RAINIER VALLEY CHIROPRACTIC P.S.
David A. Butters D.C. — Natasha Butters D.C. — Mitchell Gottschalk D.C.
4236 36th Avenue S. Seattle, WA 98118
Phone 206-723-2820 Fax 206-722-3664

Patient Health History

Full Name_____ Date_____

Street Address_____ City _____State_____ Zip _____

Cell #_____Home #_____ Email_____

Gender_____ Date of Birth_____ Age_____

How did you hear about our office? _____

Marital Status_____ # of Children? ____ Currently Pregnant? / How Long? _____

Occupation_____ Employer_____

Work Address_____Work #_____

Are you insured? ❑Yes ❑No Name of Insurance Company_____

Today's Major Complaints

Please check ✓ *Please* (Circle) *Your Level of Pain.*

Area of Pain and Type of Pain							*0= No Pain through 10=Extreme Pain*										
❑Headache	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Neck Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Shoulder Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Arm Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Mid Back Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Low Back Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Hip Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Leg Pain	❑Lt ❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing		0	1	2	3	4	5	6	7	8	9	10
❑Other _____							0	1	2	3	4	5	6	7	8	9	10
❑Other _____							0	1	2	3	4	5	6	7	8	9	10

I feel more pain when doing the following activities:

Check ✓ the activities that cause pain and then (Circle) minimal, mild, moderate or severe.

❑Sleeping	Minimal	Mild	Moderate	Severe
❑Sitting	Minimal	Mild	Moderate	Severe
❑Walking	Minimal	Mild	Moderate	Severe
❑Standing	Minimal	Mild	Moderate	Severe
❑Lifting	Minimal	Mild	Moderate	Severe
❑Household Chores	Minimal	Mild	Moderate	Severe
❑Routine Personal Care	Minimal	Mild	Moderate	Severe
❑Other _____	Minimal	Mild	Moderate	Severe
❑Other _____	Minimal	Mild	Moderate	Severe

Is your condition due to a work injury or automobile collision? **❑Yes** **❑No**
(If yes, then please alert the front desk assistant. You will have some additional paperwork to fill out.)

What happened to cause the condition(s)? If you are not sure, just write "unknown".

_____

_____

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Name_____ Date: ____/____/_____

How long has this been bothering you?

_____

Has this bothered you **before**? When?

_____

Please list **other health care providers** you have seen for the condition(s), and **treatment** received.

_____

_____

Have you found any activities that make your complaints feel better? (Examples are ice, heat, stretching, other treatment)

_____

_____

Describe briefly and give approximate dates for any **major injuries, illnesses, surgeries or accidents**:

_____

_____

_____

Does your immediate family have a history of any diseases? (Cancer, Heart Disease, Diabetes, Etc.)

Mother's side _____

Father's side _____

Are you presently on any medications? (please specify)

_____

_____

Do you smoke? ❑Yes ❑No Drink Alcohol? ❑Yes ❑No Number of drinks per week _____

Exercise Regularly? ❑Yes ❑No

Height_____ Weight_____

Have you been to a chiropractor before? ❑Yes ❑No

Chiropractor's name/ location: _____ Last seen: _____

Name of Primary Care Physician_____Date of last Physical_____

_____ _____

Patient Signature (Guardian if under 18) **Date**

Neck Index

Form N1-100

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

Form BI100

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

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Name_____ Date: ____/____/_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period:_____

Signature:_____ *Date:*_____

HEALTH INSURANCE INFORMATION

Patient's Name_____ ***DOB***_____

Insured's Name_____ ***Insured's DOB***_____

Insured's Address if different than yours_____

_____

ID#_____ **Group#**_____

Insurance Company_____

Please present insurance card to front desk so we can make a copy for your file.

***If not insured, list the Name & Address of person RESPONSIBLE FOR PAYMENT.**

_____

_____

_____

_____

VERY IMPORTANT------PLEASE READ AND SIGN BELOW

ASSIGNMENT OF INSURANCE BENEFITS

I understand that as a courtesy Rainier Valley Chiropractic, P.S. will attempt to verify my Chiropractic and/or Massage benefits but that I should confirm my benefits on my own as well. Benefit quotes are not a guarantee of payment. I understand that ultimately I am responsible for charges not covered by my insurance.

I hereby authorize payment directly to Rainier Valley Chiropractic, P.S. for the chiropractic services that I am provided.

Signature:_____ Date:_____

(Policy Holder/Child's Guardian)