoporosis
- o Pacemaker
- o Parkinson's Disease
- o Pinches Nerve
- o Pneumonia
- o Polio
- o Prostate Problems
- o Prosthesis
- o Psychiatric Care
- o Rheumatoid Arthritis
- o Rheumatic Fever
- o Scarlet Fever
- o Stroke
- o Suicide Attempt
- o Thyroid Problems
- o Tonsillitis
- o Tuberculosis
- o Tumors, Growths
- o Typhoid Fever
- o Ulcers
- o Vaginal Infections
- o Venereal Disease
- o Whooping Cough
- o Other _____ _____ _____

Dates of last exams: _____
Are you pregnant? YES/NO Nursing: YES/NO Taking birth control pills? YES/NO
List any types of surgeries which you have had, and the dates which they occurred: _____
_____
Do you have any allergies? _____

5. Daily Habits

What type of exercise do you perform on a daily basis? _____
What do your daily work habits include? (ex. sitting, standing, light labor, heavy labor, computer work) _____
_____
Do you smoke? YES/NO How much per day? _____
How much liquor do you consume on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____

6. Medications

What vitamins do you currently take? _____
What kind of other nutritional supplement do you take (if any)? _____
Please list all prescribed and non-prescribed medications you are currently taking: _____
_____

Patient's Name: _____

Signature: _____ Date: _____

Low Back Pain Disability Questionnaire

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage your everyday life. Please answer every section by marking only one box which applies to you in each section. 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 problems.

Section 1 ~ Pain Intensity

- ○ I can tolerate the pain without having to use pain killers
- ○ The pain is bad but I can manage without taking pain killers
- ○ Pain killers give complete relief from pain
- ○ Pain killers give moderate relief from pain
- ○ Pain killers give very little relief from pain
- ○ Pain killers 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 the 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 1 mile
- ○ Pain prevents me from walking more than 1/2 of a mile
- ○ Pain prevents me from walking more than 1/4 of a mile
- ○ I can only walk using a cane 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 for as long as I like
- ○ Pain prevents me from sitting more than 1 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

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 me 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

- ○ I get no pain in bed
- ○ I get pain in bed, but it does not prevent me from sleeping well
- ○ Because of pain, my normal night's sleep is reduced by less than 1 hr.
- ○ Because of pain, my normal night's sleep is reduced by less than 1-2 hrs.
- ○ Because of pain, my normal night's sleep is reduced by less than 3-4 hrs.
- ○ 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. golfing, sports
- ○ Pain has restricted my social life and I do not go out as often
- ○ Pain has restricted my social life to my house
- ○ 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 less than 1 hour
- ○ Pain restrict me to short necessary journeys under 30 minutes
- ○ Pain prevents me from traveling except to the doctor or hospital

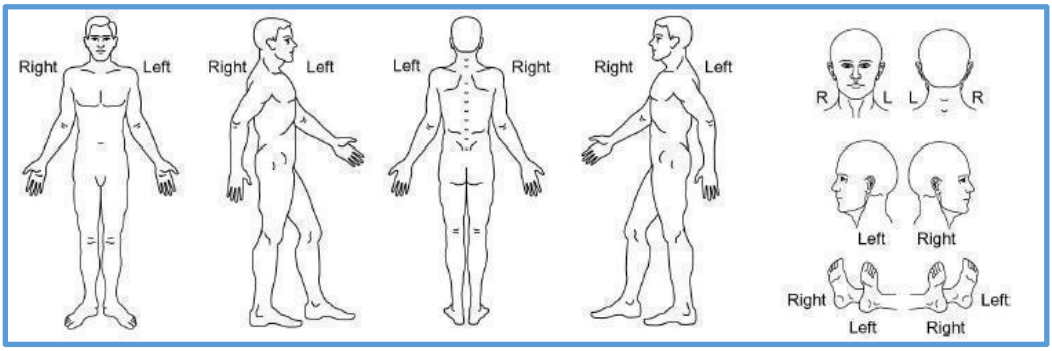
Section 10 ~ Changing Degree of Pain

- ○ 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

How long have you had low back pain? _____

Is this your first episode of low back pain? Y / N

Use the letters below to indicate the type and location of your sensations right now, on the diagram to the right.
A ~ Ache
P ~ Pins and Needles
B ~ Burning
S ~ Stabbing
N ~ Numbness



Patient's Name: _____ Signature: _____ Date: _____

Neck Pain Disability Index Questionnaire

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage your everyday life. Please answer every section by marking only one box which applies to you in each section. 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 problems.

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 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 the 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 cannot 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

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 cannot do my usual work
- I can hardly do any work at all
- I cannot 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 cannot 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)

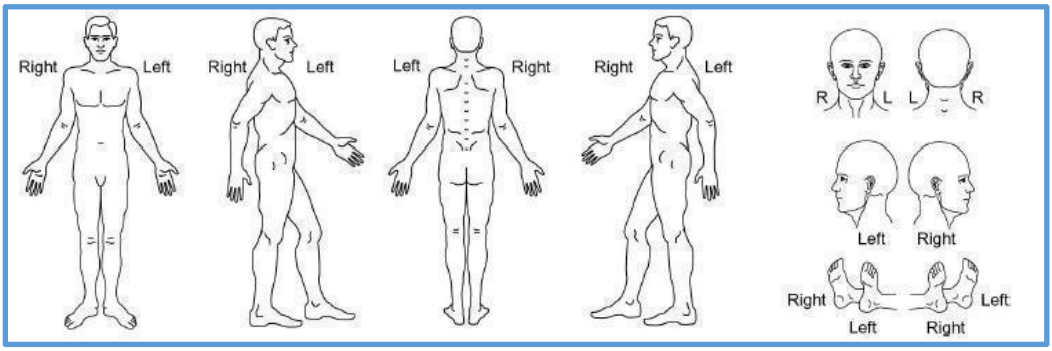
Section 10 ~ Recreation

- I am able to engage in all my recreational activities with no neck pain at all
- I am able to engage in all my recreational activities, with some pain in my neck
- I am able to engage in most, but not all of my usual recreational activities because of pain in my neck
- I am able to engage in a few of my usual recreational activities because of pain in my neck
- I cannot do any recreational activities at all

How long have you had neck pain? _____

Is this your first episode of neck pain? YES NO

Use the letters below to indicate the type and location of your sensations right now on the diagram to the right.
A ~ Ache
P ~ Pins and Needles
B ~ Burning
S ~ Stabbing
N ~ Numbness



Patient's Name: _____ Signature: _____ Date: _____