CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

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

PHONE NUMBERS

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

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

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

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) _____

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) _____

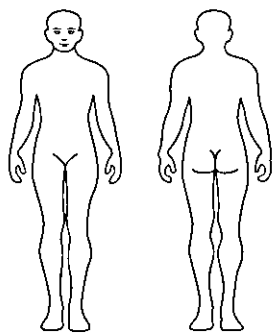
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

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



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 _____

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		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
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 _____
☐ 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		

MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

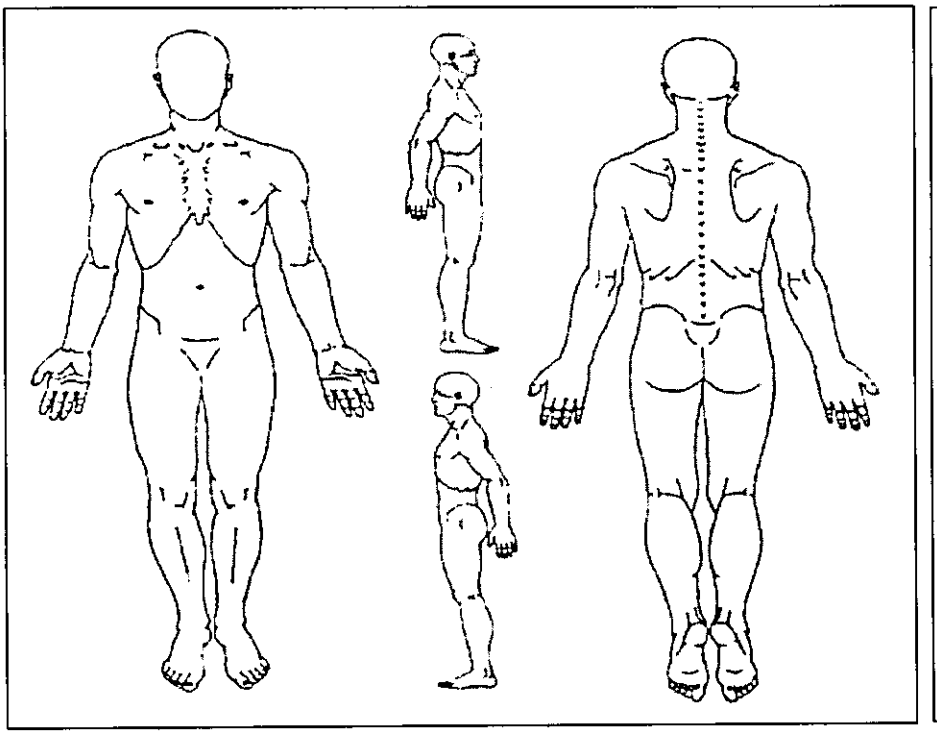
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____

Areas Of Discomfort

Patient Name: _____ Date: _____



USING THE SYMBOLS GIVEN, MARK THE AREAS ON THE BODY WHERE YOU FEEL THE DESCRIBED SYMPTOMS:

ACHING: ++++++

NUMBNESS: ======

BURNING: XXXXXX

PINS & NEEDLES: //////

STABBING: ^^^^^^

OTHER: OOOOOO

To complete the picture, draw a face on the model.

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question being asked. If you have more than one complaint, circle them separately and label each. Please indicate your pain level right now, average pain, and pain at its best and worst.

1.) What is your pain **RIGHT NOW**?

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2.) What is your **TYPICAL or AVERAGE** pain?

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3.) What is your pain level **AT ITS BEST** (how close to "0" does your pain get at its best)?

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4.) What is your pain level **AT ITS WORST** (how close to "10" does your pain get at its worst)?

No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Other Comments: _____

_____

_____

PATIENT SIGNATURE: _____ _____

David J. Ballenger, D.C

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science

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NECK DISABILITY INDEX QUESTIONNAIRE

Patient's Name: _____ **Today's Date:** _____/_____/_____

SS# _____ **DOB:** _____/_____/_____ **Member ID #** _____

Instructions: This questionnaire has been designed to give your doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section with the ONE answer that applies best to you. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

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.

Lifting
- ❑ I can lift heavy weights without 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 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.

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

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 help every day in most aspects of self-care.
- ❑ I need some help every day in most aspects of self-care.
- ❑ I do not get dressed, I wash with difficulty and stay in bed.

Reading
- ❑ I can read as much as I want with no pain in my neck.
- ❑ I can read as much as I want with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ 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 because of severe pain in my neck.

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

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 cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Sleeping
- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❑ My sleep is mildly disturbed (1 – 2 hr's. sleepless).
- ❑ My sleep is moderately disturbed (2 – 3 hr's. sleepless).
- ❑ My sleep is greatly disturbed (3 – 5 hr's. sleepless).
- ❑ My sleep is completely disturbed (5 – 7 hr's. sleepless).

Driving
- ❑ I can 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 at all because of severe pain in my neck.
- ❑ I can't drive my car at all.

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 can hardly do any recreational activities because of pain in my neck.
- ❑ I can't do any recreational activities at all.

Patient's Signature: _____

DOCTOR Last Name: Ballenger **First:** David **MI:** J

REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Patient's Name: _____ **Today's Date:** _____/_____/_____

DOB: _____/_____/_____ **Member ID #** _____

Instructions: This questionnaire has been designed to give your doctor information as to how your low back pain has affected your ability to manage everyday life. Please answer every section and mark in each section the ONE answer that applies to you best. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

Pain Intensity
- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is severe.
- ❑ The pain is severe and does not vary much.

Lifting
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. 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 only lift very light weights at the most.

Sitting
- ❑ I can sit in any chair as long as I like without pain.
- ❑ 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 ½ hour.
- ❑ Pain prevents me from sitting more than ten minutes.
- ❑ Pain prevents me from sitting at all.

Personal Care (Washing, Dressing, etc.)
- ❑ I do not have to change my way of washing or dressing in order to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain, I am unable to do some washing and dressing without help.
- ❑ Because of the pain, I am unable to do any washing or dressing without help.

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 ½ mile.
- ❑ Pain prevents me from walking more than ¼ mile.
- ❑ I can only walk while using a cane or on crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Standing
- ❑ I can stand as long as I want without pain.
- ❑ I have some pain while standing, but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than ½ hour without increasing pain.
- ❑ I cannot stand for longer than ten minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away.

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 one-quarter.
- ❑ Because of pain, my normal night's sleep is reduced by less than one-half.
- ❑ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ❑ Pain prevents me from sleeping at all.

Traveling
- ❑ I get no pain while traveling.
- ❑ I get some pain while I travel, but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

Social Life
- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal, but increases the degree of my pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ❑ Pain has restricted my social life and I do not go out very much.
- ❑ I have hardly any social life because of the pain.
- ❑ I can't drive my car at all because of the pain.

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 present.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

Patient's Signature: _____

DOCTOR Last Name: Ballenger **First:** David **MI:** J

Please Print Legibly