40 Brookwood Avenue, Carlisle, PA 17015 ** (717) 609-1333

Case History/Patient Information

Date:_____ Name_____ Nickname:_____

Age:___ Birth Date:_____ Marital: M S W Height:____Weight:_____ Social Security#_____

Address:_____City:_____ State:___ Zip:_____

Home Phone:_____ Cell Phone:_____ E-mail:_____

Would you like appointment reminders? Y N If yes, would you prefer (circle one) Call Text Email

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone: _____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____ Names of Children:_____

How were you referred to our office?_____

Family Medical Doctor:_____

May we have your permission to update your medical doctor regarding your care?_____

Please check any and all insurance coverage that may be applicable in this case:

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident

□ Medical Savings Account & Flex Plans □ Other

Name of Primary Insurance Company:_____

Name of Insured: _____ Birth Date:_ _____

Name of Secondary Insurance Company (if any):_____

Name of Insured: _____ Birth Date: _____

The following person(s) have my permission to receive my personal health information:

Name:_____ Relationship:_____

NO SHOW POLICY: A $35 fee will be assessed to your account after your 2nd offense of not calling or showing up for your scheduled appointment.

Signature:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____DATE _____

HISTORY OF PRESENT AND PAST ILLNESS

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? □ Yes □ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? □ Yes □ No

If yes, describe:_____

Do you have any allergies of any kind? □ Yes □ No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches___ Frequency	_____	Loss of Balance	_____	Rheumatoid Arthritis	_____
Neck Pain	_____	Fainting	_____	Excessive Bleeding	_____
Stiff Neck	_____	Loss of Smell	_____	Osteoarthritis	_____
Sleeping Problems	_____	Loss of Taste	_____	Pacemaker	_____
Back Pain	_____	Unusual Bowel Patterns	_____	Stroke	_____
Nervousness	_____	Feet Cold	_____	Ruptures	_____
Tension	_____	Hands Cold	_____	Eating Disorder	_____
Irritability	_____	Arthritis	_____	Drug Addiction	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____	Gall Bladder Problems	_____
Dizziness	_____	Frequent Colds	_____	Seizures/Epilepsy	_____
Shoulder/Arm Pain	_____	Fever	_____	Low Blood Pressure	_____
Numbness in Fingers	_____	Sinus Problems	_____	Osteoporosis	_____
Numbness in Toes	_____	Diabetes	_____	Heart Disease	_____
High Blood Pressure	_____	Indigestion Problems	_____	Cancer	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____	Coughing Blood	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____	Alcoholism	_____
Breathing Problems	_____	Weight Loss/Gain	_____	HIV Positive	_____
Fatigue	_____	Depression	_____	Ulcers	_____
Lights Bother Eyes	_____	Loss of Memory	_____		
Ears Ring	_____	Buzzing in Ears	_____		
Broken Bones/Fractures	_____	Circulation Problems	_____		

PATIENT NAME _____DATE _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

NAME:_____ **DATE:** _____

Back Disability Index (Oswestry)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which 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, 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 (i.e. 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 only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and causes me no extra 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, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

NAME:_____ **DATE:** _____

Neck Disability Index

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

Section 1 – Pain Intensity

- ❑ I have no pain at the moment. (0)
- ❑ The pain is very mild at the moment. (1)
- ❑ The pain is moderate at the moment. (2)
- ❑ The pain is fairly severe at the moment. (3)
- ❑ The pain is very severe at the moment. (4)
- ❑ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

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

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck. (0)
- ❑ I can read as much as I want to with slight pain in my neck. (1)
- ❑ I can read as much as I want with moderate pain in my neck. (2)
- ❑ I cannot read as much as I want because of moderate pain in my neck. (3)
- ❑ I can hardly read at all because of severe pain in my neck. (4)
- ❑ I cannot read at all. (5)

Section 5 – Headaches

- ❑ I have no headaches at all. (0)
- ❑ I have slight headaches that come infrequently. (1)
- ❑ I have moderate headaches which come infrequently. (2)
- ❑ I have moderate headaches which come frequently. (3)
- ❑ I have severe headaches which come frequently. (4)
- ❑ I have headaches almost all the time. (5)

Section 6 – Concentration

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

Section 7 – Work

- ❑ I can do as much work as I want to. (0)
- ❑ I can do my usual work, but no more. (1)
- ❑ I can do most of my usual work, but no more. (2)
- ❑ I cannot do my usual work. (3)
- ❑ I can hardly do any work at all. (4)
- ❑ I cannot do any work at all. (5)

Section 8 – Driving

- ❑ I can drive my car without any neck pain. (0)
- ❑ I can drive my car as long as I want with slight pain in my neck. (1)
- ❑ I can drive my car as long as I want with moderate pain in my neck. (2)
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- ❑ I can hardly drive at all because of severe pain in my neck. (4)
- ❑ I cannot drive my car at all. (5)

Section 9 – Sleeping

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

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ❑ I am able to engage in all my recreation activities, with some pain in my neck. (1)
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ❑ I can hardly do any recreation activities because of pain in my neck. (4)
- ❑ I cannot do any recreation activities at all. (5)

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Name_____
Print Patient's Name

Dated this _____ day of _____, 20 ____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)