WELCOME

Section I: Patient Information

Date:_____

Name:_____ I Prefer to be called:_____
Address:_____ City:_____ State:_____ Zip Code:_____
Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____
Check Appropriate Box I would prefer to be contacted on my ☐ HOME PHONE ☐ WORK PHONE ☐ CELL PHONE
Date of Birth:_____ Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse or Parents Name:_____ If Student, School Name:_____ Employer:_____
Person to contact in case of emergency:_____ Phone:_____
Email Address:_____
Whom may we thank for referring you?_____

Section II: Reason For Treatment

Major
Complaints:_____

_____

How did this condition develop? (what caused it? How did it start?)_____

_____

When was the very first time you were aware of this problem?_____
Have you ever had this problem or similar problem before? If yes, please explain_____

_____

Have you ever received any treatment for this condition? If yes, when and where, and what were your results?_____

_____

If you are in pain please describe the type and frequency of your pain, as well as the activities which bring on or aggravates the pain. For example: dull, sharp, constant, off and on, when standing, when sitting, etc_____

_____

Has this problem been ☐ Getting Better ☐ Getting Worse ☐ Staying the Same
Is there anything that makes your condition worse?_____
How has the condition affected your life? (home, occupational, recreational, rest, and sleep)_____

_____

Has there been any accidents, falls, automobile accidents, etc that may have caused the problem?

_____

Any surgeries that have been done?_____
Any Medications?:_____
Any Chiropractic care in the past?_____ Name of Chiropractor:_____
Date consulted?_____ For what problem?_____
Have you ever been diagnosed with cancer? ☐ YES ☐ NO If yes, please explain:_____
Do you have an implanted neurostimulator device? ☐ YES ☐ NO If yes, where:_____
Do you have a pacemaker? ☐ YES ☐ NO
Please check any of the following that may apply to you:

_____Take medications that increase sensitivity to sunlight
_____Have a seizure disorder that is triggered by light
_____Have hemorrhagic diatheses
_____Been injected with steroids in the past 2-3 weeks
_____Have a cancerous lesion(s) or history of cancerous lesion(s)
_____Take anticoagulants
_____Are Pregnant
_____Have HIV positive history
_____Have a pacemaker
_____Leukemia

Our office strives to offer each patient an integrated wellness plan based on your condition(s). Please check off any of the following services you may be interested in addition to chiropractic/physical therapy treatments:
☐ MLS Laser Therapy ☐ Essential Oils ☐ Reflexology ☐ Weight loss ☐ Nutritional/Life Coaching

Fees are payable at the time of examinations, x-rays, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of Chicago Chiropractic Center.

Patient's Signature:_____ **Date:**_____

Lifestyle / Self Care Issues

Have you ever smoked cigarettes? ☐ Yes ☐ No
If yes,_____packs per day. Smoked for____ years
Are you still smoking? ☐ Yes ☐ No
Do you drink caffeinated beverages? ☐ Yes ☐ No
If yes, _____cups, cans, etc/per day
Do you drink alcohol? ☐ Yes ☐ No
If yes, _____ number of drinks /week_____
Previous drug/alcohol problems? ☐ Yes ☐ No
Do you manage stress well? ☐ Yes ☐ No ☐ Need Help
Do you exercise regularly? ☐ Yes ☐ No
Type/Frequency _____
Do you sleep soundly? ☐ Yes ☐ No
Are you satisfied with your social life? ☐ Yes ☐ No
Is your diet healthy enough? ☐ Yes ☐ No
☐ Not Sure ☐ Need Help

Diet Habits and Typical Daily Intake

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Fluids: Cups of water:_____ Other Fluids:_____

Current Medications	Dosage	Times/day

Current Vitamins/Herbs	Dosage	Times/day

Review of Systems: (circle current problems, check past problems)

Constitutional
__ decreased sleep
__irregular sleep
__excessive sleep
__ poor appetite
__fevers
__chills
__food cravings
__weight loss
__weight gain
__fatigue

Immune System
__too many infections
__allergies to food or environment
__other concerns

Mood, Thoughts, And Emotions
__manic episodes
__energy problems
__spiritual needs
__anger problems
__depression
__lonliness
__apathy
__don't care anymore
__panic/fear attacks
__anxiety
__hopelessness
__isolated from family Friends, & coworkers

Skin & Hair
__mole changes
__dry skin/eczema
__rashes/ hives
__hair loss

Hormones/Metabolism
__thyroid trouble
__fluid retention
__weight and diet trouble

Ears, Nose, Mouth, Throat
__ringing ears
__nose bleeds
__postnasal drip
__sinus problems
__trouble with taste/smell
__ poor hearing
__earaches
__bad breath
__headaches
__facial pain
__jaw clicks
__teeth problems
__grinding teeth
__trouble chewing
__sore throats

Eyes
__eye pain
__blurred vision
__Poor vision__day__night
__wear corrective lenses
__near or far sighted
__ other:_____

Breathing and Lungs
__shortness of breath
__wheezing or asthma
__repeated colds or flu
__cough, dry or irritating
__cough up mucus or blood

Heart & Circulation
__chest pain
__lightheadedness
__palpations
__cold hands/feet
__fainting
__swelling feet
__blood clots
__varicose veins

Digestion and Intestines
__ indigestion
__ belching
__difficult swallowing
__heartburn
__nausea
__liver trouble
__vomiting
__ blood in stools
__diarrhea
__foods that upset your stomach
_____
__cramping bowels
__gassy gut
__constipation
__abdominal pain
__rectal pain or itching
__hemmroids

Nerves, Movement, Brain
__seizures
__nerve pains
__poor balance
__ poor coordination
__tremors or shaking
__numbness
__dizziness
__poor memory
__trouble sleeping

Muscles, Bones, Joints
__neck pain
__back pain
__muscle pain
__muscle weakness
__muscle cramps
__joint swelling
__painful joints R__L__
__shoulder __elbow
__hip __knee __ankle
__foot __toe __hand
__wrist __fingers

Urine, Kidneys, Bladder
__ decreased urine flow
__ blood/pus in urine
__ painful urination
__ wake up to urinate
__kidney stones
__loss control of urine
__ sudden urges to pee
__frequent urination

Women's Reproductive
__ age period started
__number of pregnancies
__pregnancies lost
__past fertility problems
__number of live births
__children currently living
__age period stopped/ menopause

Sexual Organs
__sores on genitals
__lumps or swelling
__erection problems
__poor sexual response
__pain with sex
__infertility
__repeated infections
Women:
__pelvic pain
__vaginal discharge
__painful periods
__PMS symptoms
__hot flashes
__itching or soreness
__breast lumps or pain
__breasts leak fluid

Blood System
__lymph gland swelling
__anemia
__easy bruising

CHICAGO CHIROPRACTIC CENTER
Anne Gordon, D.C.
Alicia Vulchev, D.C.

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks of treatment, including but not limited to fractures, disc injuries strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name:_____

Patient/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____

CHICAGO CHIROPRACTIC CENTER
NOTICE OF PRIVACY PRACTICES

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

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than treatment.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have a right to request that we amend your protected health information. Please be advised. ,however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Chicago Chiropractic Center.
- You have a right to a paper copy of the Notice of Privacy Practices at any time upon request.

Chicago Chiropractic Center is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosures of Your Health Care Information

Treatment
We may disclose your health care information to other health care providers within our practice for the purpose of treatment, payment, or healthcare operations. "It is our policy to provide a substitute health care provider, authorized by Chicago Chiropractic Center, to provide assessment and/or treatment to our patients, without advance notice, in the event of your primary care provider's absence due to vacation, sickness, or other emergency situation."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
If payment is not made or arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

Workers' Compensation
If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or other person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons
We may disclose your information to coroners or medical examiners.

Organ Donation & Research
Though highly unlikely or probable we must inform you that there may be a need to release your health information to organizations involved in procuring, banking, or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institution Review Board.

Public Safety
It may be necessary to disclose your information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing & Other Communication
We may contact you for marketing purposes or fundraising purposes, as described below: (example)
"As a courtesy to our patients, it is our policy to call your home on the day prior or the day of your scheduled appointment to remind you of your appointment time. If you are not home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."

Changes to this Notice of Privacy Practices
This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Complaints
Complaints about your privacy rights, or how Chicago Chiropractic Center has handled your health information should be directed to Christy Tatara, office manager, by calling this office at (312) 726-1353. If Christy Tatara is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201

For additional information about your privacy, please visit www.hcfa.gov/medicaid/hipaa

CHICAGO CHIROPRACTIC CENTER

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices for the office of Chicago Chiropractic Center detailing how my information may be used and disclosed as permitted under federal and state law.

Printed Patient Name:_____

Signature:_____ Date:_____

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient:_____

Relationship:_____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name:_____ **Date:**_____

Please read carefully:
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than 1 complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and its worst.

Example:

No Pain **Worst Possible Pain**

Headache Neck Low Back

0 1 2 (3) 4 5 (6) 7 8 (9) 10

1. What is your pain **RIGHT NOW?**

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

2. What us your **TYPICAL** or **AVERAGE** pain?.

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best?

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level **AT ITS WORST** (how close to "10" does your pain get at its worst?

No Pain **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

Comments:_____

Neck Disability Index Questionnaire (NDI)

Name: **Date:**

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 just 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 is 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 (Washing, Dressing etc.)

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 dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

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

DISABILITY INDEX SCORE: **%**_____

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without 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 my car 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 engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in 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 all all.

Source: Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. J Manipulative Physiol Ther 1991;14(7):409-15.

Revised Oswestry Disability Index (ODI)

Name: **Date:**

*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 just circle the one choice which 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 is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would 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 or dressing without help.
F. Because of the pain, I am unable to do any washing and dressing without help.

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 if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights off of the floor.
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 4 – Walking

A. I have no pain walking.
B. I have some pain walking, but I can still walk my required normal distances.
C. Pain prevents me from walking long distances.
D. Pain prevents me from walking intermediate distances.
E. Pain prevents me from walking even short distances.
F. Pain prevents me from walking at all.

SECTION 5 – Sitting

A. Sitting does not cause me any pain.
B. I can sit as long as I need provided I have my choice of sitting surfaces.
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. Pain prevents me from sitting at all.

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for more than one hour without increasing pain.
D. I cannot stand for more than ½ hour without increasing pain.
E. I cannot stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases my pain right away.

SECTION 7 – Sleeping

A. I have no pain in bed.
B. I have pain in bed but it does not prevent me from sleeping well.
C. Because of pain I only sleep ¾ of normal time.
D. Because of pain I only sleep ½ of normal time.
E. Because of pain I only sleep ¼ of normal time.
F. Pain prevents me from sleeping at all.

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 pain.
C. Pain prevents me from participating in more energetic activities, eg sports, dancing.
D. Pain prevents me from going out very often.
E. Pain has restricted my social life to home.
F. I hardly have any social life because of pain.

SECTION 9 – Traveling

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 some pain while traveling, but it does not cause me to seek alternative forms of travel.
D. I get extra pain from travel that causes me to seek alternative forms of travel.
E. Pain restricts me from all forms of travel.
F. Pain restricts me from all forms of travel, except that done lying down.

SECTION 10 – Employment / Homemaking

A. My normal job/homemaking activities do not cause me pain.
B. My normal job/homemaking activities cause me extra pain, but I can still perform all that is required of me.
C. I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities eg, lifting, vacuuming.
D. Pain prevents me from doing anything but light duties.
E. Pain prevents me from doing even light duties.
F. Pain prevents me from performing any job or homemaking chore.

DISABILITY INDEX SCORE: %_____

Source: Fairbank JC, Couper J, Davies JB, O'Brien JP. The Oswestry low back pain disability questionnaire. Physiotherapy 1980;66(8):271-3.