PERSONAL HISTORY

Date_____ Doctor_____
Name_____ Address_____
City_____State_____Zip_____
Age _____ Sex_____ Birth Date _____
Height _____Weight _____Marital Status: **M S W D S**
Please circle 2 contact choices:
Email: home _____work_____
Phone :home_____ cell _____work_____
Occupation_____ Employer_____
Medical Doctor:_____ If needed, may we contact your doctor? Yes No
Name and phone number of person to contact in case of emergency other than your spouse:

_____
Name of spouse or parent (if patient is a minor):_____
Birth Date:_____
Spouse's or parent's employer _____work phone_____
Ages of your children _____Referred to this office by_____
Who is responsible for your bill? **[ ]** Self **[ ]** Spouse **[ ]** Insurance Other:_____

CHECK TYPE OF INSURANCE COVERAGE FOR THIS CONDITION:

[ ] Health Insurance (Group Policy)
[ ] Medicare
[ ] Automobile Insurance
[ ] Medicaid
[ ] Workman's Compensation
[ ] Other _____
If dually insured, which insurance is primary? _____

REASON FOR CONSULTING THIS OFFICE:

[ ] I have no problem. I need to maintain my good health with regular Chiropractic treatments.
[ ] I have a problem now, and I need Chiropractic to help me reach my maximum health potential.
[ ] I have a problem now that I need help with. I want to learn how to prevent it in the future.
[ ] I have a problem, and I need help only with this specific problem.

OPERATIONS: (Please date!)

Spinal _____ Heart_____ Appendectomy_____
Female Organs _____ Gall Bladder_____ Hernia_____
Others _____

ACCIDENTS AND FALLS: (Please date and describe!) _____

_____
_____

BROKEN BONES AND DISLOCATIONS:

_____
Are you taking any drugs? (Please name) _____
_____
_____
Have you ever had a nervous breakdown? _____
Have you been treated for a mental disorder? _____

PLEASE CIRCLE IF YOU EVER HAVE HAD……

Alcoholism
Anemia
Cancer
Diabetes
Dizziness
Epilepsy
Goiter
Heart disease
Hepatitis B
Implants
Mental disorder
Osteoporosis
Pacemaker
Pleurisy
Pneumonia
Polio
Recent fractures
Rheumatic fever
Scarlet fever
Seizures
Spinal injection
Spinal tap
Stroke
T.I.A.
Tuberculosis
Rheumatoid arthritis
Joint replacements
Sexually transmitted disease
Plastic or metal plates

PLEASE CIRCLE ALL THAT APPLY TO YOU……

UPPER SPINE:

Neck Problems
Shoulder Problems
Elbow Problems
Wrist Problems
Hand Problems
Headaches Frequently
Headaches Occasionally
Eye Problems
Sinus Trouble
Ear Problems
Noises in Ears
Hay Fever
T.M.J. Problems

MIDDLE SPINE:

Back Pain (problems)
Side Pain (ache)
Chest Pain (problems)
Abdominal Pain
Digestive Problems
Breathing Problems
Nausea
Constipation
Diarrhea
Anxiety Attacks
Gall Bladder Trouble
Colon Problems
Compression Fracture

LOWER SPINE:

Low Back Problems
Hip Problems
Tail Bone Pain
Abdominal Pain
Groin Pain
Muscle Spasms
Kidney Problems
Urination Problems
Bed Wetting
Leg Problems
Knee Problems
Ankle/Foot Trouble
Sciatica
Spinal Disc Problems
Neuropathy
Foot Drop

FOR WOMEN ONLY

Menstrual Problems
Excessive Flow
Hot Flashes
Irregular Cycle
Fertility Problems
Are You Pregnant?

_____Yes _____No

_____Maybe

PAIN DESCRIPTION:

Sharp pain on motion (joint)
Constant pain (joint or nerve)
Burning or Hot pain (nerve)
Sharp pain at rest (nerve)
Stabbing or shooting (nerve)
Tingling or numbness (nerve)
Cramp or knot pain (muscle)
Spasm pain (muscle)
Dull ache (muscle)
Throbbing pain (vascular)

Radiating dull or deep ache (referred ligament or muscle)

Deep burning or dull pain (bone/ligament)

Pin point or spot pain (myofascial trigger-point)

Crawling sensation (myofascitis)

_____

PATIENT'S SIGNATURE

Oswestry Disability Questionnaire

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 circling **one 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

0 I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
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

Section 2: Personal Care (eg. washing, dressing)

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 can manage most of my personal care
4. I need help every day in most aspects of self-care
5. I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

0 I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives me extra pain
2. Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table)
3. Pain prevents me lifting heavy weights 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

Section 4: Walking

0 Pain does not prevent me walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ½ mile
3. Pain prevents me from walking more than 100 yards
4. I can only walk using a stick or crutches
5. I am in bed most of the time

Section 5: 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 sitting more than one hour
3. Pain prevents me from sitting more than 30 minutes
4. Pain prevents me from sitting more than 10 minutes
5. Pain prevents me from sitting at all

TOTAL: _____

0 – 10 Minimal disability
11 – 20 Moderate disability
21 – 30 Severe disability
31 – 40 Incapacitated
41 – 50 Bed-bound

Section 6: Standing

0 I can stand as long as I want without extra pain
1. I can stand as long as I want but it gives me extra pain
2. Pain prevents me from standing for more than 1 hour
3. Pain prevents me from standing for more than 30 minutes
4. Pain prevents me from standing for more than 10 minutes
5. Pain prevents me from standing at all

Section 7: Sleeping

0 My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain I have less than 6 hours sleep
3. Because of pain I have less than 4 hours sleep
4. Because of pain I have less than 2 hours sleep
5. Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

0 My sex life is normal and causes no extra pain
1. My sex life is normal but causes some extra pain
2. My sex life is nearly normal but is very painful
3. My sex life is severely restricted by pain
4. My sex life is nearly absent because of pain
5. Pain prevents any sex life at all

Section 9: 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 effect on my social life apart from limiting my more energetic interests e.g. sport
3. Pain has restricted my social life and I do not go out as often
4. Pain has restricted my social life to my home
5. I have no social life because of pain

Section 10: Traveling

0 I can travel anywhere without pain
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but I manage journeys over two hours
3. Pain restricts me to journeys of less than one hour
4. Pain restricts me to short necessary journeys under 30 minutes
5. Pain prevents me from travelling except to receive treatment

Patient's Signature:

_____

Date: _____

REITER CHIROPRACTIC OFFICES
Consent for Chiropractic Services

CONSENT FOR CHIROPRACTIC CARE:

I hereby request and consent to chiropractic treatment including physical examination, diagnostic x-rays, manipulations, meridian therapy (acupuncture) and various physical therapy by the doctors and staff of Reiter or Grand Chiropractic offices. I shall have the opportunity to discuss the nature, the purpose, and the cost of procedures before they are administered. I understand that results can never be guaranteed. I understand that in the practice of chiropractic, as in the practice of medicine, there are some risks which include sprains, disc injuries, dislocations, strokes, and fractures. I do not expect my doctor to be able to anticipate or explain all risks or complications. I wish to rely on the doctor to use judgment during my course of treatment which he/she believes is in my best interest. I have read or have had read to me this consent and may take the opportunity to ask questions whenever I choose. It is my intention that this consent apply to treatment at any time in the future when I decide to take treatment at Reiter or Grand Chiropractic offices.

_____ _____

Patient's or Guardian's signature **Date**

CONSENT TO TREATMENT OF A MINOR (17 years old or less):

I authorize the doctors and staff at Reiter/Grand Chiropractic offices to administer chiropractic treatment as deemed necessary to

_____my_____(relationship to patient).

_____ _____

Parent or guardian signature **Date**

Please note, the parent or guardian must accompany the minor for the first visit.

INSURANCE AUTHORIZATION and RELEASE:

Name of primary Insurance Company:_____

Secondary Insurance Company (if any): _____

I authorize payment of insurance benefits directly to the chiropractor or the office. I authorize the doctor to release all information to communicate with insurance personnel and other healthcare providers in order to secure the payment of benefits and/or the coordination of care. I understand that I am ultimately responsible for all costs of chiropractic treatment, regardless of insurance coverage. **I hereby promise to assist collections at this office by completing, signing, and mailing insurance forms when necessary.**

In so much as I have agreed to allow the use of my patient health information for the purpose of insurance payment and coordination of care, I am still entitled to privacy. I understand my rights to privacy are detailed in the "HIPPA NOTICE" which describes the policy and procedures of this office. This manual is available for my review at the receptionist desk.
(If you want us to discuss your condition with a family member or friend, we need your permission to do so.)

_____ _____

Patient's or Guardian's signature **Date**