



Tel: (334) 270-3333
 Fax: (334) 270-3367
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Zink Chiropractic Center

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:			Date:		
Address:		Street	City	State	Zip
Home phone:		Work phone:			
Cell phone:		Cell Carrier:			
Best time/place to contact you:		Email address:			
Date of birth:		Age:			
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Height:		Weight:			
Social Security number:					
Marital status: M S W D			Spouse/guardian name:		
Occupation:					
Employer's name & address:					
Spouse's Occupation/Employer:					
Name of person responsible for account:					
Do you have insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>			Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Insurance Company:					
Insurance Policy number:			Insurance Company phone number:		
Insurance Company address:					

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition? _____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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What lesson(s) have you taken home from your healing process to date?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Is there anything else which may help to better understand you which has not been discussed?

Why are you here at this point in time?

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

Zink Chiropractic Center
2117 Taylor Road
Montgomery, Al 36117
334-270-3333

Patient Consent, Authorization, Assignment of Benefits and Agreement to Pay:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent form I authorize you to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other health care providers involved in my treatment), obtaining payment from third party payers and the day to day health care operations of your practice

I have also been informed of and given the right to secure a copy of a Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the rights to change the terms of this notice from time to time and I may contact you to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I hereby authorize the doctor to care for my through the use of chiropractic adjustments to my spine and/or extremities. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or for any medical diagnosis.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I also understand that this doctor's office will prepare any necessary reports and will assist me in making collections from insurance company and that I authorize assignment of benefits to be payable directly to Zink Chiropractic Center. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment all fees for professional services rendered to me will be considered a lawful debt. I, the undersigned accept these fees charged as legal and lawful debt and agree to pay said fee, including any/all collection fees, collection agency fees (33.33%), attorney fees and/or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I agree, in order for your office and your agents to service by account or to collect monies I may owe, your office can contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. You can also contact me by sending text messages, or emails, using any email address I provide to use. Methods of contact may include using pre-recorded artificial voice messages and/or use of automatic dialing service, as applicable.

I have read this disclosure an agree Zink Chiropractic Center, its employees, and/or agents may cont me as described above.

Date _____

Print Patient Name _____ Relationship to Patient: _____

Social Security Number _____

Signature: _____

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient _____ Age _____

Check ONE: _____ INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

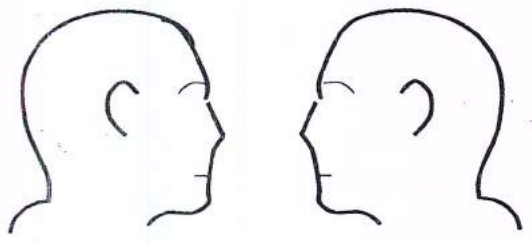
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

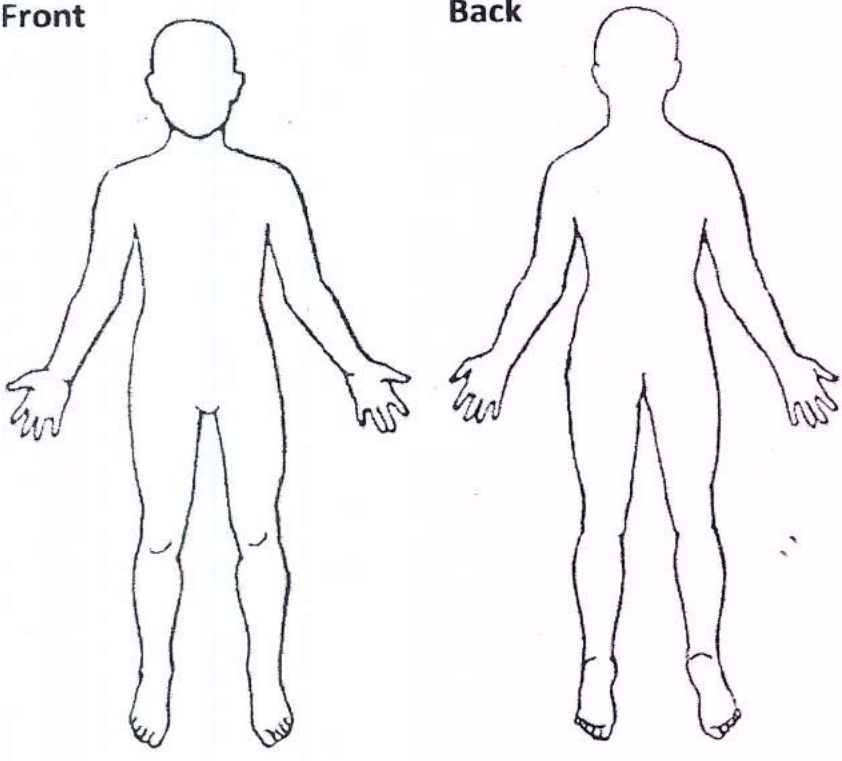
Right

Left



Front

Back



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE _____

DATE _____

Neck Pain Disability Index Questionnaire

Patient Name: _____

Case Number: _____

This questionnaire is designed to enable us to understand how much your neck condition affects your ability to manage your everyday activities. Please answer every section by marking the one statement that best applies to you. We realize that more than one statement may relate to you, however please mark the one that most closely describes your problem.

PAIN INTENSITY

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

LIFTING

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights, but it causes extra pain.
- 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.
- ⑥ I cannot lift or carry anything at all.

DRIVING

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

HEADACHES

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

CONCENTRATION

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

WORK

- ① I can do as much work as I want.
- ② I can only do my usual work, but no more.
- ③ I can only do most of my usual work, but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

READING

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I cannot read as much as I want because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

PERSONAL CARE

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally, but it causes extra pain.
- ③ It is painful to look after myself, and I am slow and careful.
- ④ I need some help, but manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty, and I stay in bed.

SLEEPING

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

RECREATION

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my recreation activities with some neck pain.
- ③ I am able to engage in most, but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

Patient Signature

Today's Date

FOR OFFICE USE ONLY

Low Back Pain Disability Index Questionnaire

Patient Name: _____

Case Number: _____

This questionnaire is designed to enable us to understand how much your back condition affects your ability to manage your everyday activities. Please answer every section by marking the one statement that best applies to you. We realize that more than one statement may relate to you, however please mark the one that most closely describes your problem.

PAIN INTENSITY

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is severe.
- ⑥ The pain is severe and does not vary much.

LIFTING

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights, but it causes extra pain.
- 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.
- ⑥ I cannot lift or carry anything at all.

TRAVELING

- ① I get no pain while traveling.
- ② I get some pain while traveling, but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling, but it does not cause me to seek alternative forms of travel.
- ④ I get extra pain while traveling, which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

PERSONAL CARE

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
- ⑤ Because of the pain, I am unable to do some washing and dressing without help.
- ⑥ Because of the pain, I am unable to do any washing and dressing without help.

WALKING

- ① I have no pain while walking.
- ② I have some pain while walking, but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

SITTING

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting, because it increases pain immediately.

STANDING

- ① I can stand as long as I want without pain.
- ② I have some pain while standing, but it does not increase with time.
- ③ I cannot stand for longer 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing, because it increases pain immediately.

SOCIAL LIFE

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal, but it increases the degree of pain.
- ③ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.).
- ④ Pain has restricted my social life, and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

CHANGING DEGREE OF PAIN

- ① My pain is rapidly getting better.
- ② My pain fluctuates, but overall is definitely getting better.
- ③ My pain seems to be getting better, but improvement is slow.
- ④ My pain is neither better nor worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Patient Signature

Today's Date

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