CLARKSVILLE
CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

Patient Name _____ Date _____

What would you prefer to be called? _____

Date of Birth _____ Age _____
Social Security Number _____ Male Female

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone_____ Work Phone _____
Would you like to be notified by text of office closings and other announcements? Yes ☐ No ☐
Cell Phone Carrier _____
Email Address _____May we send you updates/offers? Yes No
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation _____ Employer _____

Spouse's Name _____

Primary Care Physician_____Phone_____

How did you hear about us? _____

Insurance you would like us to file _____

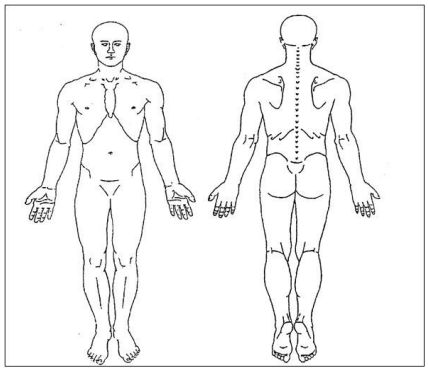
Emergency Contact _____ Relationship _____
Phone _____

Is your visit due to an accident or injury? _____
If yes, please specify _____
Briefly describe your symptoms _____
_____

Pain Scale 1 2 3 4 5 6 7 8 9 10
(Discomfort) (Intense)

Please label the area(s) in which you are hurting:

Pain (P) Burning (B)
Tingling (T) Stiffness (S)
Numbness (N)



Clarksville Chiropractic
Financial Policy

Thank you for choosing our office for your healthcare needs. We are committed to your treatment being successful. If you have any questions regarding your treatment, please feel free to ask. The following is our financial policy.

We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. Please be aware that some and perhaps all of the services may not be covered by your insurance company. You will still b responsible for them.

Full payment is due at the time of service, unless other arrangements have been made. By signing below you agree that in the evet of default you will pay all costs of collection including atorney fees, collection fees, **and contingent fees to collection agencies of not less than 35%. Such contingency fees to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.**

By signing you are authorizing Clarksville Chiropractic Center to release any information necessary to receive payment on your account, to include speaking with a spouse and/or parent. If you would prefer we not speak to them, we will need a written statement.

We strive to make your experience with us exceptional. However, due to laws passed to protect your privacy we request written authorization to proceed with certain office practices. We may leave a message at your home with someone or on an answering machine. We may email you health articles, newsletters or other information.

Your signature below will verify that you have read and understand the above procedures and you have ben given/offered a notice of privacy practices and an oportunity to review them.

_____ _____

Signature Date

Clarksville Chiropractic Center
Confidential Patient Health History

Patient Name _____ **Date** _____

The items below may relate to your current condition. In the space provided, enter **(Y)** if you have **ever had** the problem.

General

1. _____Fever
2. _____Chills
3. _____Night Sweats
4. _____Loss of Sleep
5. _____Fatigue
6. _____Nervousness
7. _____Weight Loss or Gain
8. _____Allergies
9. _____Bleeding Problems
10. ____Anemia
11. ____Diabetes
12. ____Cancer
13. ____Thyroid Disease/Goiter
14. ____Alcoholism
15. ____Drug Abuse

Ear, Eye, Nose, Throat

16. ____Poor Vision
17. ____Pain in Eye(s)
18. ____Deafness/Difficulty Hearing
19. ____Nosebleeds
20. ____Nose Problems
21. ____Sinus Trouble
22. ____Dental Problems
23. ____Hoarseness
24. ____Tonsillectomy

Gastrointestinal

25. ____Poor Appetite
26. ____Poor Digestion
27. ____Difficulty Swallowing
28. ____Belching or Gas
29. ____Frequent Nausea
30. ____Vomiting
31. ____Vomiting Blood
32. ____Pain over Abdomen
33. ____Ulcer
34. ____Black or Bloody Stools
35. ____Liver Problems
36. ____Gall Bladder Problems
37. ____Jaundice
38. ____Hernia
39. ____Diarrhea
40. ____Constipation
41. ____Hemorrhoids
42. ____Appendicitis

Men Only

43. ____Testicular Swelling/Pain
44. ____Prostate Problems

Respiratory

45. ____Difficulty Breathing
46. ____Chronic Cough
47. ____Spitting Phlegm
48. ____ Spitting Blood
49. ____Wheezing/Asthma
50. ____Pneumonia
51. ____Tuberculosis

Cardiovascular

52. ____Irregular Heartbeat
53. ____High Blood Pressure
54. ____Pain Over Heart
55. ____Previous Heart Trouble
56. ____Ankle Swelling
57. ____Varicose Veins
58. ____Rheumatic Fever
59. ____Stroke

Genitourinary

60. ____Frequent Urination
61. ____Painful Urination
62. ____Blood in Urine
63. ____Kidney Disease
64. ____Urinary Infection
65. ____Inability to Control Urination
66. ____Difficulty Starting Urine Flow
67. ____Get Up at Night to Urinate
68. ____Breast Lump or Pain
69. ____Venereal Infection
70. ____Sexual Difficulties

Skin

71. ____Itching
72. ____Bruising Easily
73. ____Change in Mole(s)
74. ____Skin Cancer
75. ____Scars Location

Neurologic

76. ____Weakness
77. ____ Twitching
78. ____Tremors
79. ____Headache
80. ____Fainting
81. ____Dizziness
82. ____Convulsions
83. ____Epilepsy/Seizures
84. ____Numbing/Tingling
85. ____Arm/Leg Pain
86. ____Mental Disorder

Musculoskeletal

87. ____Neck Stiffness/Pain
88. ____Pain Between Shoulders
89. ____Low Back Pain
90. ____Swollen Joints
91. ____Painful Joints
92. ____Muscle Aches/Soreness
93. ____Spinal Curvature
94. ____Arthritis

Women Only

95. ____Painful Periods
96. ____Excessive Flow
97. ____Irregular Cycles
98. ____Vaginal Bleeding
99. ____Hot Flashes
100. _____Date Last Period Began
101. _____Date of Last Pap Smear

Exercise

102. ____None
103. ____1-2 times per week
104. ____3-5 times per week
105. ____6-7 times per week

Habits

106. ____Smoking
____# of packs per day
107. ____Drinking
108. ____Recreational Drug Use
109. ____Caffeine

Family History

Do Not Include Yourself
(Include information on brothers, sisters, parents, and grandparents)

110. ____Diabetes
111. ____Thyroid Disease/Goiter
112. ____Tuberculosis
113. ____Kidney Disease
114. ____High Blood Pressure
115. ____Heart Disease
116. ____Cancer
117. ____Muscle, Bone, or Nerve Disorder
118. ____Lung Disease
119. ____Ulcers
120. ____Arthritis
121. ____Seizure/Strokes

List any medications you are currently taking _____

_____

_____

Patient Signature _____

Clarksville Chiropractic Center
1636 Madison St.
Clarksville, TN 37043

Neck Index

Kenneth A. Gilman, D.C.
Joe Linza, D.C., FIAMA

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the **one** statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

	0	I have no pain at the moment
	1	The pain is very mild at the moment
	2	The pain comes and goes and is moderate
	3	The pain is fairly severe at the moment
	4	The pain is severe at the moment
	5	The pain is the worst imaginable at the moment

Sleeping

	0	I have no trouble sleeping
	1	My sleep is slightly disturbed (less than 1 hour sleepless)
	2	My sleep is mildly disturbed (1-2 hours sleepless)
	3	My sleep is moderately disturbed (2-3 hours sleepless)
	4	My sleep is greatly disturbed (3-5 hours sleepless)
	5	My sleep is completely disturbed (5-7 hours sleepless)

Work

	0	I can do as much work as I want
	1	I can only do my usual work but not more
	2	I can only do most of my usual work but no more
	3	I cannot do my usual work
	4	I can hardly do any work at all
	5	I cannot do any work at all

Recreation

	0	I can stand as long as I like without pain
	1	I have some pain while standing but it does not increase with time
	2	I cannot stand for longer than 1 hour without increasing pain
	3	I cannot stand for longer than ½ hour without increasing pain
	4	I cannot stand for longer than 10 minutes without increasing pain
	5	I avoid standing because it increases pain immediately

Headaches

	0	I have no headaches at all
	1	I have slight headaches which come frequently
	2	I have moderate headaches which come frequently
	3	I have mild headaches which come frequently
	4	I have severe headaches which come frequently
	5	I have headaches almost all the time

Driving

	0	I can drive my car without neck pain
	1	I can drive my car as long as I want with slight neck pain
	2	I can drive my car as long as I want with moderate neck pain
	3	I cannot drive my car as long as I want because of moderate neck pain
	4	I can hardly drive at all because of severe neck pain
	5	I cannot drive my car at all because of neck pain

Concentration

	0	I can concentrate fully when I want with no difficulty
	1	I can concentrate fully when I want with slight difficulty
	2	I have a fair degree of difficulty concentrating when I want
	3	I have a lot of difficulty concentrating when I want
	4	I have a great deal of concentrating when I want
	5	I cannot concentrate at all

Reading

	0	I can read as much as I want with no neck pain
	1	I can read as much as I want with slight neck pain
	2	I can read as much as I want with moderate neck pain
	3	I cannot read as much as I want because of moderate neck pain
	4	I can hardly read at all because of severe neck pain
	5	I cannot read at all because of neck pain

Lifting

	0	I can lift heavy weights without extra pain
	1	I can lift heavy weights but it causes extra pain
	2	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. placed on a table)
	3	Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
	4	I can lift only very light weights
	5	I cannot lift or carry anything at all

Personal Care

	0	I can look after myself normally without causing pain
	1	I can look after myself but it causes extra pain
	2	It is painful to look after myself and I am slow and careful
	3	I need some help but I manage most of my personal care
	4	I need help every day in most aspects of self-care
	5	I do not get dressed. I was with difficulty and stay in bed

Clarksville Chiropractic Center
1636 Madison St.
Clarksville, TN 37043

Back Index

Kenneth A. Gilman, D.C.
Joe Linza, D.C., FIAMA

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the **one** statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

	0	The pain comes and goes and is very mild
	1	The pain is mild and does not vary much
	2	The pain comes and goes and is moderate
	3	The pain is moderate and does not vary much
	4	The pain comes and goes and is very severe
	5	The pain is very severe and does not vary much

Sleeping

	0	I get no pain in bed.
	1	I get pain in bed but it does not prevent me from sleeping well
	2	Because of pain my normal sleep is reduced by less than 25%
	3	Because of pain my normal sleep is reduced by less than 50%
	4	Because of pain my normal sleep is reduced by less than 75%
	5	Pain prevents me from sleeping at all.

Sitting

	0	I can sit in any chair as long as I like
	1	I can only sit in my favorite chair as long as I like
	2	Pain prevents me from sitting more than 1 hour
	3	Pain prevents me from sitting more than ½ hour
	4	Pain prevents me from sitting more than 10 min
	5	I avoid sitting because it increases pain immediately

Standing

	0	I can stand as long as I like without pain
	1	I have some pain while standing but it does not increase with time
	2	I cannot stand for longer than 1 hour without increasing pain
	3	I cannot stand for longer than ½ hour without increasing pain
	4	I cannot stand for longer than 10 minutes without increasing pain
	5	I avoid standing because it increases pain immediately

Changing Degree of Pain

	0	My pain is rapidly getting better
	1	My pain fluctuates but overall is getting better
	2	My pain seems to be getting better but improvement is slow
	3	My pain is neither getting better or worse
	4	My pain is gradually worsening
	5	My pain is rapidly worsening

Social Life

	0	My social life is normal and gives me no extra pain
	1	My social life is normal but it increases the degree of pain
	2	Pain has no significant effect on m social life apart fro limiting my more energetic interests (e.g. dancing, etc.)
	3	Pain has restricted my social life and I do not go out very often
	4	Pain has restricted my social life to my home
	5	I have hardly any social life because of pain

Walking

	0	I have no pain while walking
	1	I have some pain with walking but it does not increase with distance
	2	I cannot walk more than 1 mile without increasing pain
	3	I cannot walk more than ½ mile without increasing pain
	4	I cannot walk more than ¼ mile without increasing pain
	5	I cannot walk at all without increasing pain

Traveling

	0	I get no pain with traveling
	1	I get some pain while traveling but none of my usual forms of travel make it worse
	2	I get extra pain while traveling but it does not cause me to see alternate forms of travel
	3	I get pain while traveling which causes me to seek alternate forms of travel
	4	Pain restricts all forms of travel except that which is done while lying down
	5	Pain restricts all forms of travel

Lifting

	0	I can lift heavy weights without extra pain
	1	I can lift heavy weights but it causes extra pain
	2	Pain prevents me from lifting heavy weights off the floor
	3	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. placed on a table)
	4	Pain prevents me from lifting heavy weights off the floor but I can manage light to medium weights if they are conveniently positioned
	5	I can only lift very light weights

Personal Care

	0	I do not have to change my way of washing or dressing in order to avoid pain
	1	I do not normally change my way of washing or dressing even though it causes some pain
	2	Washing and dressing increases the pain but I manage not to change my way of doing it
	3	Washing and dressing increases the pain but I find it necessary to change my way of doing it
	4	Because of the pain I am unable to do some washing and dressing without help
	5	Because of the pain I am unable to do any washing and dressing without help

NAME_____**DATE**_____

RACE/ETHNICITY

☐ White/Caucasian	☐ Black/African American	☐ Asian
☐ American Indian	☐ Native Hawaiian	☐ Hispanic/Latino/Spanish Origin
☐ Other _____	☐	☐

LANGUAGE

English Spanish Chinese Other _____

Do you have high blood pressure? Yes No (Circle One)

Do you have diabetes? Yes No (Circle One)

Do you take any medications? Yes No (Circle One)
If **YES**, please list at least one:
_____
_____

Do you have any allergies to foods, medications, or the environment? Yes No (Circle One)
If **YES**, please list at least one:
_____
_____

Are you a smoker? Yes No (Circle One)

Height _____ Weight _____

FOR OFFICE USE ONLY

Blood Pressure _____/_____ Pulse _____