

# CHIROPRACTIC REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

~~CC/MCO/ID # \_\_\_\_\_~~

Patient Name \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

~~CC/MCO/ID # \_\_\_\_\_~~

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 INSURANCE INFORMATION

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
 Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## 3 PHONE NUMBERS

Cell Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## 4 ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## 5 PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

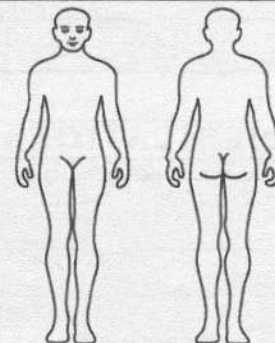
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# 6

## HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

### EXERCISE

- None
- Moderate
- Daily
- Heavy

### WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

### HABITS

- Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_
- Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_
- Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_
- High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

# 7

## MEDICATIONS

## ALLERGIES

## VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

# Quadruple Numerical Rating Scale

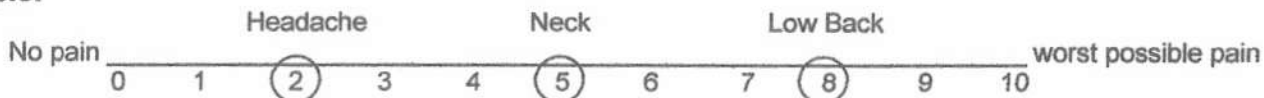
FAX (800) 599-3330

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY)
			/ /
Provider Last Name	Provider First Name	Provider ID	

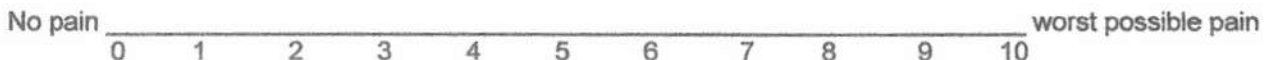
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one 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 worst.

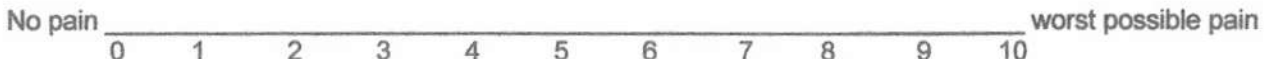
**Example:**



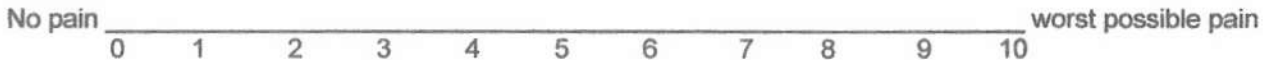
1. What is your pain **RIGHT NOW**?



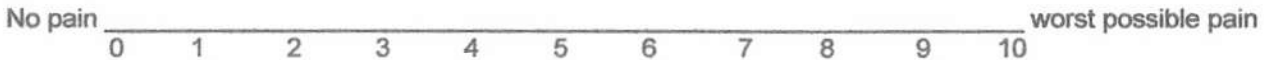
2. What is your **TYPICAL** or **AVERAGE** pain?



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



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



**OTHER COMMENTS:**

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I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

# Neck Disability Index Questionnaire

FAX (800) 699-8380

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY)
Provider Last Name	Provider First Name	Provider Phone (area code first)	

**Instructions:** 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 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 pain.
- B. I can look after myself normally but it causes 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 infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

## 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 at all

DISABILITY INDEX SCORE: % \_\_\_\_\_

I understand that the information I have provided above is current and correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

SpineCare Decompression and Chiropractic Center  
3134 Niles Rd. Unit B – St. Joseph, MI 49085  
(269) 408-8439

**PATIENT CONSENT FORM**

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: SpineCare Decompression and Chiropractic Center.

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: \_\_\_/\_\_\_/\_\_\_