

Patient Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Date of Birth: _____

Employer's Name and Address: _____

Email: _____ How did you hear about us?: _____

If referred, who referred you to our office?: _____

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

List approximately how long you have noticed these problems:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Is there a certain time of day any of these problems are better or worse?

List the treatments you have used for these problems:

- Ice Heat Exercise Massage Chiropractic Rest
 Medication(s): _____

 Other: _____

Describe any sudden movements, injuries, falls, accidents, etc. that have caused your problem(s): _____

Have you had similar health problems or injuries before? Yes No _____

Names of all doctors you have seen for these problems and treatment you received: _____

Have your health problems: Improved Worsened Stayed the Same

List anything that makes your conditions worse: _____

Please check off and describe how this problem interferes with your work and/or personal life:

Work Activities Effected: _____

Have you missed any days of work? Yes No If yes, dates missed: _____

Home Activities Effected: _____

Recreational Activities Effected: _____

Previous Health History

Who is your primary care physician/family doctor?: _____

When were you last seen there: _____

May we send them updates on your treatment/condition: Yes No

During the last year, has a doctor treated you for any health problem? Yes No

If yes, please explain: _____

Have you ever received Chiropractic care? Yes No If yes, please list the doctor's name and for what problems: _____

Please check the prescription drugs you are currently taking: Anti-depressants Anti-Inflammatory

Birth Control Pills Blood Pressure Medication Diet Pills Blood Sugar Medication

Muscle Relaxers Insulin Pain Pills Sleeping Pills

Other (please list): _____

Please check the over the counter drugs you are using and how much you take:

Aspirin: _____ Tylenol: _____ Motrin: _____ Alleve: _____

Advil: _____ Other: _____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____

List any vitamins or nutritional supplements you are currently taking or have taken recently: _____

Check any of the following you are interested in learning more about or would like information on:

Massage Therapy Acupuncture Nutrition Testing Live Blood Cell Analysis Spinal Decompression

Physician Supervised Weight Loss Wellness Coaching Health Workshops and Seminars

Financial Responsibility

Who is responsible for your bill? Insurance My Employer Spouse I am

Other

Type of Insurance: Automobile Health Worker's Comp

Insurance Company's Name, Address and Phone #: _____

Your fees are due and payable at the time examination, X-rays and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature: _____ Social Security No.: _____ Date: _____

Parent or Guardian Signature (if patient is minor)

_____ Social Security No.: _____ Date: _____

Family Health History

Marital Status: Married Single Widowed Separated Divorced

Name of spouse: _____

Spouse Phone Number: _____

Name and ages of children: _____

To help your doctor determine if your health problem is hereditary please fill out the following table on the health of your immediate family members.

	Age (if living)	Age at death (if deceased)	Chronic Health Problems
Mother			
Father			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Social History

Do you smoke? Yes No If yes, how many packs/daily: _____

Do you drink? Yes No If yes, how many drinks/week: _____

Do you exercise regularly? Yes No If yes, describe what type and how often: _____

Do you consider yourself to have a good social support system (friends/family)? Yes No

Describe a typical daily diet (only include meals/snacks you regularly eat):

Breakfast: _____ Snack (time eaten): _____

Lunch: _____ Snack (time eaten): _____

Dinner: _____ Snack (time eaten): _____

Review of Systems

Check any symptoms you've had in the past year:

- | | | | | | |
|--|--|---|---|---|---|
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Headaches | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Nosebleed | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Skin changes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Joint stiffness |
| <input type="checkbox"/> Difficult/
painful urination | <input type="checkbox"/> Unexpected
weight loss or gain | <input type="checkbox"/> Difficulty
swallowing | <input type="checkbox"/> Heart
Palpitations | <input type="checkbox"/> Poor wound
healing | <input type="checkbox"/> Shortness of
breath |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tremors | <input type="checkbox"/> Seizures | <input type="checkbox"/> Easy bleeding/
bruising | <input type="checkbox"/> Excessive thirst
or urination | <input type="checkbox"/> Allergic
Reactions |

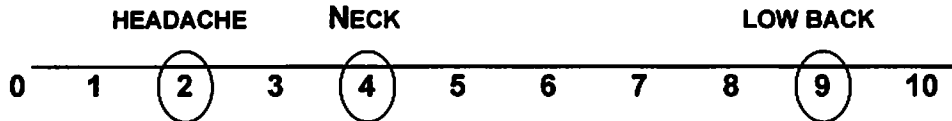
QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

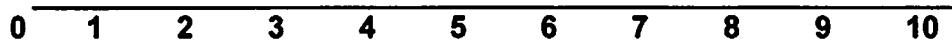
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

EXAMPLE:



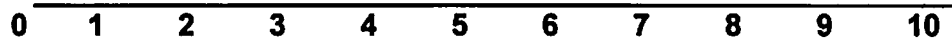
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

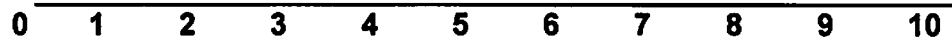


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

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



What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

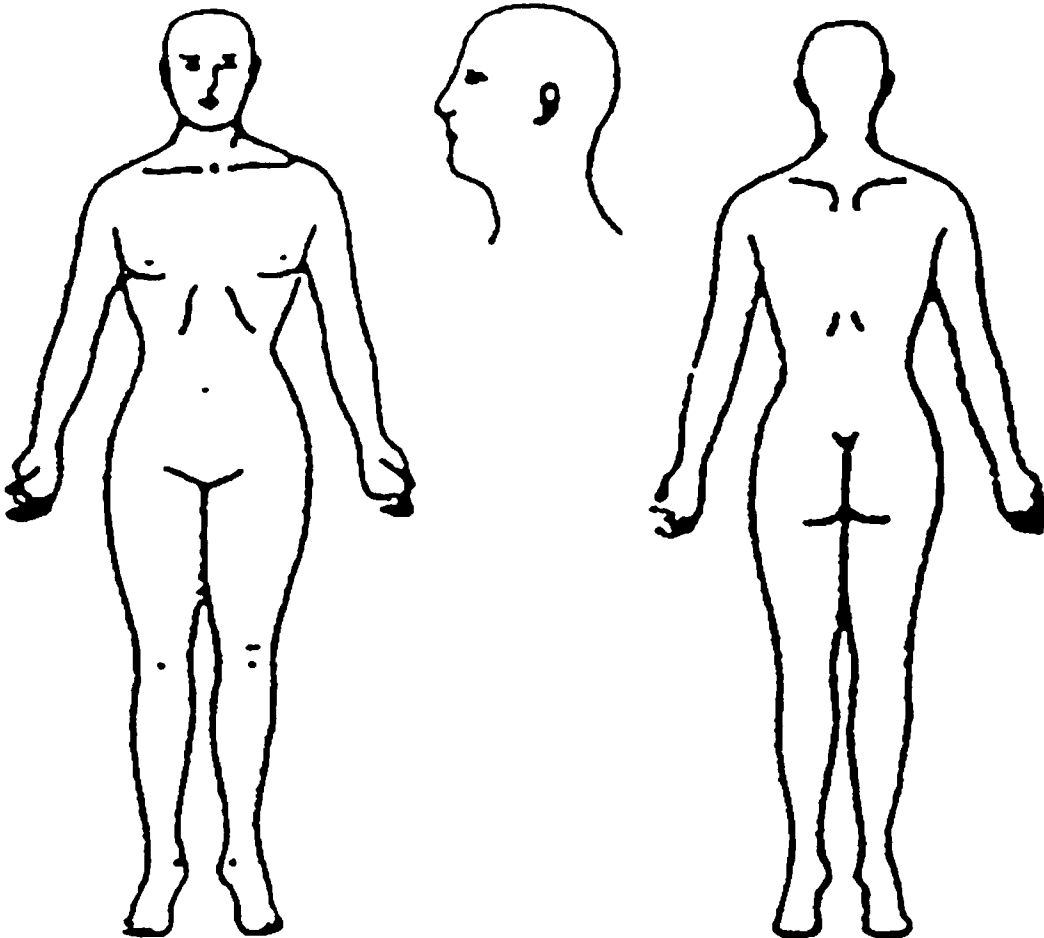
Aches $\wedge\wedge\wedge$

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

Stabbing ///



LOW BACK DISABILITY QUESTIONNAIRE (REVISED 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 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 can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

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 positioned, for example 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 from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than one-half mile.
- Pain prevents me from walking more than one-quarter mile.
- 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 only sit in my favorite chair as long as I like
- Pain prevents me from 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 almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
 (Score x 2) / (Sections x 10) = %ADL

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 extra pain.
- Pain prevents me from standing 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

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 -- 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, e.g. dancing.
- 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 9 -- Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain is bad but I manage journeys less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

Section 10 -- Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments _____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

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 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, 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 positioned, for example 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 -- 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 with moderate pain.
- 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 5-Headaches

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

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 7--Work

- I can do as much work as I want to.
- I can only 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 8 -- Driving

- I 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 pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9 -- Sleeping

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

Section 10 -- Recreation

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

Comments _____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

FORM 501

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
 (Score x 2) / (Sections x 10) = _____ %ADL

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(Signature)

Dr. Brett A. Keyser, D.C.
(814) 382-8840

(Date)

**Informed Consent to Treat for Chiropractic Care
Conneaut Lake Chiropractic-- Dr. Brett A. Keyser, DC**

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed for all new patients. These procedures are performed to assess your specific condition, your overall health and in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I, the undersigned, hereby authorize Conneaut Lake Chiropractic Center to administer treatment as it so deems necessary in the course of my chiropractic health care. I understand that this treatment may include, but is not limited to, palpation, spinal examination, orthopedic and neurological examinations, x-rays, chiropractic adjustments, and trigger point therapy. Further, I understand that chiropractic care is not a substitute for medical care, nor is it intended to diagnose, treat, or cure any disease, condition, ailment or medical condition.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ Patient Name (printed)	_____ Relationship to patient
_____ Patient or legal Guardian Signature	_____ Date
_____ Witness Signature (office staff)	_____ Date

Conneaut Lake Chiropractic, PC X-ray Consent Form

The doctor has explained the purpose of the x-rays about to be taken; is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers non-chiropractic “unusual findings” when reviewing these x-rays, I will be informed. The doctor at that time will suggest that I consult with another provider, and I then must determine if I should see the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding.

At Conneaut Lake Chiropractic we are concerned about a fetus receiving x-rays. Please initial the following questions.

Females only:

_____ To the best of my knowledge, I am not pregnant, and I give Conneaut Lake Chiropractic permission to take all necessary x-rays.

_____ I have been advised that the ten (10) days following the onset of a menstrual period is generally considered to be safe for x-ray exams.

_____ I have reached menopause and it is safe to take x-rays.

All Patients:

_____ I have been informed prior to services rendered that I may be financially responsible and accept responsibility for payment if my insurance denies or otherwise does not pay for the services I received today.

The charge for x-rays taken in our office may not be a covered benefit of your insurance plan. The fee for our in office x-rays are \$35.00 for 2-3 views and \$45.00 for 4 + views. You will be responsible for payment of the x-rays taken today if your insurance denies or otherwise does not pay for the services rendered.

I fully understand the above and consent to chiropractic spinal x-rays.

Patient Signature: _____ Date: _____