

Confidential Case History- **Please Print.**

Patient Type: **New Patient** **Existing Patient- New Injury/Episode**

Name: _____ Date of Birth: _____ Date: _____

Primary Care Physician: _____

Who may we thank for referring you to our office? _____

Occupation: _____ Employer: _____

Main Complaint: 1) _____
2) _____
3) _____

When did it start? Date: _____ How did it start? _____

Is the above condition(s) due to: Auto Accident Work-Related Injury Neither of these

How Would You Rate The **Current** Intensity Of Your Pain (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(Extreme Pain)

Indicate the range of your symptoms since they began: (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(Extreme Pain)

Have You Had Similar Pain In The Past Y or N If yes When: _____

Are you currently out of work due to this problem? Y N If yes, when did disability begin? _____

The symptoms began: Gradually Suddenly The Pain has been getting: Better Worse

Does you feel the pain in any other part of your body? If yes, where? _____

Is your pain 76-100% 51-75% 26-50% less than 25% of the day?

Which terms best describe your symptoms: Dull Sharp Achy Stabbing Radiating Tingling
Numbness Burning Stiffness Weakness Soreness Other _____

What makes your increases your symptoms? Sitting Standing Walking Exercise Lying On Stomach
 Lying On Your Back Rotation Side Bending Looking Down Looking Up Touching Toes Leaning
Backward Lifting Coughing Sneezing Rest Driving Typing/Computer Work Stair Stepping
 Changing Positions Other _____

What makes your symptoms better? Heat Ice Movement No Movement/Rest Ibuprofen/Aspirin
 Medications Sitting Standing Lying Down Support/Brace Stretching/Exercise Manipulation
 Other _____

Is your pain worse in the: morning afternoon evening night same all day

What doctors have you seen and tests have you done for this condition? _____

What medication or home remedies have you tried for this problem? _____

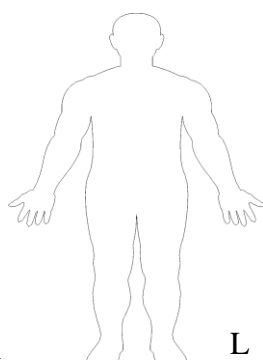
Have there been any other changes in any other body functions? Y N Explain: _____

Has your condition affected your daily activities or work in any way? Y N Explain: _____

What do you want to be able to do that your pain prevents? _____

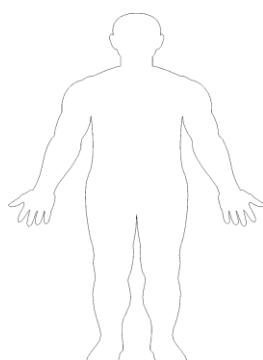
Indicate areas of discomfort: (indicate: /// pain, O pins & needles, X ache, = = = numbness)

Front



R L

Back



L R

Is your pain
<input type="checkbox"/> sharp
<input type="checkbox"/> dull
<input type="checkbox"/> achy
<input type="checkbox"/> weak
<input type="checkbox"/> throbbing
<input type="checkbox"/> numb
<input type="checkbox"/> shooting
<input type="checkbox"/> gripping
<input type="checkbox"/> burning
<input type="checkbox"/> tingling

Patient Signature: _____ Date: _____

Patient Goals:

- 1) _____
- 2) _____
- 3) _____

_____ Dr. Initials/Date

Review of Systems

Patient Name: _____ Date Of Birth: _____

CHECK ALL THOSE THAT APPLY:

GENERAL APPEARANCE

- Unexplained Weight Loss
- Unexplained Weight Gain
- Change in Sleeping Patterns
- Change in Activity

NEUROLOGICAL

- Anxiety
- Headaches
- Depression
- Meningitis
- Paralysis
- Seizure
- Stroke
- Tingling
- Tremors
- Memory Loss
- Fainting spells
- Dizziness
- Head injuries
- Blackouts or near blackouts
- Change in sensation anywhere on your body
- Localized weakness or numbness

EARS, EYES, NOSE, & THROAT

- Hay fever
- Glaucoma
- Polyps
- Allergy
- Cataracts
- Goiter
- Hoarseness
- Double vision
- Gum problems
- Eye problems
- Ear Infections
- Glasses/contacts
- Hearing Loss
- Ear discharge/pain
- Frequent nosebleeds
- Ringing in your ears
- Sinus infections
- Swollen glands

CARDIOVASCULAR

- Angina
- Leg cramps
- Ankle swelling
- Awakening at night short of breath & getting out of bed
- Cardiac catheterization
- Cold hands or feet
- Congenital heart defects
- Dizziness when standing up quickly
- Heart attacks
- Heart failure
- High or low blood pressure
- Irregular heart rate
- Purple fingers or lips
- Leg pain that resolves with rest
- Heart palpitations
- Varicose veins
- Chest pains
- Murmurs

RESPIRATORY

- Asthma
- Breathlessness when lying flat
- Prolonged cough
- Coughing up blood
- Emphysema
- Shortness of breath
- Tuberculosis
- Pneumonia
- Frequent infections (bronchitis)
- Wheezing
- Pleurisy

SKIN

- Abscess
- Dandruff
- Acne
- Oily skin
- Boils
- Rashes
- Hives
- Dry skin
- Lumps
- Psoriasis
- Jaundice
- Athlete's foot
- Excessive body odor
- Excessive sweating
- Fungal infections
- Nail problems
- Moles- irregular
- Moles - change/new

KIDNEYS & URINARY TRACT

- Blood in urine
- Brown urine
- Dribbling after urination
- Painful urination
- Excessive thirst
- Involuntary urination/incontinence
- Urinating frequently (day)
- Urinating frequently (night)
- Urine hesitancy
- Weak flow
- Frequent bladder infections
- Kidney disease
- Kidney stone

ENDOCRINE

- Diabetes
- Sick cell
- Abnormal body hair
- Changes in skin texture
- Cold intolerance
- Heat intolerance
- History of "borderline" diabetes
- Hypothyroidism

MUSCULOSKELETAL

- Anemia
- Arthritis
- Back pain
- Bursitis
- Gout
- Joint aches
- Neck pain
- Tendinitis
- Abnormal Blood Counts
- Blood clots in legs/lungs
- Bone Marrow Biopsy
- Easy Bleeding
- Easy bruising
- Joint swelling
- Morning stiffness
- Muscle aches

GASTROINTESTINAL

- Diarrhea
- Reflux
- Ulcers
- Hepatitis
- Abdominal pain
- Anal fissures
- Black tarry stools
- Vomiting blood
- Constipation
- Nausea
- Problems swallowing
- Hiatal Hernia
- Intestinal obstruction
- Liver disease
- Hemorrhoids
- Red blood after bowel movements
- Gallstones
- Vomiting
- Heartburn
- Indigestion

Other Conditions Not Listed Above: _____

Current Medications: _____

Family Disease History: _____

Surgical History: _____

Musculoskeletal Injury History: _____

Do you currently smoke? Yes No

Have You Smoked In The Past: Yes No

Do you consume alcohol? Yes No

How many drinks per week: _____

I affirm that to the best of my knowledge the above is true (*patient signature*)

Date

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy ___ palpation ___ vital signs ___ range of motion testing ___ orthopedic testing ___ basic neurological ___ muscle strength testing ___ postural analysis testing

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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 will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
 - Hospitalization
 - Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Blean 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 decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Dated: _____

Patient's Name

Doctor's Name

Signature

Signature of Parent or Guardian
(if a minor)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge that I have been provided an opportunity to review Freedom Chiropractic & Rehab's HIPAA policies.

I acknowledge that Freedom Chiropractic & Rehab may, at times, contact me via email or text messaging, without disclosing PHI, and I authorize them to do so.

Patient or Personal Representative Signature

Date

Printed Name

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

PATIENT _____

DOB _____

AUTHORIZATION & ASSIGNMENT

This is to certify that I have engaged Freedom Chiropractic & Rehab for professional services. I hereby authorize the following and will permit a photocopy to be considered as valid as the original, and may be used in lieu of the same.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Freedom Chiropractic & Rehab to release any appropriate information concerning my condition to any insurance company, attorney, or adjuster in order to receive reimbursement for any charges incurred by me as a result of services rendered at Freedom Chiropractic & Rehab.

I also authorize Freedom Chiropractic & Rehab to collect information that is necessary for and relevant to my treatment in the office.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

I authorize direct payment to you of any sum that I owe you now or in the future from any insurance company that is obligated to reimburse me for charges incurred in your office in part or full, or my attorney and other sources of benefits out of the proceeds of my settlement.

ASSIGNMENT OF CAUSE OF ACTION

I hereby assign and give you the right to take action against any insurance company that is obligated by contract to make payment to me. I authorize you to take action in either my name or your name to resolve this claim. It is understood that all reasonable efforts will be made to collect from the insurance company before I will be responsible for this bill. I do understand that whatever amounts are not collected from the insurance company will become my responsibility, and I am obligated to pay these charges upon receipt of a bill. I waive any claims arising under any statutes of limitations.

AUTHORIZATION TO USE LIKENESS IN PHOTOS OR VIDEOS

I authorize Freedom Chiropractic & Rehab and it's representatives to take photographs or videos of me. I grant them permission to use, exhibit, display, broadcast, and distribute these images in current or future media. I acknowledge that Freedom Chiropractic & Rehab owns all the right to the images or video. I hereby release, defend, indemnify, and hold harmless the producers from and against any claims, damages, or liability.

Patient Signature _____ Date _____

Parent Signature if patient is a minor _____

Name : _____ Primary Complaint: _____ Date: _____

1. Please indicate your usual level of pain during the past week.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

2. Does pain, numbness, tingling or weakness extend into your leg (from low back) &/or arm (from neck)?

None of the time 0 1 2 3 4 5 6 7 8 9 10 All of the time

3. How would you rate your general health? (0-10)

Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?

Delighted 0 1 2 3 4 5 6 7 8 9 10 Terrible

5. How anxious (eg. tense, irritable, fearful, difficulty in relaxing) you have been feeling during the past week:

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely anxious

6. How much have you been able to control (i.e., reduce) your pain on your own during the past week:

I can reduce it 0 1 2 3 4 5 6 7 8 9 10 I can't reduce it at all

7. Please indicate how depressed (eg. sad, pessimistic) you have been feeling in the past week:

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely depressed

8. On a scale of 0-10, how certain are you that you will be doing normal activities or working in six months?

Very certain 0 1 2 3 4 5 6 7 8 9 10 Not certain at all

9. I can do light housework for an hour.

Agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

10. I can sleep at night.

Agree 0 1 2 3 4 5 6 7 8 9 10 Completely disagree

11. An increase in pain is an indication that I should stop what I'm doing until the pain decreases.

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

12. Physical activity makes my pain worse

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

13. I should not do my normal activities including work with my present pain

Completely disagree 0 1 2 3 4 5 6 7 8 9 10 Completely agree

Neck Disability Index Questionnaire

Name: _____ Date: _____

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 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 clearly 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 of 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, 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 (5-7hr'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.