

## **The Family Chiropractic Center**

### **Patient Office Policy**

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#### **To Our Patients:**

Welcome to The Family Chiropractic Center. We are pleased that you have chosen what we believe is one of the best non-drug approaches to patient care available today. Our practice is committed to providing you with the finest personalized health care through comprehensive evaluation of your condition, concise explanation of our findings and recommendations, and the most effective treatment – expertly performed. We focus on alternative approaches for the treatment of degenerative and chronic conditions of the musculoskeletal system and believe that the body has superior recuperative capabilities when it is restored to proper balance and given the environment necessary to function optimally. The goal of The Family Chiropractic Center is to restore our patients to the most functional and distress-free state possible – without the use of pharmaceuticals or surgery. We understand the special needs of our patients and want your visit to our facility to be as comfortable and pleasant as possible.

The following information is provided to familiarize you with the policies and procedures of The Family Chiropractic Center, to allow us to serve you more completely, and to get the best results in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results.

#### **New Patients**

Initial visits are comprehensive information gathering sessions. Complete evaluation and review of your medical history are essential. In order to provide you with the most effective treatment, it is important that you complete the new patient documentation forms in as much detail and as accurately as possible.

#### **Insurance**

In an effort to keep costs down and still provide the best service for our patients, we have set up procedures and payment options. In this era of rising health costs, etc., we are doing our utmost to provide the best service for a fair cost. The two options available for insurance patients are:

- If you want to utilize your health insurance and have our office file, we will itemize services by procedures and code accordingly. We are in-network providers for BlueCross BlueShield and PHCS. We will file on out-of-network insurance if the deductible is \$1000 or less.
- If you are self pay but file on your own with insurance or payflex, then for paperwork purposes, you are like an insurance patient and will have an additional \$5.00 processing fee per visit.

Please provide the front office with your specific insurance information and our office manager will be happy to assist you with any questions or concerns about your individual needs.

#### **Self Pay**

If you are self pay, we will code by time and give you a receipt.

Also, please note that while we do accept personal injury coverage for auto accidents, these fees vary. We do not accept cases only utilizing a 3<sup>rd</sup> party liability for auto accidents.

#### **Signing In**

When you arrive, please take a clipboard, fill out the front side, in detail, and return it to the front desk. You will be called and assigned a treatment room as soon as the doctor is ready for you. Other patients may be called before you because of the particular services being received that day, or their doctor may be available before yours.

### **New Injuries**

In the event you sustain a new injury, please let the front desk know when you schedule your appointment. There may be additional paperwork to be filed, or the doctors may need to refer you for x-rays of an injured area and perform an exam of the injured area before being able to treat.

### **Appointments**

After your visit, please stop at the front desk to make or confirm your next appointment.

### **Missed Appointments**

If you find it necessary to change your scheduled appointment, we will not charge you if you provide a minimum of 24 hour notice. The first missed appointment will be charged \$25.00. Every missed appointment after that will be charged \$50.00.

### **Payment of Bills**

Payment is due at the time services are rendered. We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our office immediately so that arrangements can be made. Our policy is that patients maintain a zero balance. Any and all unpaid balances are subject to a 10% or minimum of \$10.00 monthly late fee. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible. Please also bring in the attached explanation of benefits.

### **Rescheduling Appointments**

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time on the same day. If the same day is not possible, be sure to make up the missed appointment within one week.

### **Progress Evaluations & Re-examinations**

Progress evaluations & re-examinations will be performed periodically to determine your rate of progress and future course of treatment. A special time will be set up for your re-evaluation appointments. If you haven't been treated for more than 3 months or after 12 visits, whichever comes first, you will need to be scheduled for a re-examination.

### **Upsets**

We are here to serve you. Please speak with the staff or doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion.) We see your comments as helping us to help you and others.

### **Technique**

We are trained in a wide variety of adjusting techniques – AK, NET, ATM, DTS, activator, S.O.T. and diversified, to name a few. Each patient's treatment protocol will be designed to meet their particular needs, whatever they may be. Our light force adjusting is specifically designed to meet the needs of young children and senior patients.

Nutrition plays a vital role in the recovery and maintenance of health. We use the most effective vitamins, minerals, herbs and natural health products available to facilitate your body's healing.

Please discuss any concerns or questions about your nutrition before purchasing any item. **There are absolutely NO refunds on opened nutritional products.**

### **BioAllergenix**

To assist the body in its healing process, it is often necessary to rid the body of allergies or sensitivities. We utilize a non-invasive allergy evaluation and desensitization technique to achieve clearing of any allergies. Ask us for more information.

## **STAGES OF CHIROPRACTIC CARE**

### **1. INTENSIVE CARE / RELIEF**

The purpose of this stage is in correcting and/or stabilizing the subluxation complex so that the body can begin its natural healing process. This is the time visits will be most frequent. This stage includes **any** new patient or established patient with an injury, exacerbation, accident or new condition. The completion of intensive care is determined by re-examination through chiropractic and physical examinations.

### **2. RE-CONSTRUCTIVE CARE (CORRECTIVE)**

This stage begins after the completion of the intensive care stage. The purpose is stabilizing and normalizing your body's capacity to function normally and express its natural healing process completely.

### **3. WELLNESS CARE**

This stage begins after the completion of the previous stage (re-constructive care). This stage is based on maintaining optimal health. The frequency of visits are less than during the previous stages because the body is functioning more effectively and without the hindrances that are seen in the intensive care stage; however, this is the most important stage for your long term health.

## **ARRANGEMENTS FOR YOU**

It is our sincerest desire to provide care for you and your entire family.

This office is here to serve you to the best of our ability and at a reasonable fee. Thank you for choosing this office for your health care. No patient has ever been refused chiropractic care in this office due to finances. If at any time during your care at this office finances become a problem, please do not hesitate to discuss it with any of the staff. We are here to serve you and provide the services YOU need.

**THANK YOU FOR TAKING PERSONAL RESPONSIBILITY FOR YOUR HEALTH AND FOR  
ALLOWING US TO SHARE IN YOUR WELL BEING.**

**YOURS IN HEALTH,**

**DRS. CHUCK AND JAN**

**I have read and understand the procedure policies of the TFCC and agree to abide by the above policies.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

The Family Chiropractic Center  
1124 N. Locust  
Denton, TX 76201

I have read and understand my rights under the HIPAA regulations but have refused a copy.

I have read and understand my rights under the HIPAA regulations and have taken a copy with me for my records.

\_\_\_\_\_

Printed Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

The Family Chiropractic Center  
1124 N. Locust  
Denton, TX 76201

Please complete the following information to be added to our special events mailing and email update list:

Name and Mailing Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Email:

\_\_\_\_\_

**The Family Chiropractic Center**  
**CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Best # to Call \_\_\_\_\_ E-Mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: Male Female

Driver License # with State: \_\_\_\_\_

Guardian Social Security # (if patient is under 18 years of age): \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Office Phone \_\_\_\_\_ May we contact you at this number? Yes No

**Do you have insurance? Yes No** *If you would like for us to file your claim, please give your insurance card to the front office staff to be copied, and we will call to verify your benefits.*

Marital Status: S M D W Spouse's name \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Doctor's name \_\_\_\_\_

Reported findings \_\_\_\_\_

List all surgeries / serious illnesses / hospitalizations (include years in brackets) \_\_\_\_\_

List all broken bones / dislocations / major dental work (include years in brackets) \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of closest relative not living with you \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Person responsible for account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

I hereby give my consent to The Family Chiropractic Center to provide services to me and/or my family. I understand that there is a fee for services and that fees are payable at the time services are rendered. **I hereby agree to such fees and understand that I am liable for any and all legal fees and/or reasonable interest if collection services become necessary.**

Responsible  
 Party/Patient \_\_\_\_\_ Date \_\_\_\_\_

# The Family Chiropractic Center

## CONFIDENTIAL DETAILED HISTORY FORM – PLEASE PRINT

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

### PERSONAL INFORMATION:

**Height:** \_\_\_\_\_ **Weight:** Current \_\_\_\_\_ One year ago \_\_\_\_\_ Change in the past two years \_\_\_\_\_

**Vision:** Corrected? Yes \_\_\_\_\_ No \_\_\_\_\_ What is your vision? RT \_\_\_\_\_ LT \_\_\_\_\_

Vision recently changed? Yes \_\_\_\_\_ No \_\_\_\_\_ How? \_\_\_\_\_

**Chiropractic:** Have you previously received chiropractic care? Yes \_\_\_\_\_ No \_\_\_\_\_ If "yes," date of last care: \_\_\_\_\_

**Auto accidents:** Past year \_\_\_\_\_ Past five years \_\_\_\_\_ Over five years \_\_\_\_\_ Describe: \_\_\_\_\_

**X-Ray history:** (Include all X-rays, CAT scans / MRIs / dye studies / dental x-rays)

TYPE	AREA OF THE BODY	TYPE	AREA OF THE BODY
------	------------------	------	------------------

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Transfusions:** Have you ever had a blood transfusion? \_\_\_\_\_ Blood type? \_\_\_\_\_

**Dental visits:** Every 6 months \_\_\_\_\_ Annual \_\_\_\_\_ Toothache/emergency only \_\_\_\_\_ Complete dentures \_\_\_\_\_

**Psychological:** Ever diagnosed as having a mental/emotional disorder? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_

Any family member diagnosed as having such disorders? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_

**Drugs:** Currently taking... nerve pills, pain killers, muscle relaxers, tranquilizers, birth control pills, "pep" pills, others.

**Please list all the medications you are currently taking.**

Name _____	Function/Purpose _____
Name _____	Function/Purpose _____
Name _____	Function/Purpose _____
Name _____	Function/Purpose _____
Name _____	Function/Purpose _____
Name _____	Function/Purpose _____
Name _____	Function/Purpose _____

**Elimination:** Approximately how many times during the day do you urinate? \_\_\_\_\_ night? \_\_\_\_\_

How often do you have a bowel movement? \_\_\_\_\_ any problem? \_\_\_\_\_

**Women:** Currently... Periods began at what age? \_\_\_\_\_ pain during cycle \_\_\_\_\_ regular menstrual periods \_\_\_\_\_  
irregular menstrual periods \_\_\_\_\_ pre-menopausal \_\_\_\_\_ post-menopausal \_\_\_\_\_ hysterectomy \_\_\_\_\_

**Allergies?** Yes \_\_\_\_\_ No \_\_\_\_\_ List \_\_\_\_\_

**Do you smoke?** Yes \_\_\_\_\_ No \_\_\_\_\_ What? \_\_\_\_\_ # per day? \_\_\_\_\_ How many years? \_\_\_\_\_

**Do you diet?** Yes \_\_\_\_\_ No \_\_\_\_\_ Explain? \_\_\_\_\_

01-27-16

Take vitamins? Yes\_\_\_ No\_\_\_

What?\_\_\_\_\_Function?/Purpose\_\_\_\_\_  
What?\_\_\_\_\_Function?/Purpose\_\_\_\_\_  
What?\_\_\_\_\_Function?/Purpose\_\_\_\_\_  
What?\_\_\_\_\_Function?/Purpose\_\_\_\_\_  
What?\_\_\_\_\_Function?/Purpose\_\_\_\_\_  
What?\_\_\_\_\_Function?/Purpose\_\_\_\_\_

Vegetarian? Yes\_\_\_ No\_\_\_ Eat red meat? Yes\_\_\_ No\_\_\_

Eat fast foods? Yes\_\_\_ No\_\_\_ # times/week \_\_\_\_\_

Drink coffee? Yes\_\_\_ No\_\_\_ # cups/day \_\_\_\_\_ Drink cola? Yes\_\_\_ No\_\_\_ # per day \_\_\_\_\_

Drink tea? Yes\_\_\_ No\_\_\_ # cups/day \_\_\_\_\_ Drink water? Yes\_\_\_ No\_\_\_ # glasses/day \_\_\_\_\_

Drink alcohol? Yes\_\_\_ No\_\_\_ What?\_\_\_\_\_ # per day?\_\_\_\_\_ # per week? \_\_\_\_\_

Play sports? Yes\_\_\_ No\_\_\_ What?\_\_\_\_\_ Currently in training? Yes\_\_\_ No\_\_\_

Describe your exercise program: \_\_\_\_\_

Have hobbies? Yes\_\_\_ No\_\_\_ What? \_\_\_\_\_

Energy level: Sufficient for normal activities? Yes\_\_\_ No\_\_\_ Comment: \_\_\_\_\_

Work schedule: # business work hours/week \_\_\_\_\_ # home work hours/week \_\_\_\_\_

Sleep: # hours/night \_\_\_\_\_ quality? \_\_\_\_\_

age of mattress \_\_\_\_\_ comfortable? Yes\_\_\_ No\_\_\_ use a bed board? Yes\_\_\_ No\_\_\_

PLEASE INDICATE BY CHECKING IN THE APROPRIATE SPACE ANY SYMPTOMS YOU ARE  
CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST

**THIS IS A CONFIDENTIAL HEALTH REPORT**

___ Alcoholism	___ Cold sores	___ Goiter	___ Miscarriage	___ Scarlet fever
___ Anemia	___ Diabetes	___ Gout	___ Multiple sclerosis	___ Stroke
___ Appendicitis	___ Diphtheria	___ Heart disease	___ Mumps	___ Tuberculosis
___ Arteriosclerosis	___ Eczema	___ Influenza	___ Pleurisy	___ Typhoid fever
___ Arthritis	___ Emphysema	___ Lumbago	___ Pneumonia	___ Ulcers
___ Cancer	___ Epilepsy	___ Malaria	___ Polio	___ Venereal disease
___ Whooping cough	___ Fever blisters	___ Measles	___ Rheumatic fever	___ Chorea

**Family history of:**

___ arteriosclerosis	___ hypertension
___ cardiovascular disease	___ antihypertensive meds
___ oral contraceptives	___ other
___ TIAs	___ stroke
___ diabetes	___ other _____





**THE FAMILY CHIROPRACTIC CENTER**  
**DOCTOR/PATIENT RELATIONSHIP IN CHIROPRACTIC**  
**\* INFORMED CONSENT FORM \***

Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical, and spinal conditions. It is important to understand what to expect from chiropractic health care services.

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Complexes (VSC). When VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body, and gives the body an opportunity to use its inherent recuperative powers.

A patient, in coming to the chiropractor, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnoses, and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial, and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through health care procedures, whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor. The chiropractor provides a specialized, non-duplicating health service. The chiropractor is licensed in a special practice and is available to work with other types of providers in your health care regime.

At The Family Chiropractic Center, we use a combination of different treatment procedures. We will use our hands, our adjusting table, and/or our activator device to deliver safe and gentle adjustments. This may cause an audible "pop" or "click," much as you experience when you crack your knuckles. You may or may not experience or feel a sense of movement in the joint being adjusted.

Conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under the control, or be helped through, medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both make great strides in alleviating pain and controlling disease.

With any health care procedure there are certain complications that may arise, and we strive to inform you of such risks. High force, extreme rotation adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Massage and trigger point therapies have an associated risk of bruising and/or release of emboli. Heat therapies may cause first and second-degree burns and/or hemorrhage. Risks associated with over-the-counter medications and prescription drugs are undesirable side effects such as liver damage and patient dependence. The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, and an extended convalescent period. The risks associated with remaining untreated are the formation of adhesions and reduction of mobility depending on the severity.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to The Family Chiropractic Center to perform the treatment and acknowledge that no guarantee as to the results that may be obtained from this treatment has been given to me.

**I understand that full payment is due at time of service and that all nutritional products once taken off premises are ineligible for return/refund. Our office endeavors to treat people with all needs, so if special circumstances exist, please discuss these with the doctors or office manager. I also understand and agree to pay for scheduled appointments that I am unable to keep and was not able to give at least 24 hours notice of wishing to cancel. I understand that your time and my time are valuable. If for any reason there is a balance in any account (insurance or nutrition), and payment is not made within 30 days of request for payment, TFCC is entitled to charge me up to 2% interest per month.**

Patient Name (please print): \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Parent/Guardian (print): \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# The Neck Disability Index

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Please read instructions:

This questionnaire has been designed to give the 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 only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

## 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 (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 a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, 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 to, 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.

## 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 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 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.

## SECTION 8-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.

## SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

## SECTION 10-RECREATION

- ☐ I am able to engage in all my recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

## The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: \_\_\_\_\_

Date: \_\_\_\_\_

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

### 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 very severe.
- ☐ The pain is severe and does not vary much.

### SECTION 2-PERSONAL CARE

- ☐ 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 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 and dressing without help.

### SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ 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.
- ☐ 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 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

### 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 right away.

### 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 night's 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-TRAVELLING

- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel makes it any worse.
- ☐ I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, 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

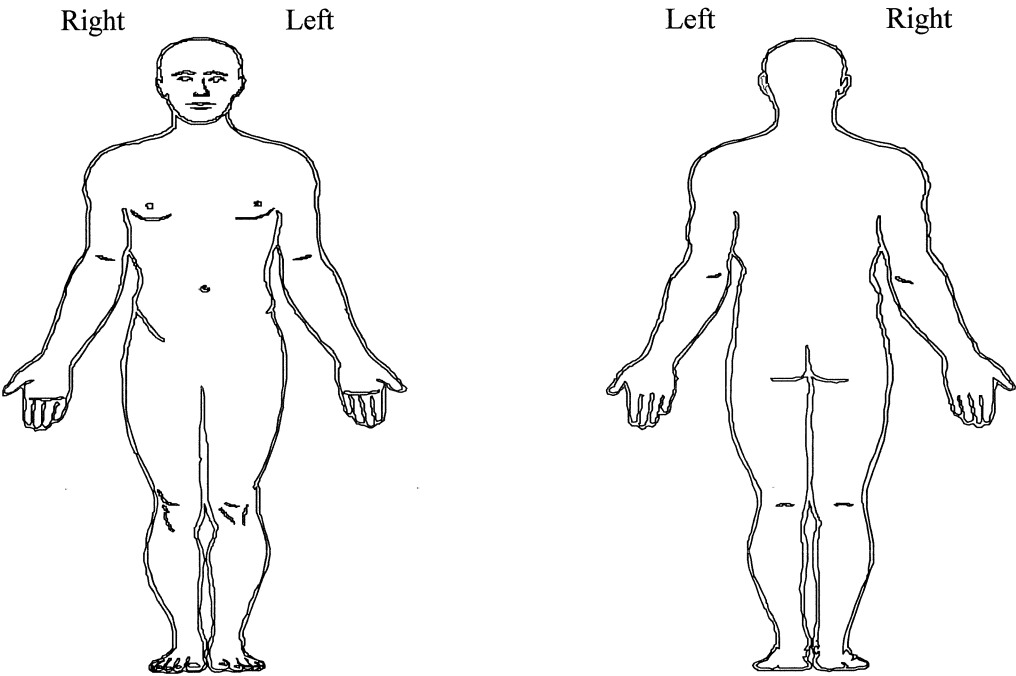
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

For Exams & Re-exams Insurance / Cash

COMPLAINTS & TREATMENT AUTHORIZATION

I, \_\_\_\_\_, certify that the complaints listed below are true as related by me. I wish to be treated for these complaints and any additional complaints or problems, which may arise during the course of my consultant, exam and treatment(s).

Please circle ALL the areas of your complaints that use the appropriate symbol below that best depicts your complaint(s).



- |              |   |           |   |            |    |
|--------------|---|-----------|---|------------|----|
| Dull & Achy: | D | Cramping: | C | Throbbing: | TH |
| Burning:     | B | Numbness: | N |            |    |
| Tingling:    | T | Sharp:    | S |            |    |

As well if you have any scars or bruises, please circle area and label accordingly.

Use the pain scale below to describe the complaint(s) that you have circled in the diagram above.

- |                          |                        |                    |
|--------------------------|------------------------|--------------------|
| No Pain = 0              | Uncomfortable = 4      | Terrible Pain = 10 |
| Mildly Uncomfortable = 2 | Very Uncomfortable = 6 |                    |
|                          | Unable to Work = 8     |                    |

**CHIEF COMPLAINTS OR SYMPTOMS:**

**WHEN COMPLETING THE FOLLOWING COMPLAINT SECTION PLEASE BE THOROUGH. ANY AREA(S) OF PAIN THAT YOU LIST, SUCH AS NECK PAIN, MUST HAVE CORRESPONDING ACTIVITIES THAT AGGRAVATE THIS PAIN. FOR EXAMPLE, ACTIVITIES SUCH AS TURNING YOUR HEAD WHILE DRIVING OR READING OR WORKING ON THE COMPUTER MAY ALL INCREASE NECK PAIN.**

**Neck Pain:**      **Left**                      **Right**                      **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

**Circle all areas of radiation, if any:**

left shoulder	left arm	left forearm	left hand	base of skull
right shoulder	right arm	right forearm	right hand	none

The neck pain also seems to be related to:    headaches      upper back pain

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Upper Back Pain:**    **Left**                      **Right**                      **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

Select or list the areas of radiation, if any or circle none.

left neck	left shoulder	left arm	none
right neck	right shoulder	right arm	Other _____

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Middle Back Pain:**    **Left**                      **Right**                      **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins & needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (<75%), occasional (<50%), or intermittent (<25%), in duration.

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Low Back Pain:**    **Left**       **Right**    **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins &amp; needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (&lt;75%), occasional (&lt;50%), or intermittent (&lt;25%), in duration.

Select the areas of radiation, if any:    left hip       left thigh                      left knee                      left foot

no radiation of pain                      right hip right thigh                      right knee                      right foot

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Shoulder Pain:**       **Left**    **Right**    **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins &amp; needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (&lt;75%), occasional (&lt;50%), or intermittent (&lt;25%), in duration.

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Elbow Pain:**       **Left**    **Right**    **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins &amp; needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (&lt;75%), occasional (&lt;50%), or intermittent (&lt;25%), in duration.

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Wrist Pain:**       **Left**    **Right**    **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins &amp; needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (&lt;75%), occasional (&lt;50%), or intermittent (&lt;25%), in duration.

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Hip Pain:**       **Left**    **Right**    **Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins &amp; needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (&lt;75%), occasional (&lt;50%), or intermittent (&lt;25%), in duration.

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Knee Pain:**                      **Left    Right    Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins &amp; needles.

Describe the intensity (severity) of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (&lt;75%), occasional (&lt;50%), or intermittent (&lt;25%), in duration.

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Foot Pain:**                      **Left    Right    Bilateral**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins &amp; needles.

Describe the severity of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (&lt;75%), occasional (&lt;50%), or intermittent (&lt;25%), in duration.

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Other Complaints:**

Describe the sensation: dull, achy, stiff, sore, tight, sharp, stabbing, burning, shooting, tingling or pins &amp; needles.

Describe the intensity (severity) of your complaint on a scale of 0 –10. 0 1 2 3 4 5 6 7 8 9 10 \_\_\_\_\_.

This pain is constant (100%), frequent (&lt;75%), occasional (&lt;50%), or intermittent (&lt;25%), in duration.

**List any particular activity that aggravates this condition:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

The following are complicating factors that have a tendency to slow down healing and response to care;  
please circle all apply:

- |   |  |
|---|--|
| <input type="checkbox"/> age greater than 45  |  |
| <input type="checkbox"/> Metabolic disorders such as diabetes, fibromyalgia, chronic fatigue, celiac disease, lupus |  |
| <input type="checkbox"/> History of numerous injuries or auto accidents, > 4 minor or greater than 1 major          |  |
| <input type="checkbox"/> Congenital anomalies of the spine such as spina bifida                                     |  |
| <input type="checkbox"/> Developmental anomalies of the spine   |  |
| <input type="checkbox"/> Rheumatoid arthritis or other arthritides affecting the spine                              |  |
| <input type="checkbox"/> Ankylosing spondylitis or other spondylarthropathy   |  |
| <input type="checkbox"/> Degenerative disc disease  | <input type="checkbox"/> Spinal stenosis or foraminal stenosis |
| <input type="checkbox"/> Disc protrusions (HNP)   | <input type="checkbox"/> Prior spinal injury                   |
| <input type="checkbox"/> Scoliosis  | <input type="checkbox"/> Smoker                                |
| <input type="checkbox"/> Prior cervical spinal surgery  | <input type="checkbox"/> Prior drug or alcohol abuse           |
| <input type="checkbox"/> Prior lumbar spinal surgery  | <input type="checkbox"/> Poor diet                             |
| <input type="checkbox"/> Prior vertebral fracture   | <input type="checkbox"/> Poor fitness habits                   |
| <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Overweight greater than 25 lbs.       |

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_