

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____

Today's Date: ___/___/___

Social Security Number _____ Birth Date: ___/___/___ Age: ___ Gender: F M

Driver's License number: _____ State: _____

Patient's E-mail address: _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? Mother and Father Father Mother Legal Guardian None of these

Marital Status: Married Separated Widowed Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ FULL-TIME PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (____) _____

Spouse is a student at _____ FULL-TIME PART-TIME

Who should we contact in the event of an emergency? _____ Relationship of emergency

contact to patient: _____ Phone (____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? YES NO Date of accident: ___/___/___

Did the condition or injury result from *automobile* accident? YES NO Please check ALL that apply.

Did it result from a *work-related* accident or cause? YES NO (briefly describe): _____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

Approximately, when did your injury or condition occur? ___/___/___

Describe your condition, symptoms, or the purpose of this appointment: _____

Have you ever had the same or similar condition? YES NO If yes, when and describe: _____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/___

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Date of last physical examination? _____

What surgery have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe: _____

What medications or drugs are you taking? _____

Have you ever suffered from:

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Cancer |

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? YES NO UNCERTAIN

Do you have health insurance? YES NO Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/___

Health insurance Id: _____ Group number: _____ Does the policy holder have the insurance through his/her employer? YES NO If yes, who is the employer? _____

Attorney name: _____ Contact info: _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself - not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers. I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/____/____

MEDICATION RECORD

PATIENT NAME: _____

DATE	NAME OF MEDICATION	STRENGTH	DOSE HOW OFTEN

ALLERGIES TO MEDICATIONS? YES NO (CIRCLE ONE)
NAME OF ALLERGY: _____

DOB: ___ / ___ / ___

GENDER: ___ MALE ___ FEMALE

PREFERRED LANGUAGE SPOKEN/USED: _____

RACE: _____

ETHNICITY: _____

DO NOT SMOKE? YES NO (CIRCLE ONE) IF YES, HOW LONG _____

Score: _____

The Neck Disability Index

Date: _____

Please rate the severity of your pain by circling a number below:

No pain

0 1 2 3 4 5 6 7 8 9 10

Unbearable Pain

Instructions: This questionnaire has been designed to give the 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 only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that 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 6 – CONCENTRATION

- I can concentrate fully when I want to, with no difficulty.
- I can concentrate fully when I want to, with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

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; I wash with difficulty and stay in bed.

SECTION 7 – HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 3 – LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me lifting heavy weights off the floor, but I can manage light to medium weights when conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 8 – WORK

- I can do as much work as I want to.
- I can do my usual work, 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.

SECTION 4 – SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr sleepless).
- My sleep is mildly disturbed (1-2 hrs sleepless).
- My sleep is moderately disturbed (2-3 hrs sleepless).
- My sleep is greatly disturbed (3-5 hrs sleepless).
- My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 9 – 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 neck pain.
- 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.

SECTION 5 – READING

- I can read as much as I want to, with no pain in my neck.
- I can read as much as I want to, with slight pain in my neck.
- I can read as much as I want to, 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.

SECTION 10 – RECREATION

- I am able to engage in all my recreation activities with no neck pain.
- I am able to engage in all my recreation activities with some neck pain.
- I am able to engage in most, but not all of my usual recreation activities, because of pain in my neck.
- I am able to engage in few of my recreation activities, because of pain in my neck.
- I can hardly do any recreation activities, because of neck pain.
- I can't do any recreational activities at all.

Patient Name: First Last

Initial Visit Date: _____

Score: _____

Oswestry Low Back Pain Scale

Date: _____

Please rate the severity of your pain by circling a number below:

No pain

0 1 2 3 4 5 6 7 8 9 10

Unbearable Pain

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

SECTION 1 – PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)

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

SECTION 3 – LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me lifting heavy weights off the floor.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift light weights at most.

SECTION 4 – WALKING

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than 1 mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 – SITTING

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

SECTION 6 – STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7 – SLEEPING

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain my normal nights sleep is reduced by less than one-quarter.
- Because of pain my normal nights sleep is reduced by less than one-half.
- Because of pain my normal nights sleep is reduced by less than three-quarter.
- Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

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

SECTION 9 – TRAVELING

- I get no pain when traveling.
- I get some pain when traveling but none of my usual form of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts me to short necessary journeys under ½ hour.
- Pain restricts all forms of travel.

SECTION 10 – CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates, but is definitely getting better.
- My pain seems to be getting better, but improvement is slow.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Initial Visit Date: _____

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: _____ [enter your office's full name].

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/___