

**Muncie Spine
& Rehab Center**

*John W. Moore D.C.
Seth R. Moore D.C.*



Appointment Time _____ Date _____

Name _____

Age _____ D.O.B _____ M F

M S W D Email _____

Home Ph # _____ Cell Ph # _____

Address _____

Employer _____

Occupation _____

Patient # _____ Referred by _____ Dr. Preference _____

Can you relate your pain to a specific incident? _____

Parent or Spouse Information

Spouse/Parent Name _____ D.O.B _____

Spouse/Parent's Employer _____ Work Ph # _____

In Case of Emergency, Notify _____ Ph # _____

Insurance Information

Do you have insurance? Y / N What type? MM MC MD AC WC PI GM

Release of Information

I authorize Muncie Spine & Rehab to release information regarding my care and treatment to my insurance company, benefit plan administrator, or attorney. This authorization is only for evaluation and or settlement of a claim made on my behalf. This authorization is for the term coverage of the policy of settlement of any outstanding balance incurred at this office. I agree that a photocopy of this authorization is as valid as the original.

Signature _____ Date _____

Assignment of Benefits / Financial Disclosure

I assign any insurance benefits that would be paid to me for expenses incurred in this office to Muncie Spine & Rehab. I understand that any and all charges that are denied are my responsibility for immediate payment. I also understand that my deductible, co-payments and non-covered services are due and payable at time of service. Muncie Spine & Rehab reserves the right to charge interest at 8% per year on an outstanding account. We also reserve the right to recover any expenses incurred in collecting such debt, including but not limited to use of a collection agency or attorney.

Signature _____ Date _____

Consent to Treat Minor Child

I hereby authorize Muncie Spine & Rehab to administer treatment as deemed necessary to my son/daughter

Signature _____ Date _____



MUNCIE SPINE & REHAB
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PATIENT PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received and read a copy of Muncie Spine & Rehab Center's Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

Name _____ Patient # _____ Date _____

CHECK ALL THAT APPLY

- | | | | | |
|--|---|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Light Bothers eyes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Feet cold | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever | <input type="checkbox"/> Hands cold | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Back stiff | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Nausea | <input type="checkbox"/> Weakness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Constipation | | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Tingling in _____ | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Cold sweats | | |

1. When did your symptoms first appear?

2. What incident or activity do you feel may have caused your symptoms?

3. Have you ever had similar symptoms? **Y / N** If so, when?

4. Have you seen other doctors for this condition? **Y / N**

If so, when? _____ Who? _____

Were any images (X-ray, CT, MRI) taken?

5. List activities or movements that aggravate your condition

6. This condition is progressively getting worse
 better
 remains the same

7. List daily activities that are affected by your condition

8. What percentage of your day do you feel affected by your pain (circle one)

0-25% 26-50% 51-75% 76-100%

9. Does this condition interfere with work, school, or sports? **Y / N**

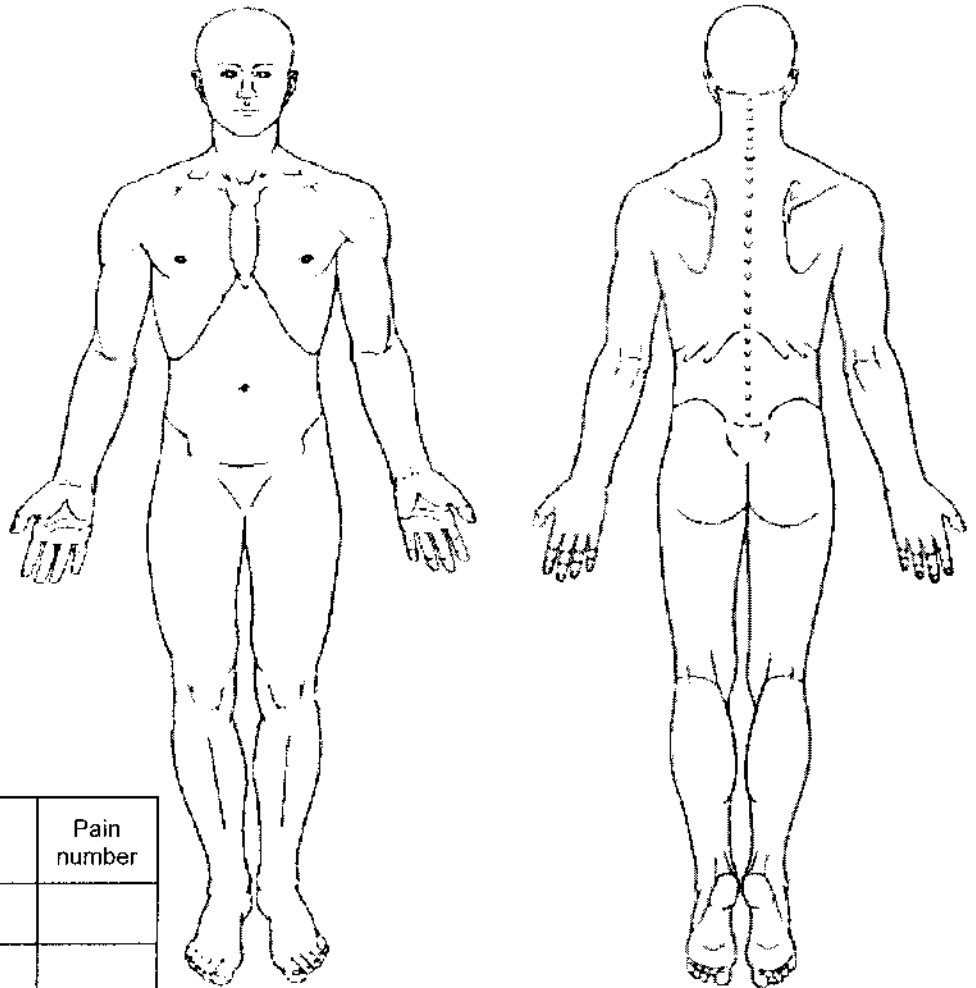
If so, explain how:

PAIN DRAWING

Name _____ Date _____

Directions:

Mark areas on the body with an **X** where you feel your symptoms. Include all affected areas. If the pain radiates, use an arrow from where it starts and extend the arrow as far as the pain travels.



List the areas where you are having pain and give a number 1-10 and be sure to use the Muncie Spine and Rehab pain scale.	Area	Pain number

Describe your symptoms (mark all that apply)

- | | | |
|---------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Shooting | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Tight | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Radiating |

Neck Index

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.

Neck
Index
Score

Back Index

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.

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Index
Score**