

Patient Name: _____ Date: _____

Address _____ City _____ State _____ Zip Code _____

H. Phone _____ W. Phone _____ Cell Phone _____

Would you like text message or email reminder? Yes No Cell Phone Carrier: Verizon, AT&T, etc.: _____

Email Address: _____ Occupation _____ Employer _____

Date of Birth ____ / ____ / ____ Age _____ Sex: M F Marital Status: M S D W

Insurance company _____ Secondary _____

Primary Physician: _____ Referred by: _____

In case of Emergency call: _____ Relationship to Patient: _____ Phone: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

3. Past Health History:

A. Please indicate if you have a history of any of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
- Lung problems/shortness of breath Cancer (type _____) Diabetes Psychiatric disorders
- Bipolar disorder Major depression Schizophrenia Stroke/TIA's Other _____
- None of the above

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

Patient Name: _____ Date: _____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____

Is there any chance that you could you be pregnant? _____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

- Cancer (type _____) Strokes/TIA's Headaches Cardiac disease Neurological diseases
- Adopted/Unknown Cardiac disease below age 40 Psychiatric disease Diabetes
- Other _____ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death	Age at death
_____	_____
_____	_____

Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities/ Hobbies: _____

D. Lifestyle circle: Exercise: __ days/week Alcohol: __/week Tobacco: __ packs/day/week Drug use: Y/N Poor Diet: Y/N

Review of Systems

Have you had any of the following pulmonary (lung-related) issues?

- Asthma/difficulty breathing COPD Emphysema Other _____ None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?

- Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks/MIs Heart disease/problems Hypertension Pacemaker Angina/chest pain Irregular heartbeat Other _____
- None of the above

Have you had any of the following neurological (nerve-related) issues?

- Visual changes/loss of vision One-sided weakness of face or body History of seizures One-sided decreased feeling in the face or body Headaches Memory loss Tremors Vertigo Loss of sense of smell
- Strokes/TIAs Other _____ None of the above

Patient Name: _____ Date: _____

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease
- Hormone replacement therapy
- Injectable steroid replacements
- Diabetes
- Other _____
- None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones
- Hematuria (blood in the urine)
- Incontinence (can't control)
- Bladder Infections
- Difficulty urinating
- Kidney disease
- Dialysis
- Other _____
- None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea
- Difficulty swallowing
- Ulcerative disease
- Frequent abdominal pain
- Hiatal hernia
- Constipation
- Pancreatic disease
- Irritable bowel/colitis
- Hepatitis or liver disease
- Bloody or black tarry stools
- Vomiting blood
- Bowel incontinence
- Gastroesophageal reflux/heartburn
- Other _____
- None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia
- Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
- HIV positive
- Abnormal bleeding/bruising
- Sickle-cell anemia
- Enlarged lymph nodes
- Hemophilia
- Hypercoagulation or deep venous thrombosis/history of blood clots
- Anticoagulant therapy
- Regular aspirin use
- Other _____
- None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns
- Significant rashes
- Skin grafts
- Psoriatic disorders
- Other _____
- None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis
- Gout
- Osteoarthritis
- Broken bones
- Spinal fracture
- Spinal surgery
- Joint surgery
- Arthritis (unknown type)
- Scoliosis
- Metal implants
- Other _____
- None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis
- Depression
- Suicidal ideations
- Bipolar disorder
- Homicidal ideations
- Schizophrenia
- Psychiatric hospitalizations
- Other _____
- None of the above

For females only: Are you or is there a chance that you are pregnant? _____ if yes, how far along _____

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. I certify that I, and/or my dependent(s), assign directly Lodes Chiropractic Center 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 facility 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.

Patient or Guardian/Personal Representative Signature _____
Date _____

Patient Name: _____

Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities and employee review activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

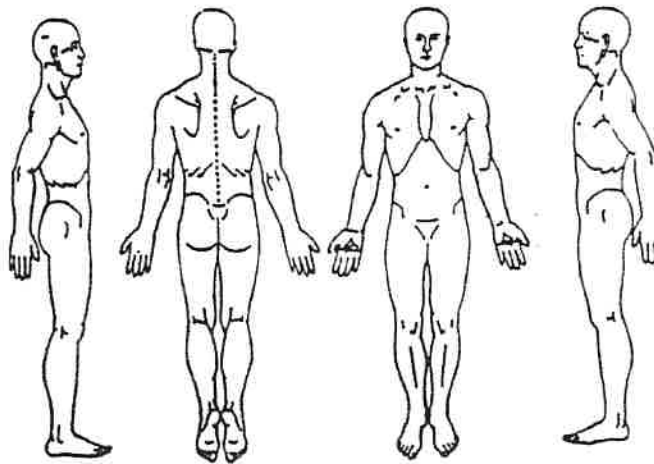
Date

Printed Name

Patient Name: _____

Date: _____

Indicate all areas of complaint on the diagram provided:



Please describe symptoms below:

Start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom 1 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

Patient Name: _____

Date: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
 - Did the symptom begin suddenly or gradually? (circle one)
 - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
 - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
 - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
 - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
 - Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
 - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
 - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: _____

Date: _____

Welcome to our wellness center,

We are here to discover your goals and priorities as it relates to your health and wellness. Your answers will help us determine how we can best help you.

On a scale of 1 – 10, rate the importance for you to achieve the following:

1 = not important 10 = necessary

Lose weight	1 2 3 4 5 6 7 8 9 10
Get fit	1 2 3 4 5 6 7 8 9 10
Eat better	1 2 3 4 5 6 7 8 9 10
Reduce stress	1 2 3 4 5 6 7 8 9 10
Stop smoking	1 2 3 4 5 6 7 8 9 10
Reduce pain	1 2 3 4 5 6 7 8 9 10
Increase my mobility	1 2 3 4 5 6 7 8 9 10
Improve my posture	1 2 3 4 5 6 7 8 9 10
Improve my sleep	1 2 3 4 5 6 7 8 9 10
Learn about wellness	1 2 3 4 5 6 7 8 9 10
Learn about wellness products that are right for me	1 2 3 4 5 6 7 8 9 10
Other _____	1 2 3 4 5 6 7 8 9 10

Which of the above would you say is the most important goal for you to achieve and why?

Have you ever attempted to accomplish this goal in the past? Yes No
If yes, what happened and what prevented you from maintaining your results?

Do you have any questions or comments?

Remember: your health is your greatest asset, the more of it you have the healthier you are. We are looking forward to meeting you soon!

Sincerely,

Patient Name: _____ Date: _____

Dr. Michael Lodes and Dr. Brett Wharton

NAME: _____

DATE: _____

PDR Oswestry Neck Pain Questionnaire

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage 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 circle the one choice which closely describes your problem right now.**

Section 1 – Pain Intensity

- A. I have no pain at the moment.
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate
- D. The pain moderate and does not vary much.
- E. The pain is severe, but comes and goes.
- F. The pain is severe and does not vary much.

Section 2 – Personal Care

- A. I can look after myself 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 undressed, 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 only 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 to because of moderate pain in my neck.
- E. I cannot read as much as I want to because of severe pain in my neck
- F. I cannot read at all.

Section 5 – Headache

- A. I have no headaches at all.
- B. I have slight headaches that come infrequently.
- C. I have moderate headaches that come infrequently.
- D. I have moderate headaches that come frequently.
- E. I have severe headaches that 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 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 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 usual recreational activities because of pain in my neck.
- D. I am able to engage in only a few of my usual 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.

Section 11 – Numeric Rating Scale (NRS)

Try and assign a number from 0 to 10 to your current pain level. If you have no pain, use a 0. As the numbers get higher, they stand for pain that is getting worse. A 10 means the pain is as bad as it can be.

0 1 2 3 4 5 6 7 8 9 10
No pain Mild Moderate Severe Worst Possible Pain

OSW-SCORE: _____ %

P-SCORE: _____

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

PATIENT NAME: _____

DATE: _____

Please read: This questionnaire is designed to enable us to understand how much your low back 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 The pain comes and goes and is very mild.
- B The pain is mild and does not vary much.
- C The pain comes and goes and is moderate.
- D The pain is moderate and does not vary much.
- E The pain comes and goes and is severe.
- F The pain is severe and does not vary much.

SECTION 6 - Standing

- A I can stand as long as I want without pain.
- B I have some pain on standing but it does not increase with time.
- C I cannot stand for longer than one hour without increasing pain.
- D I cannot stand for longer than 1/2 hour without increasing pain.
- E I cannot stand for longer than 10 minutes without increasing pain.
- F I avoid standing because it increases the pain immediately.

SECTION 2 - Personal Care

- A I do not have to change my way of washing or dressing in order to avoid pain.
- B I do not normally change my way of washing or dressing even though it causes some pain.
- C Washing and dressing increases the pain but I manage not to change my way of doing it.
- D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E Because of the pain I am unable to do some washing and dressing without help.
- F Because of the pain I am unable to do any washing and dressing without help.

SECTION 7 - Sleeping

- A I get no pain in bed.
- B I get pain in bed but it does not prevent me from sleeping well.
- C Because of pain my normal night's sleep is reduced by less than 1/4.
- D Because of pain my normal night's sleep is reduced by less than 1/2.
- E Because of pain, my normal night's sleep is reduced by less than 3/4.
- F Pain prevents me from sleeping at all.

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.
- D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F I can only lift very light weights at the most.

SECTION 8 - Social Life

- A My social life is normal and gives me no pain.
- B My social life is normal but increases the degree of my pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D Pain has restricted my social life, and I do not go out very often.
- E Pain has restricted my social life to my home.
- F I have hardly any social life because of the pain.

SECTION 4 - Walking

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

SECTION 9 - Travel

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

SECTION 5 - Sitting

- A I can sit in any chair as long as I like.
- B I can sit only in my favorite chair as long as I like.
- C Pain prevents me from sitting more than one hour.
- D Pain prevents me from sitting more than 1/2 hour.
- E Pain prevents me from sitting more than 10 minutes.
- F I avoid sitting because it increases pain straight away.

SECTION 10 - Changing degree of pain

- A My pain is rapidly getting better.
- B My pain fluctuates but overall is definitely getting better.
- C My pain seems to be getting better but improvement is slow at present.
- D My pain is neither getting better nor worse.
- E My pain is gradually worsening.
- F My pain is rapidly worsening.

SIGNATURE: _____