WELCOME to Back on Track Family Chiropractic! Confidential Patient Information

Name _____ Social Security # _____ Home Phone _____

Address_____ Cell Phone _____

Address City State Zip

Best Telephone number to reach you at during the day: □Home □Work □Cell □Other_____

Email _____ Age ___ Birth Date __/____/_____ Height ____ Weight ___ Sex □M □F

Marital Status: M S W D How many children? ___ Who referred you to our office?_____

If you found us on the internet, what words did you put in the search engine?_____

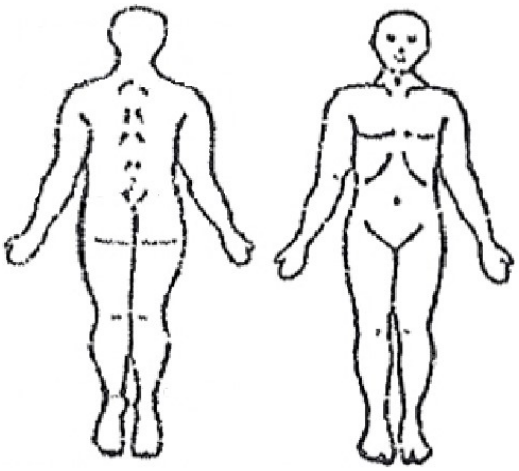
Why did you pick our office? _____

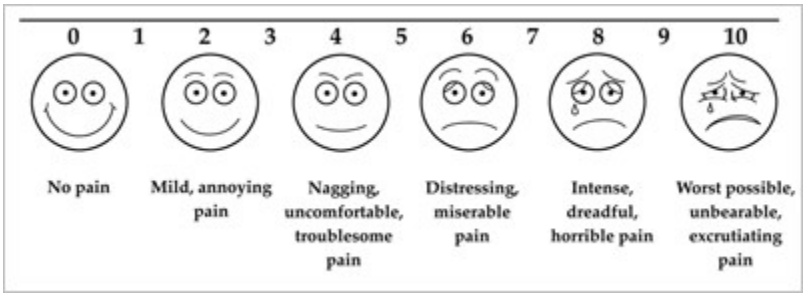
Occupation _____ Employer _____ Phone _____

Spouse's Name _____ Employer _____ Phone_____

Emergency Contact _____ Relation_____ Phone _____

Current State:





Please Mark the Body above with the areas that are in pain or that you are concerned about.

On a scale to the right, how much pain are you in now?___/10 Same scale, max pain with this problem?___/10

Health History Information:

Main physical problem you are concerned about_____

What caused your condition: □ Auto/Work Accident □ Fall/Trip/Slip Where?_____

□ Gradual Onset □ Repetitive Movement/Posture □ Overexertion Lifting, Pulling, etc

□ Unknown □ Question does not apply □ Other _____

Date symptom(s) appeared? _____ Are symptoms: □ Getting Worse □ Getting Better □ Staying Same

How would you describe your chief complaint? _____

Have you seen another doctor regarding this? □ Y □ N Name_____ When _____

What have you done up till now to treat your problem? Has it helped? _____

_____

Have you had X-rays of your back/neck or area that you are having trouble with? □ Y □ N If yes, When? Results? _____

_____

What is your expected ultimate outcome from seeing us?_____

Have you ever had any of the following (please check all that apply): □ Anemia □ Arthritis
□ Asthma □ Back Surgery □ Sinus Trouble □ Cancer □Diabetes
□ Digestive Disorders □ Fainting □ Heart Disease/Stroke □ Nervousness □ Neuritis

Do you have any of the following symptoms: □ Headache □ Blurry Vision □ Difficulty Concentrating
□ Memory problems □ Ringing in the ears □ Depression □ Nervousness □ Anxiety
□ Dizziness □ Difficulty Sleeping □ Fatigue □ Easily Get sick □ Increased Irritability
□ Upper Back Pain □ Mid Back Pain □ Neck Pain □ Low Back Pain □ Numbness in Hands/Arms
□ Pelvis/Hip Pain □ Difficulty Breathing □ Chest Pain □ Heart Burn □ Numbness in legs/feet
□ Excessive Gas □ Constipation □ Diarrhea □ Upset Stomach □ Changes/Difficulty Urinating
□ Groin Pain □ Hemorrhoids □ Sciatica □ Difficulty Having a Sexual Desire/Performing Sexually
□ Tingling in Legs/Feet □ Tingling in Hands/Arms □ Weakness in Legs/Feet □ Weakness in Arms/Hands

Other problems in Hands/Arms or Legs/Feet _____

Other Symptoms that you feel may or may not be related to the current problem: _____

_____

_____

Allergies_____

Injuries or surgeries in your life(include dates of surgery)_____

Hospitalizations_____Accidents/Falls_____

Other traumas to your body _____

Current medications: _____ Are you pregnant? □ Y □ N

Do you have a normal menstrual period? □ Y □ N What contraceptives are you taking? _____

How many hours of sleep do you get a night? ____ Are the hours you go to bed and get up consistent? □ Y □ N

How often do you exercise? _____ Type of exercise_____

Do you eat healthy? □ Y □ N Types of foods you eat?_____

_____

Do you smoke? □ Y □ N _____ packs a day. Do you drink alcohol? □ Y □ N ___ time per week

Do you take any recreational Drugs? □ Y □ N Which ones do you take and how often?_____

What are at least 3 things can you not do now that you would normally do? Please score these activities are your ability to do them as things are currently using the scale below. _____

_____

_____

Patient Specific Functional Scale (PSFS)

0 = Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 10=Able to perform activity at same level as before injury or problem

Family History: (this applies only to Grandparents, parents, siblings, children and grandchildren)

Do you have any family history of Cancer, Diabetes, high blood pressure, high cholesterol, heart issues, thyroid issues, or similar problems to which you are presenting with today, any other family history problems? □ Y □ N

If yes, who and what are the issues? _____

_____

_____

_____

_____

Health Insurance Information: (please fill out even though we will get a copy of the card)

Primary Company _____ ID #_____ Group # _____

Address _____ Phone _____

Name of Insured_____ Birth Date _____ SS # _____
(Address, City, State, Zip)

Insured's Address_____ Phone _____ Relation to Patient_____

Secondary Company_____ ID #_____ Group # _____

Address _____ Phone _____

Name of Insured_____ Birth Date _____ SS # _____
(Address, City, State, Zip)

Insured's Address_____ Phone _____ Relation to Patient_____
(Address, City, State, Zip)

Policies: All the information I have provided is accurate and I understand that it will be used to help determine appropriate chiropractic care for my condition. I authorize the performance of X-rays and other diagnostic and therapeutic procedures for treatment purposes for myself or for my dependent. I also acknowledge the receipt of the federally required Notice of Privacy Practices. I acknowledge and consent to have my personal health information (PHI) to be used in administrative operations of the clinic, to be used to collect on the bill and to be used in my care. I recognize that some treatment may be done in a common area and if privacy is needed I can request more privacy for the duration of my care. I further authorize Back on Track Family Chiropractic to contact me via text to my cell phone/unencrypted email or encrypted email if I request it.

INSURANCE AUTHORIZATION: I authorize Back on Track Family Chiropractic (BTFC) the use of my signature and PHI on insurance claim submissions to seek reimbursement and release of all information as needed for treatment, payment, or health care operations. I hereby advise all insurance companies providing benefits of any kind to me/us for treatment rendered by (BTFC) to pay in full the bill for services rendered by BTFC following your receipt of such bill for services to the extent they are payable under the terms of my/our policy for benefits less any amounts which I/we owe personally which are not payable under the terms of your policy. I understand that if my insurance company denies or delays payment(s) 60 days from the date of service that I will be responsible to pay BTFC in-full for services rendered and seek reimbursement directly from my insurance company.

FINANCIAL RESPONSIBILITY: I agree that the responsibility for payment of all services in this office, for me or my dependent(s), is mine and is expected at the time of service unless other arrangements are made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 30 days. In the event of default, I promise to pay any legal interest on the indebtedness, together with collection costs in the amount of not less than 33.33% nor more than 50% of the principal balance due and reasonable attorney fees and court costs as may be required to effect collection of this note.

Signature of Responsible Party _____ Date _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____

Pregnancy Release

This is to certify to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of my last menstrual period: _____

_____

Signature Date

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation

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

- □ 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 3 – Lifting

- □ I can lift heavy weights without causing extra pain.
- □ I can lift heavy weights, but it gives me extra pain.
- □ Pain prevents me from lifting heavy weights off the floor but
  I can manage if items are conveniently positioned, i.e. on a table.
- □ Pain prevents me from lifting heavy weights, but I can manage
  light weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

Section 4 – Work

- □ I can do as much work as I want.
- □ I can only do my usual work, but no more.
- □ I can do most of my usual work, but no more.
- □ I can't do my usual work.
- □ I can hardly do any work at all.
- □ I can't do any work at all.

Section 5 – 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 6 – Concentration

- □ I can concentrate fully without difficulty.
- □ I can concentrate fully with slight difficulty.
- □ I have a fair degree of difficulty concentrating.
- □ I have a lot of difficulty concentrating.
- □ I have a great deal of difficulty concentrating.
- □ I can't concentrate at all.

Section 7 – Sleeping

- □ I have no trouble sleeping.
- □ My sleep is slightly disturbed for less than 1 hour.
- □ My sleep is mildly disturbed for up to 1-2 hours.
- □ My sleep is moderately disturbed for up to 2-3 hours.
- □ My sleep is greatly disturbed for up to 3-5 hours.
- □ My sleep is completely disturbed for up to 5-7 hours.

Section 8 – Driving

- □ I can drive my car without neck pain.
- □ I can drive as long as I want with slight neck pain.
- □ I can drive as long as I want with moderate neck pain.
- □ I can't drive as long as I want because of moderate neck pain.
- □ I can hardly drive at all because of severe neck pain.
- □ I can't drive my car at all because of neck pain.

Section 9 – Reading

- □ I can read as much as I want with no neck pain.
- □ I can read as much as I want with slight neck pain.
- □ I can read as much as I want with moderate neck pain.
- □ I can't read as much as I want because of moderate neck pain.
- □ I can't read as much as I want because of severe neck pain.
- □ I can't read at all.

Section 10 – Recreation

- □ I have no neck pain during all recreational activities.
- □ I have some neck pain with all recreational activities.
- □ I have some neck pain with a few recreational activities.
- □ I have neck pain with most recreational activities.
- □ I can hardly do recreational activities due to neck pain.
- □ I can't do any recreational activities due to neck pain.

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly 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, I 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 placed
  (eg. 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 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 from walking more than 1 mile
- □ Pain prevents me from walking more than ½ mile
- □ Pain prevents me from walking more than 100 yards
- □ I can only walk using a stick or crutches
- □ I am in bed most of the time

Section 5 – Sitting

- □ I can sit in any chair as long as I like
- □ I can only sit in my favorite chair as long as I like
- □ Pain prevents me sitting more than one hour
- □ Pain prevents me from sitting more than 30 minutes
- □ Pain prevents me from sitting 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 for more than 1 hour
- □ Pain prevents me from standing more than 30 minutes
- □ Pain prevents me from standing 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 gives 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 (eg. Sports)
- □ Pain has restricted my social life and I do not go out as often
- □ Pain has restricted my social life to my home
- □ I have no social life because of pain

Section 10 – Travelling

- □ I can travel anywhere without pain
- □ I can travel anywhere but it gives me extra pain
- □ Pain is bad, but I manage journeys over 2 hours
- □ Pain restricts me to journeys of less than 1 hour
- □ Pain restricts me to short necessary journeys under 30 minutes
- □ Pain prevents me from travelling except to receive treatment