Patient Information Sheet

Name_____ Date_____
Address_____ City_____ State____ Zip Code_____
Home Phone( )_____ Cell Phone ( )_____
Employer Name _____ Work Phone ( )_____
E-mail_____ Emergency Contact_____
Social Security Number_____-____-_____ Date of Birth_____ Age_____
Male / Female Marital Status _____ Spouse _____
Who referred you to this office?_____

Is this case related to current or previous employment? Y__ N__
Is the condition related to an auto accident? Y__ N__
Is the condition related to another type of accident? Y___N___
Is there another health benefit plan? Y___N___

Release of Information

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long term authorization card.
Signed_____Date_____

Assignment of Benefits

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I the undersigned patient irrevocably sign and transfer assignment of benefits to Chung & Waggoner Health Center, Inc. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe and agree to pay in a current manner.
Signed_____Date_____

CHUNG & WAGGONER HEALTH CENTER

7000 NORTHWEST EXPRESSWAY, STE. H
OKLAHOMA CITY, OK 73132

OFFICE: (405) 773-1113
FAX: (405) 773-1114

Notice of Privacy Practices

Privacy Officer: Dr. David B. Waggoner

Information may be released to the following individuals/organizations: (example: Family members) _____

_____

Information May **NOT** be released to the following individuals/organizations: _____

_____

You May _____ May **NOT** _____ leave appointment reminders on my message service.

I understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release further information shall remain in force until I revoke it in writing.

I acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Name: _____

Signature: _____ Date: _____

If not signed by the patient, please indicate the relationship: _____

Witness: _____

Confidential Patient Case History

Name:_____ Date:_____

CURRENT CONDITION

Please describe the **primary** problem / reason for this visit _____

How and when did symptoms first occur?_____

Is the condition progressively worsening? Yes____ No____ Symptoms: Are constant____ Come and go____

What aggravates your condition? _____

What helps / alleviates your condition?_____

Does this condition interfere with: Work___ Sleep___ Daily Routine___ How? _____

Have you had this or similar conditions in the past?_____

Have you had previous chiropractic care?_____ If yes, Name of doctor _____

Response to treatments _____ Date of last care: _____

List any other doctors seen for these problems_____

List previous diagnosis or treatments you have received for present condition: _____

List any **secondary / other** complaints: _____

Details about above complaints: _____

ADDITIONAL HISTORY

List surgical operations and years:_____

Have you ever been in an auto accident: Yes / No _____ Approximately how long ago? _____

Describe _____

List any fractures, trauma, concussion, or hospitalizations you have suffered: _____

Have you ever had mental or emotional disorders? Yes /No___ Describe_____

List medications (both over-the-counter & prescriptions). Please indicate name, dosage and duration of use):
Include NSAIDs, analgesics, muscle relaxants, antidepressant/anxiety, sedatives, hormones, birth control pills, anti-hypertensives, antibiotics/virals/fungals, allergy/sinus medications, ulcer medications...

List any medications you are allergic to_____

When was the last time you really felt good? _____

List any vitamins or herbs take _____

Name: _____

Family History

	RELATIONSHIP	DESCRIBE
Cancers		
Heart disease		
Diabetes		
Spinal disorders		
Other		

Please check the appropriate boxes for any symptoms which you currently have.

GENERAL
- ☐ Allergies
- ☐ Bruise Easily
- ☐ Chronic Cough
- ☐ Dizziness/Fainting
- ☐ Depression
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Itching / Rash
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Tremors

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Bursitis
- ☐ Poor Posture
- ☐ Spinal curvature

PAIN or NUMBNESS in:
- ☐ Low Back
- ☐ Hip or Knee
- ☐ Leg or Foot
- ☐ Neck
- ☐ Shoulder or Elbow
- ☐ Arm or Hand

GASTRO-INTESTINAL
- ☐ Abdominal pain
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids
- ☐ Intestinal Parasites
- ☐ Liver Trouble / Jaundice
- ☐ Nausea
- ☐ Vomiting

EYES/EARS/ NOSE
- ☐ Asthma
- ☐ Colds
- ☐ Ear aches
- ☐ Ear Noises
- ☐ Eye Pain
- ☐ Failing Vision
- ☐ Gum disease
- ☐ Nose Bleeds
- ☐ Thyroid Problems
- ☐ Sinus Infection
- ☐ Spit / Cough Blood
- ☐ Sore Throat

CARDIO-VASCULAR
- ☐ Chest Pain
- ☐ Difficult Breathing
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Poor Circulation
- ☐ Swelling of Ankles/Legs
- ☐ Varicose Veins

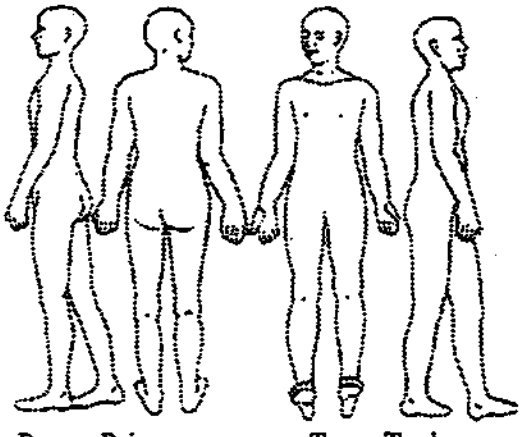
GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Uncontrolled Urination
- ☐ Kidney Infection / Stones
- ☐ Painful Urination
- ☐ Prostate Problems
- ☐ Hernia

FOR WOMEN ONLY
- ☐ Breast Pain / Tenderness
- ☐ Menstrual Cramps / Pain
- ☐ Excessive Menstruation
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Menopausal Symptoms
- ☐ Menstrual Low Back Pain
- ☐ Vaginal Discharge

ARE YOU PREGNANT?

☐ Yes ☐ No

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

CHECK THE FOLLOWING CONDITIONS YOU HAVE / HAD:

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Miscarriages
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home)

Name:_____ Phone:_____ Relationship:_____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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 _____