SPINECARE
CHIROPRACTIC CENTER

PATIENT INTAKE FORM

WELCOME and THANK YOU for seeking out care at our office. We are a very unique team specializing in research based spinal and postural rehabilitation that helps our patients recover their optimal health; often where many other systems have failed. Please know we will make certain your healing will be our top priority.

_____

PATIENT'S PREFERED NAME

_____

DATE COMPLETED

Patient Information

Name: _____ DOB: ____/____/_____ Gender: M F

Home Address: _____ Home Phone:_____

City, State, Zip: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

□ I do not want to receive emails with clinic/health related information from SpineCare Chiropractic

Social Security: _____ Marital Status: S M D W S

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Children's Name(s): _____

How were you referred to this office? _____

Purpose For This Visit

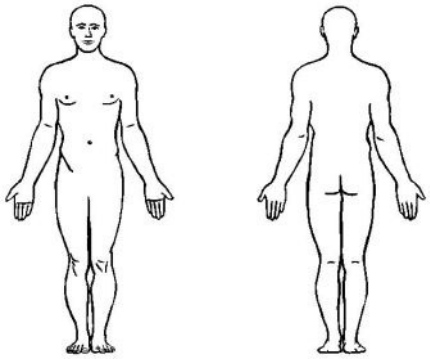
1) _____ Onset:___/___/___ How did symptom start? _____

Frequency: Constant Frequent Intermittent Occasional **Severity**: mild 1 2 3 4 5 6 7 8 9 10 severe

2)_____ __Onset:___/___/___ How did symptom start? _____

Frequency: Constant Frequent Intermittent Occasional **Severity**: mild 1 2 3 4 5 6 7 8 9 10 severe

***If your symptoms are the result of an auto accident or work related injury, please let the front desk staff know.**



Please indicate your pain on the diagram:

A = Ache	G = Stabbing	N = Numbness
B = Burning	M = Spasms	T = Tingling
S = Stiffness	O = Other	

Are they getting worse? □Yes □No **Do they interfere with**: □Work □ Sleep □ Hobbies □ Daily routine

Explain _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? Yes No If yes, explain: _____

Have you experienced these symptoms before? Yes No

If yes, explain: _____

Have you been treated for this? □Yes □ No When were your last treated? _____

What treatment was performed? _____

How did you respond? _____

Have you seen a chiropractor before? Yes No Who? _____

Health & Lifestyle

Do you exercise? □ Yes □ No How often? _____ days per week; Other _____

What activities? □ Walking □ Running □ Weight Training □ Cycling □ Yoga □ Pilates Other _____

Do you smoke? □ Yes □ No How much/often? _____

Do you drink alcohol? □ Yes □ No How much/often? _____

Do you drink coffee? □ Yes □ No How much/often? _____

Do you take any supplements? (i.e. vitamins, minerals, herbs)? _____
_____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL The areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Have you experienced any of these symptoms presently or in the past?
Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Neck Pain
___ Pain in the shoulders/arms/hands
___Numbness/tingling in arms/hands
___ Hearing disturbances
___ Weakness in grip
___ Heaviness
___ Headaches
___ Dizziness
___ Visual disturbances
___ Coldness in hands
___Thyroid conditions
___ Sinusitis
___Allergies/Hay fever
___ Recurrent colds/flus
___ Low Energy/Fatigue
___ TMJ/Pain/Clicking

Please Explain: _____
_____
_____

THORACIC SPINE (UPPER BACK)

Have you experienced any of these symptoms presently or in the past?
Please indicate (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable.

___ Heart Palpitations
___ Heart Murmurs
___ Tachycardia
___ Heart Attacks/Angina
___ Mid Back Pain
___ Pain in Ribs/Chest
___ Asthma/Wheezing
___ Indigestion/Heart Burn
___Nausea
___ Ulcers
___ Diabetes
___ Reflux

Please Explain: _____
_____
_____

LUMBAR SPINE (LOW BACK)

Have you experienced any of these symptoms presently or in the past?
Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Pain in hips/legs/feet
___ Numbness/tingling in legs/feet
___ Frequent/difficulty urinating
___ Constipation/Diarrhea
___Weakness/injuries in hips/kness/ankles
___ Recurrent bladder infections
___ Muscle cramps in legs/feet
___ Menstrual irregularities/cramping (females)
___ Low back pain
___ Coldness in legs/feet
___ Sexual dysfunction

Please Explain: _____
_____
_____
_____

Other

Please list any health conditions not mentioned: _____
_____
_____

Please list any medications (include name, dose, for what condition, and how long you've been taking it):
_____
_____
_____
_____

Please list any surgeries (include type of surgery and date it was performed): _____
_____
_____
_____
_____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following (please indicate Y for You, and O for Other than you, or both if applicable):

___ Diabetes
___ Fibromyalgia
___ High Blood Pressure
___ Kidney Disease
___ Liver Disease
___ Herniated Disc
___ Pneumonia
___ Digestive Disorders
___ Thyroid Problems
___ Blood Sugar Problems
___ High Cholesterol
___ Vertigo
___ Circulatory Problems
___ Heart Disease
___ Paralysis
___ Metal Implants
___ Appendectomy
___ Scoliosis
___ Multiple Sclerosis
___ ADD/ADHD
___ Epilepsy/Seizures
___ Other: _____
___ Neurological Problems
___ Stroke
___ Cancer
___ Migraine Headaches
___ Chronic Fatigue
___ Asthma
___ Parkinson's Disease
___ Influenza
___ Eczema/Psoriasis
___ TMJ Dysfunction
___ Lung Disease
___ Heart Murmur
___ Osteoporosis
___ Arthritis
___ Gall Bladder
___ Hernia
___ Anemia
___ Tumors
___ Bronchitis
___ Depression
_____

Women: Are you pregnant? □Yes □ No Are you nursing? □Yes □ No

Women: Are you taking birth control pills? □Yes □No Last Menstrual Period: ___/___/___

HEALTH CARE AUTHORIZATION FORM

Patient's Name _____ Date _____ DOB _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **SpineCare Chiropractic Center** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to **SpineCare** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

- If **SpineCare** contacts me by phone, I give them permission to leave a phone message with a member of my household, on my answering machine or voice mail.

- By signing this form you are giving **SpineCare** permission to use and disclose your protected health information in accordance with the directives listed above, and in accordance with our Notice of Privacy Practices. A copy of this Notice is available per request.

SpineCare Chiropractic Center utilizes an open adjusting approach to treating patients, other patients may be in the room while you are being treated and they may be able to overhear some of your protected health information during the course of care. However if you need to speak with the doctor at any time in private, the doctor will provide a room for these conversations. If you have a problem with the open room treatments please notify the doctor immediately.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this Authorization, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **SpineCare Chiropractic Center**. The written notice must contain the following information: Your name, Social Security number and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request, and your signature.
The revocation is not effective until it is received by the Privacy Official.
You have the right to refuse to sign this Authorization. If you refuse to sign this AUTHORIZATION, **SpineCare Chiropractic Center** will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.

A COPY OF THE NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME.
_____(Patients Initials)

Print Name of Patient _____ Date _____

Signature of Patient _____ Signature of Witness _____

INFORMED CONSENT FORM

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative therapy
- range of motion testing
- muscle strength testing
- Functional movement testing
- radiographic studies
- palpation
- orthopedic testing
- postural analysis
- hot/cold therapy
- myofascial release
- vital signs
- neurological testing
- electrical stim
- mechanical traction

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:
Self-administered, over-the-counter analgesics and rest, prescription drugs, hospitalization &/or surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

•A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

•Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone.

•Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

•Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

•Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

Authorization of Care:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered I authorize and agree to allow the doctor and/or the designated staff to work with my spine or the spine of the child I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function. I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these treatment plans.

I understand that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. Any balance past due 90 days will be sent to our collection agency and a $30 collection fee is added on to the balance. Also there is a $30 service fee for any returned checks.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have discussed the above information with *Dr. Creehan* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated: _____**

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Signature or Signature of Parent or Guardian (if a minor) **Signature**

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

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

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

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

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

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

Lifting

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

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____