Complete Chiropractic Health

2710 Rochester Rd Cranberry Twp PA 16066
724-779-0001
reception@contactcch.com
www.completechiropractichealth.com

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____

Preferred Name _____ Date of Birth: _____ Social Security #: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Age Category (years of age)
○ 0-6 ○ 7-17 ○ 18+

Occupation and Employer _____

2. Who may we thank for referring you to our office?

_____

3. Emergency Contact Information

Name: _____ Relationship: _____ Phone Number: _____

CONSENT TO TREATMENT OF MINOR I hereby request and authorize to perform diagnostic tests and render chiropractic, physiotherapy and other modality treatment to patient on this form. This authorization also extends to all other doctors or licensed practitioners and office staff members. As of the date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____
Signature

4. Guardian Full Name

Guardian Full Name

Relationship to the minor

5. Is your current medical condition related to:

- ○ Personal injury
- ○ Car accident
- ○ Worker's compensation
- ○ Other

6. Work Injury

Date of work injury

Employer at the time of injury

Human resources contact information

Claim number

7. Auto Insurance / Personal Injury Details

Auto insurance company

Policy number

Claim #

Adjustor name

Phone number

Do you have an attorney?
○ Yes ○ No

Attorney contact information (if you answered yes)

Do you have med pay / PIP?
○ Yes ○ No ○ Unknown

Do you have uninsured motorist?
○ Yes ○ No ○ Unknown

Date of accident

Was a traffic violation issued?
○ Yes ○ No

How many passengers in your vehicle?

Were there witnesses?
○ Yes ○ No

Please explain in detail how the accident occurred

Please list symptoms felt immediately after the accident

Did the impact to your vehicle come from the:
○ Front ○ Rear ○ Right ○ Left ○ Other

Were you the
○ Driver ○ Front seat passenger
○ Back seat passenger

Were you wearing a seat belt?
○ Shoulder harness ○ Lap harness ○ N/A

Did the airbags inflate?
○ Yes ○ No

Did any body part strike anything in the vehicle?

Did the accident render you unconscious?
○ Yes ○ No ○ Unsure

Have you seen any other doctor(s) since the accident?
○ Yes ○ No
○ Home care (medications, ice, rest, etc)

When did you seek medical care about this injury?
○ Immediately ○ Next day ○ 2+ days

How did you get there?
○ Ambulance ○ Private transportation

Please describe any treatment you received

Please check any of the following
☐ CAT scan ☐ MRI ☐ Prescription medications for pain ☐ X-rays

Have you missed any work/school since the accident?
○ Yes ○ No

Are your work activities restricted as a result of your injury?
○ Yes ○ No

8. Do you have Medical Insurance?

○ Private ○ Medicare ○ Medicaid
○ None

9. Primary Insurance

Primary Insurance Company | Member ID / Policy # | Group Name

Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured State

10. Secondary Insurance

Secondary Insurance Company | Member ID / Policy # | Group Name

Group Number

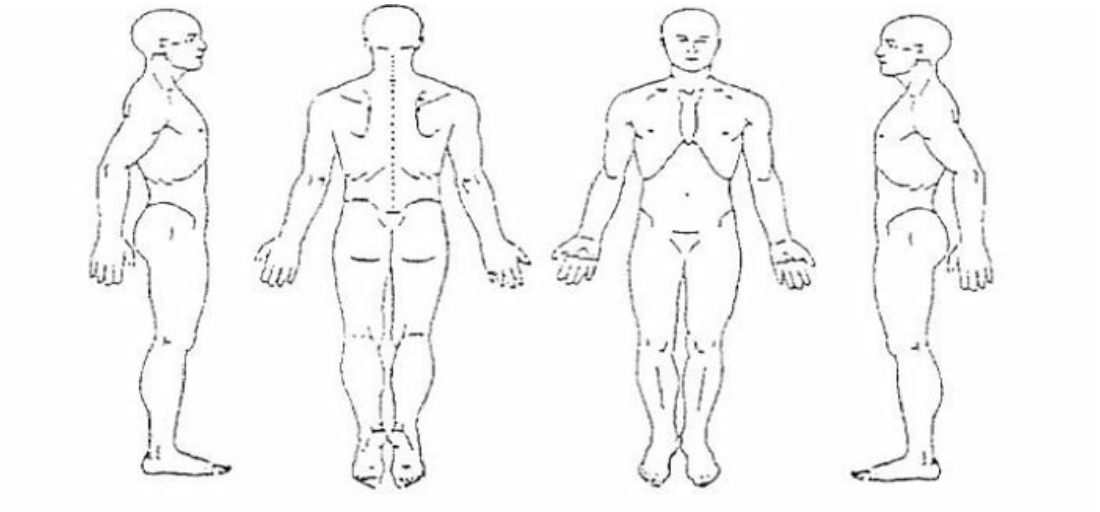
Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name	Insured Phone #	Insured Date of Birth	Insured State

11. If you are able, please upload a copy of the front and back of your insurance card & driver's license. If not, we can obtain a copy when you arrive for your appointment.

12. What brings you in today? Describe your symptoms in order of severity, with the worse symptom being #1:

13. Please draw where you feel pain on the image below:



14. Complaint # 1

Complaint # 1

Pain scale 0-10 (10 is the worst)

How often do you experience your symptoms

Is the problem worse:
○ Morning ○ Evening ○ with Activity ○ at Rest

Does it radiate to down the arm or leg? If so, where does it travel to?

Any inciting injury or trauma?

Date of trauma:

Anything make it worse?

What treatments have you already received for this condition?

☐ Acupuncture ☐ Chiropractic ☐ Physical Therapy
☐ Medications ☐ Pain Management (Injections)
☐ Surgery ☐ Other

What has been the most effective treatment or at home remedy for this condition so far?

Have you received any special imaging for this? If so what was it and approximately when was it performed?

Do you have another complaint?
○ Yes ○ No

15. Complaint # 2

Complaint # 2

Pain scale 0-10 (10 is the worst)

How often do you experience your symptoms

Is the problem worse:
○ Morning ○ Evening ○ with Activity ○ at Rest

Does it radiate to down the arm or leg? If so, where does it travel to?

Any inciting injury or trauma?

Date of trauma:

Anything make it worse?

What treatments have you already received for this condition?

☐ Acupuncture ☐ Chiropractic ☐ Physical Therapy
☐ Medications ☐ Pain Management (Injections)
☐ Surgery ☐ Other

What has been the most effective treatment or at home remedy for this condition so far?

Have you received any special imaging for this? If so what was it and approximately when was it performed?

Do you have another complaint?
○ Yes ○ No

16. Complaint # 3

Complaint # 3

Pain scale 0-10 (10 is the worst)

How often do you experience your symptoms

Is the problem worse:
○ Morning ○ Evening ○ with Activity ○ at Rest

Does it radiate to down the arm or leg? If so, where does it travel to?

Any inciting injury or trauma?

Date of trauma:

Anything make it worse?

What treatments have you already received for this condition?
☐ Acupuncture ☐ Chiropractic ☐ Physical Therapy
☐ Medications ☐ Pain Management (Injections)
☐ Surgery ☐ Other

What has been the most effective treatment or at home remedy for this condition so far?

Have you received any special imaging for this? If so what was it and approximately when was it performed?

Do you have another complaint?
○ Yes ○ No

17. Complaint # 4

Complaint # 4

Pain scale 0-10 (10 is the worst)

How often do you experience your symptoms

Is the problem worse:
○ Morning ○ Evening ○ with Activity ○ at Rest

Does it radiate to down the arm or leg? If so, where does it travel to?

Any inciting injury or trauma?

Date of trauma:

Anything make it worse?

What treatments have you already received for this condition?
☐ Acupuncture ☐ Chiropractic ☐ Physical Therapy
☐ Medications ☐ Pain Management (Injections)
☐ Surgery ☐ Other

What has been the most effective treatment or at home remedy for this condition so far?

Have you received any special imaging for this? If so what was it and approximately when was it performed?

Child Only Questions

18. For children under 6

If your child is eating solid foods, please share what they eat for breakfast, lunch, snacks and dinner

How many OZs of fluid does your child drink per day?

Do you have concerns about your child's diet?
○ Yes ○ No

19. Rating scale

	Never	Sometimes	Often
Allergies			
Antibiotics			
Asthma			
Bed Wetting			
Broken Bones			
Colic			
Earaches			
Ear Infection			
Headaches			
Pain in Arms			
Pain in Back			
Pain in Legs			
Pain in Neck			
Urinary Tract Infections			

20. Has your child had any:

☐ Recent falls or trauma ☐ Fallen down stairs or heights ☐ Car accidents
☐ Broken bones ☐ Joint dislocation ☐ Hit their head
☐ Bike, scooter, rollerblade, falls

21. Age based questions

○ 0-2 months ○ 2 months - 2 years ○ 2 years - 6 years

22. 0 months - 2 months

Was pitocin used during the delivery?
○ Yes ○ No

How many weeks into your pregnancy was your baby born?

_____

Does your baby go to sleep easily?
○ Yes ○ No

how many hours does your baby sleep between feeds?

_____

Does your baby have a preferred sleeping position?
○ Right side ○ Left side ○ Back ○ Stomach ○ No preference

Does your baby cry if you change their sleeping position?
○ Yes ○ No

Does your baby have any feeding difficulties?
○ Yes ○ No

Does your baby spit up often?
○ Yes ○ No

Does your baby cry often?
○ Yes ○ No

Check off all that apply
☐ Holds head to one side all the time ☐ Arches their head and neck backwards often
☐ Becomes irritable during diaper changes ☐ Had a fever ☐ Have a lot of gas

How often does your baby have a bowel movement

_____

Can your baby hold their head up?
○ Yes ○ No

Is your child vaccinated?
○ Yes, fully ○ Yes, partially ○ No

23. 2 months - 2 years

Is your child breast feeding?
○ Yes - No side preferred
○ Yes - Right side preferred
○ Yes - Left side preferred ○ No

Does your child feed on schedule/demand?
○ Demand ○ Schedule

How much cow's milk does mom consume?

_____

Does your child have any eating difficulties?
○ Yes ○ No

Does your child have any intermittent skin rashes?
○ Yes ○ No

Is your child vaccinated?
○ Yes, fully ○ Yes, partially ○ No

24. 2 years - 6 years

What grade is your child in?

_____

Does your child use a backpack?

_____

How many hours do they spend on electronic devices per day?

_____

How many hours do they watch TV?

_____

What sports or hobbies does your child play/have?

How many hours of sleep does your child have per night?

Is your child stressed out?
○ Never ○ Sometimes ○ Frequently ○ Always

Is your child around smokers often?
○ Yes ○ No

Do they have difficulty reading the board in class?
○ Yes ○ No

Do they get headaches sometimes when they read?
○ Yes ○ No

The Neck Disability Index

25. Please enter the patient's information.

Patient First Name: Patient Last Name: Date:

26. This questionnaire is designed to help us better understand how your neck pain affects your ability to life activities. Please mark the one that most closely describes your present day situation in each section.

	0	1	2	3	4	4
1. Pain Intensity	I have no pain at the moment	The pain is very mild at the moment	The pain is moderate at the moment	The pain is fairly severe at the moment	The pain is very severe at the moment	The pain is the worst imaginable at the moment
2. Personal Care (Washing, Dressing, etc.)	I can look after myself normally without causing extra pain	I can look after myself normally but it causes extra pain	It is painful to look after myself and I am slow and careful	I need some help but can manage most of my personal care	I need help every day in most aspects of self care	I do not get dressed, I wash with difficulty and stay in bed
3. Lifting	I can lift heavy weights without extra pain	I can lift heavy weights but it gives extra pain	Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned	I can only lift very light weights	I cannot lift or carry anything
4. Reading	I can read as much as I want to	I can read as much as I want to	I can read as much as I want with moderate	I cannot read as much as I want because of	I cannot read as much as I want because	I cannot read at all

	with no pain in my neck	with slight pain in my neck	pain in my neck	moderate pain in my neck.	of severe pain in my neck.	
5. Headaches	I have no headaches at all	I have slight headaches, which come infrequently	I have moderate headaches, which come infrequently	I have moderate headaches, which come frequently	I have severe headaches, which come frequently	I have headaches almost all the time
6. Concentration	I can concentrate fully when I want to with no difficulty	I can concentrate fully when I want to with slight difficulty	I have a fair degree of difficulty in concentrating when I want to	I have a lot of difficulty in concentrating when I want to	I have a great deal of difficulty in concentrating when I want to	I cannot concentrate at all
7. Work	I can do as much work as I want to	I can only do my usual work, but no more	I can do most of my usual work, but no more	I cannot do my usual work	I can hardly do any work at all	I can't do any work at all
8. Driving	I can drive my car without any neck pain	I can drive my car as long as I want with slight pain in my neck	I can drive my car as long as I want with moderate pain in my neck	I can't drive my car as long as I want because of moderate pain in my neck	I can hardly drive at all because of severe pain in my neck	I can't drive my car at all
9. Sleeping	I have no trouble sleeping	My sleep is slightly disturbed (less than 1 hr sleepless)	My sleep is mildly disturbed (1-2 hrs sleepless)	My sleep is moderately disturbed (2-3 hrs sleepless)	My sleep is greatly disturbed (3-5 hrs sleepless)	My sleep is completely disturbed (5-7 hrs sleepless)
10. Recreation	I am able to engage in all my recreation activities with no neck pain at all	I am able to engage in all my recreation activities, with some pain in my neck	I am able to engage in most, but not all of my usual recreation activities because of pain in my neck	I am able to engage in a few of my usual recreation activities because of pain in my neck	I am able to engage in a few of my usual recreation activities because of pain in my neck	I can't do any recreation activities at all

Scoring and References (Office Use Only):

Scoring:

Each of the 10 items scores from 0 to 5. The maximum score is 50. The obtained score can be multiplied by two to produce a percentage score.

Occasionally, a respondent will not complete one question or another. The average of all other items is then added to the completed items.

The original report provided scoring intervals for interpretation, as follows:

- 0 to 4 = no disability
- 5 to 14 = mild
- 15 to 24 = moderate
- 25 to 34 = severe
- Above 34 = complete

Please note: The means 15 – 24 out of 50 (the RAW SCORE) equates with moderate disability.

Developer:

NDI developed by: Vernon, H. & Mior, S. (1991). The Neck Disability Index: https://www.sralab.org/rehabilitation-measures/neck-disability-index. Journal of Manipulative and Physiological Therapeutics. 14, 409-415 Available from:https://www.sralab.org/rehabilitation-measures/neck-disability-index

Oswestry Disability Index (Back and Low Back)

27. Please enter the patient's information:

Patient First Name: _____ Patient Last Name: _____ Patient DOB: _____

28. Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

	0	1	2	3	4	5
1. PAIN INTENSITY	The pain comes and goes very mildly	The pain is mild and does not vary much	The pain comes and goes and is moderate	The pain is moderate and does not vary much	The pain comes and goes and is severe	The pain is severe and does not vary much
2. PERSONAL CARE (washing, dressing, etc.)	I would not have to change my way of washing or	I do not normally change my way of washing or dressing	Washing and dressing increase the pain but I manage not to change my way	Washing and dressing increase the pain and I find it necessary to change my way	Because of the pain I am unable to do some washing and dressing without help.	Because of the pain I am unable to do any washing and dressing

	dressing in order to avoid pain.	even though it causes some pain.	of doing it.	of doing it.		without help.
3. LIFTING	I can lift heavy weights without pain.	I can lift heavy weights but it gives extra pain.	Pain prevents me lifting heavy weights off the floor.	Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.	Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.	I can only lift very light weights at most.
4. WALKING	I have no pain with walking.	I have some pain with walking but it does not increase with distance.	I cannot walk more than 1 mile without increasing pain.	I cannot walk more than ½ mile without increasing pain.	I cannot walk more than ¼ mile without increasing pain.	I cannot walk at all without increasing pain.
5. SITTING	I can sit in any chair as long as I like.	I can sit only in my favorite chair as long as I like.	Pain prevents me from sitting more than 1 hour.	Pain prevents me from sitting more than ½ hour.	Pain prevents me from sitting more than 10 minutes.	I avoid sitting because it increases pain immediately.
6. STANDING	I can stand as long as I want without pain.	I have some pain with standing, but it does not increase with time.	I cannot stand for longer than 1 hour without increasing pain.	I cannot stand for longer than ½ hour without increasing pain.	I cannot stand for longer than 10 minutes without increasing pain.	I avoid standing because it increases pain immediately.
7. SLEEPING	I get no pain in bed.	I get pain in bed but it does not prevent me from sleeping well.	Because of pain my normal nights sleep is reduced by less than one quarter.	Because of pain my normal nights sleep is reduced by less than half.	Because of pain my normal nights sleep is reduced by less than three quarters.	Pain prevents me from sleeping at all.
8. SOCIAL LIFE	My social life is normal	My social life is normal but	Pain has no significant effect on my	Pain has restricted my social life and I	Pain has restricted my social life to	I have hardly any social life because

	and gives me no pain.	it increases the degree of pain.	social life apart from limiting my more energetic interests, e.g., dancing, etc.	do not go out very often.	home.	of the pain.
9. TRAVELLING	I get no pain when traveling.	I get some pain when traveling but none of my usual forms of travel make it any worse.	I get extra pain while traveling but it does not compel me to seek alternate forms of travel.	I get extra pain while traveling which compels me to seek alternative forms of travel.	Pain restricts me to short necessary journeys under ½ hour.	Pain restricts all forms of travel.
10. CHANGING DEGREE OF PAIN	My pain is rapidly getting better.	My pain fluctuates but is definitely getting better.	My pain seems to be getting better, but improvement is slow.	My pain is neither getting better nor worse.	My pain is gradually worsening.	My pain is rapidly worsening.

Scoring and References (Office Use Only):

Scoring:

0 - 4	No disability
5 - 14	Mild disability
15 - 24	Moderate disability
25 - 34	Severe Disability
35 - 50	Completely Disabled

No disability: The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting, sitting and exercise.

Mild disability: The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means.

Moderate disability: Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation.

Severe disability: Back pain impinges on all aspects of the patient's life. Positive intervention is required.

Completely disabled: These patients are either bed-bound or are exaggerating their symptoms.

References:

• Fairbank JC, Pynsent PB. "The Oswestry Disability Index." Spine 2000: 25(22):2940-2952
• Fairbank JCT, Couper J, Davies JB. "The Oswestry Low Back Pain Questionnaire." Physiotherapy 1980; 66:271-273

Quality of Life Questions

29. How have others been affected by your health condition?

- ☐ No one is affected
- ☐ Haven't noticed any problem
- ☐ They tell me to do something
- ☐ People avoid me

with whom and how does this affect your relationship?

_____

30. What are you afraid this might be (or beginning) to affect (or will affect)?

- ☐ Job
- ☐ Kids
- ☐ Future ability
- ☐ Marriage
- ☐ Self-esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

31. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples.

32. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples

33. What are you most concerned with regarding your problem?

34. Where do you picture yourself being in the next 1 - 3 years if this problem is not taken care of? Please be specific

35. What would be different/better without this problem? Please be specific

36. What would it mean for you to eliminate this issue?

37. What are your short term health goals?

38. What are your long term health goals?

MEDICAL HISTORY

39. Medications/Vitamins

Medication/Vitamins	Medication	Comments (length of time, temporary, dosage, etc)

40. Allergies

_____

41. Have you had any Past surgeries?

○ Yes ○ No

42. If yes, please list past surgeries, year of surgery, and any important notes related to the surgery:

	Type of Surgery	Year	Notes/Comments
1			
2			
3			

43. Medical History (Check all that apply)

- ☐ Heart Disease
- ☐ Stroke/TIA
- ☐ Pacemaker
- ☐ High Blood pressure
- ☐ Glaucoma
- ☐ Hearing Impairment
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Lung Disease
- ☐ Sleep Apnea
- ☐ Skin disorder
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Vertigo
- ☐ Thyroid disease
- ☐ Multiple Sclerosis
- ☐ Other Eye problems
- ☐ Osteoporosis
- ☐ Depression/Anxiety
- ☐ Seizures/Epilepsy
- ☐ Liver disease
- ☐ Dementia
- ☐ Low Blood Pressure
- ☐ Multiple sclerosis
- ☐ Bleeding disorder
- ☐ Colitis/Chron's disease
- ☐ Diabetes Type I or II
- ☐ Lupus erythema
- ☐ Cataracts
- ☐ Cancer
- ☐ Alcohol/Substance Abuse
- ☐ Muscle disorders
- ☐ Fibromyalgia
- ☐ Kidney Disease/Failure
- ☐ STDs
- ☐ Other:

If other, please specify:

_____

44. Neuropathy

Check all that apply for neuropathy
☐ Balance issues/falls ☐ Cancer ☐ Pacemaker/defibrillator ☐ Foot pain ☐ Foot numbness ☐ Leg pain
☐ Leg numbness ☐ Hand pain ☐ Hand numbness ☐ Lower back pain ☐ Spinal stenosis

Have you received any diagnostic tests for neuropathy?
☐ Autoimmunity testing ☐ B-vitamin deficiency test ☐ EMG ☐ IGG/IGE food sensitivity blood test
☐ Nerve conduction velocity ☐ Nerve skin biopsy ☐ MRI

Mark all that apply
☐ I drink alcohol ☐ I take cholesterol medications ☐ I take chemotherapy drugs
☐ I have taken chemotherapy drugs ☐ I smoke

What is the cause of your neuropathy?

List anything that makes your neuropathy worse?

List anything that makes your neuropathy better

45. Metabolic Health Evaluation

Sub-clinical symptoms
○ Headaches ○ Migraines

Hormone imbalance including
○ Emotional imbalance ○ PMS

Gastrointestinal issues including:
○ Abdominal bloating, cramps or painful gas
○ Crohn's disease and other intestinal disorders
○ Irritable bowel syndrome ○ Ulcerative colitis

Respiratory conditions including:
○ Allergies ○ Asthma ○ Chronic sinusitis

Joint conditions including
○ Hands/wrists ○ Elbow ○ Shoulder ○ Neck
○ Mid back ○ Low back ○ Hips ○ Knees
○ Foot/Ankles

Autoimmune conditions including
○ Chronic fatigue ○ Diabetes mellitus
○ Fibromyalgia ○ Lupus ○ Rheumatoid arthritis

Developmental and social concerns including:
○ ADD/ADHD ○ Autism

Skin conditions including:
○ Eczema ○ Hives ○ Skin rashes

46. Metabolic Select the number that most closely fits, then add up your results

	None	Mild	Moderate	Severe
Abdominal pain or bloating				
Constipation and/or diarrhea				
Mucous or blood in stool				
Food allergies, sensitivities or intolerance				
Chronic or frequent fatigue or tiredness				
Sinus or nasal congestion				
Asthma, hay fever or airborne allergies				
Joint pain or swelling, arthritis				
use of NSAIDS (Aspirin, Aleve, Tylenol, Motrin, e				
Alcohol consumption makes you feel sick				
Nausea				
Gluten sensitivity or Celiac's disease				
History of antibiotic use				
Confusion, poor memory or mood swings				
Weight issues				
Eczema, skin rashes or hives (urticaria)				
Chronic or frequent inflammation				