SUMNER FAMILY CHIROPRACTIC
PATIENT INTAKE FORM

Name: _____ Date: _____

Address: _____
Street

_____
City State Zip

Date of Birth: _____ Age: _____

Home #: _____ Cell #: _____

Financial: INSURED [ ] NON-INSURED [ ] AUTO [ ]

Email: _____

Relationship status: _____ Spouse/Partner Name: _____

Emergency Contact: _____
Name Relationship Phone #

Occupation: _____ Years at this job: _____

Have you ever been adjusted by a Chiropractor? Yes ☐ No ☐

If yes, what was the reason for the visit? _____

Who can we thank for sending you to us? _____

Describe Reason for Today's Visit: _____

_____

When did you first notice it? _____ What caused it? _____

How is the condition now? Better ☐ Worse ☐ Same ☐ Comes and goes ☐

When does it occur? _____ How often? _____

How long does it last? _____ Does it travel? _____

Rate your pain TODAY: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
(best) (worst)

Personal Health History

List any medications and why you are taking each one (including over-the-counter)

_____

_____

_____

Have you ever had any surgeries or been hospitalized? Yes ☐ No ☐

When and for what? _____

_____

Please list all accidents and injuries you've had, including childhood: (include dates) _____

_____

Goals of Care (choose all that apply)

- ☐ Relief of pain: Removing symptoms of pain and discomfort
- ☐ Corrective Care: correcting/relieving the cause of the problems as well as the symptoms
- ☐ Comprehensive care: bringing your body to optimal health

Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyle activities and habits. Chiropractic care is an important addition to a healthier lifestyle but requires TIME to allow your body to heal.

We ask that you commit to 12 visits in order to maximize your response to the care received in this office

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Guardian's Name (if minor patient): _____ Relationship: _____

Guardian's Signature (if minor patient): _____

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). Signing this consent allows Quintessential Chiropractic to use and disclose my protected health information for:

- Treatment
- Consulting with other health care providers about my case
- The day-to-day healthcare operations of your practice

I have also received a copy of your *Notice of Privacy Practices*, which more fully explains how my PHI may be used and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice and that I may contact you at any time to get the most current copy.

I understand that I have the right to request restrictions on how my PHI is used and disclosed but that you are not required to agree to these requests. However, if you do agree you must abide by these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to that date is not affected.

**** Patient Authorization regarding chiropractic care in an "open adjusting" environment ****

This office provides chiropractic care in an "open adjusting" environment. This means that several patients may be in the adjusting area at the same time. Some routine details of care are discussed within earshot of other patients and staff. Open adjusting is intended to make my experience with your office more efficient and productive. It will also enhance my access to quality health care and health information.

This environment is ONLY used for routine care. Patient histories and exams are done in a private confidential setting. I understand that I may also schedule time to consult with the doctor privately about my care.

I HAVE READ THIS CONSENT FORM AND UNDERSTAND WHAT I HAVE READ. I CONFIRM THAT ALL MY QUESTIONS HAVE BEEN ANSWERED AND I AGREE TO THE ABOVE STATEMENTS.

Print Name _____ Signature _____ Date _____

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

Name (Please Print): _____ Date: _____

Age: _____ Date Of Birth: _____ Occupation: _____

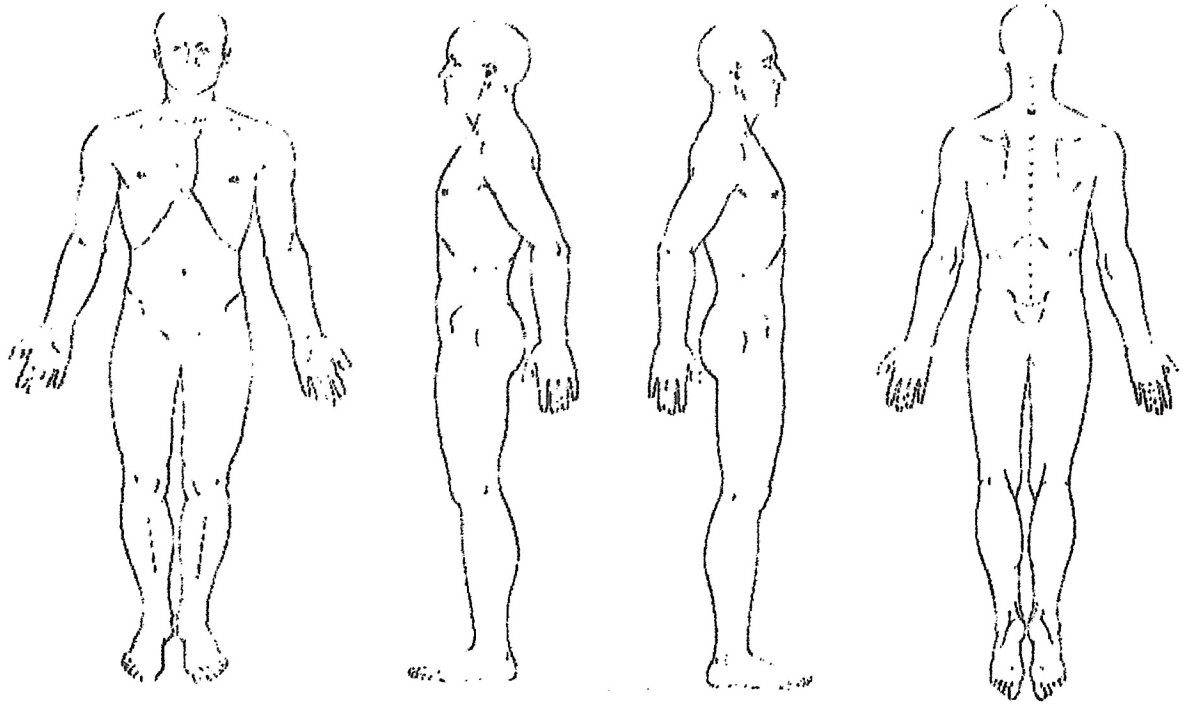
How long have you had this pain? _____ Years _____ Months _____ Weeks

Is this your first episode of this pain? _____ Yes _____ No

Name of Major Medical Health Insurance_____

NOW USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW
(Please remember to complete both sides of this form)

KEY: A= ACHE B= BURNING N= NUMBNESS S= STABBING
P= PINS & NEEDLES O= OTHER



Quadruple Visual Analogue Scale

Name:_____ **Date:**_____

Please circle the number that best describes the question being asked.
Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. **For example, you may use "N" for neck, "LB" for low back, "H" for headaches.**

What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain level AT ITS BEST

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

What is your pain level AT ITS WORST

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

Neck Pain Disability Oswestry Revised Questionnaire

PLEASE READ: 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 **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 MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1: *Pain Intensity*

A – I have no pain at the moment.
B – The pain is very mild at the moment.
C – The pain is moderate at the moment.
D – The pain is fairly severe at the moment.
E – The pain is very severe at the moment.
F – The pain is the worst imaginable at the moment.

SECTION 2: *Personal Care*

A – I can look after myself normally 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 manage if they are conveniently positioned, e.g. 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 to with slight pain in my neck.
C – I can read as much as I want to 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: *Headaches*

A – I have no headaches at all.
B – I have slight headaches which come infrequently.
C – I have moderate headaches which come infrequently.
D – I have moderate headaches which come frequently.
E – I have severe headaches which come frequently.
F – I have headaches almost all the time.

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 any 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 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 to engage in all of my recreational activities with no neck pain at all.
B – I am able to engage in all of my recreational activities with some pain in my neck.
C – I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D – I am able to engage in a few of my 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 at all.

Comments:_____

_____

Name:_____ Date:_____ Score:_____

REVISED OSWESTRY DISABILITY

Name _____ Date____/____/_____ File #_____
(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - 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.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would 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 increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase 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 and dressing without help.

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.
- ☐ 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.

SECTION 4- Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on 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 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain immediatley.

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 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal nights sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no 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., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, 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.

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

Form by N. Hudson- Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR, Eds. Back Pain.
Manchester University Press 1989; 187-204