

# Chiropractic Case History/Patient Information

Date: \_\_\_\_\_ Patient # \_\_\_\_\_ Doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Age: \_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Cell Phone Carrier: \_\_\_\_\_ Would you like to receive text messages for appointment reminders: Y N

Race: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: M S W D Primary Language: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How many children? \_\_\_\_\_ Names and Ages of Children: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case:

- Major Medical    Worker's Compensation    Medicaid    Medicare    Auto Accident  
 Medical Savings Account & Flex Plans    Other

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. **The following person(s) have my permission to receive my personal health information:****

\_\_\_\_\_  
 Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

**HISTORY OF PRESENT AND PAST ILLNESS:**

Chief Complaint: Purpose of this appointment: \_\_\_\_\_

Severity (scale of 0 – 10 , 10 being the worst) \_\_\_\_\_ Frequency ( 0 – 100% during the week) \_\_\_\_\_

Are the symptoms WORSE in the: (circle what applies)

Morning Afternoon Night Increase during the day Same all day Decrease during the day

The symptoms are :( circle what applies) Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

Date symptoms appeared or accident happened: \_\_\_\_\_

Do your symptoms radiate to any other part of your body? \_\_\_\_\_

Has your condition \_\_\_\_ Improved \_\_\_\_ Gotten Worse \_\_\_\_ Stayed the same since it began

Circle the things that make your problem worse:

Bending – Lying – Walking – Standing – Sitting – Movement – Twisting – Lifting – Sleeping

Is there anything you can do to relieve the problems? \_\_\_No \_\_\_Yes Describe: \_\_\_\_\_

If No, what have you tried? \_\_\_\_\_

Have you been treated for this before? \_\_\_\_ No \_\_\_\_ Yes

If Yes, How long ago? \_\_\_\_\_ Results of previous treatment? \_\_\_\_Good \_\_\_\_ Poor

What treatment did you receive? \_\_\_\_\_ Comments: \_\_\_\_\_

Is this due to: Auto\_\_\_\_ Work\_\_\_\_ Other\_\_\_\_\_

Have you ever had the same or a similar condition?  Yes  No If yes, when and describe:\_\_\_\_\_

Is this condition interfering with \_\_\_\_\_ Work \_\_\_\_\_ Sleep \_\_\_\_\_ Daily Routine \_\_\_\_\_ Recreation

Date of last physical examination:\_\_\_\_\_

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_

List any Musculoskeletal or Neurological Problems: \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year?  Yes  No

If yes, describe:\_\_\_\_\_

What medications or drugs are you taking?\_\_\_\_\_

Do you have any allergies to any medications?  Yes  No

If yes, describe: \_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_

**FAMILY HISTORY**

Please list any family medical history from spouse, father, mother, sibling(s), and children. (I.E Arthritis, Back trouble, Diabetes, Cancer, Headaches, High Blood Pressure, Migraine, Pinched Nerve, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

**SOCIAL HISTORY**

Please indicate beside each activity whether you engage in it:  
OFTEN= "O"    SOMETIMES= "S"    NEVER= "N"

- |                         |                              |
|-------------------------|------------------------------|
| _____ Vigorous Exercise | _____ Family Pressures       |
| _____ Moderate Exercise | _____ Financial Pressures    |
| _____ Alcohol Use       | _____ Other Mental Stresses  |
| _____ Drug Use          | _____ High Stress Activity   |
| _____ Caffeine          | _____ Others(Please Specify) |
| _____ Tobacco Use       | _____                        |
|                         | _____                        |

If yes how much per day? \_\_\_\_\_

**PERSONAL HISTORY**

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now

P = Previously

- |                                  |                                 |
|----------------------------------|---------------------------------|
| Headaches_____ Frequency _____   | Loss of Balance _____           |
| Neck Pain _____                  | Fainting _____                  |
| Stiff Neck _____                 | Loss of Smell / Taste _____     |
| Sleeping Problems _____          | Ulcers _____                    |
| Back Pain _____                  | Unusual Bowel Patterns _____    |
| Nervousness _____                | Cold Hands / Feet _____         |
| Tension _____                    | Gall Bladder Problems _____     |
| Irritability _____               | Arthritis _____                 |
| Chest Pains/Tightness _____      | Muscle Spasms _____             |
| Dizziness _____                  | Frequent Colds _____            |
| Allergies _____                  | Congenital Condition _____      |
| Shoulder/Neck/Arm Pain _____     | Fever _____                     |
| Numbness in Fingers / Toes _____ | Sinus Problems _____            |
| Diabetes _____                   | HIV Positive _____              |
| High Blood Pressure _____        | Indigestion Problems _____      |
| Difficulty Urinating _____       | Joint Pain/Swelling _____       |
| Weakness in Extremities _____    | Menstrual Difficulties _____    |
| Breathing Problems _____         | Weight Loss/Gain _____          |
| Fatigue _____                    | Depression _____                |
| Lights Bothering Eyes _____      | Loss of Memory _____            |
| Ears Ring _____                  | Buzzing in Ears _____           |
| Broken Bones/Fractures _____     | Circulation Problems _____      |
| Rheumatoid Arthritis _____       | Seizures/Epilepsy _____         |
| Excessive Bleeding _____         | Low Blood Pressure _____        |
| Osteoarthritis _____             | Osteoporosis _____              |
| Pacemaker _____                  | Heart Disease _____             |
| Stroke _____                     | Cancer _____                    |
| Ruptures _____                   | Coughing Blood _____            |
| Eating Disorder _____            | Alcoholism/Drug Addiction _____ |

**Sertell Chiropractic Clinic, L.L.C.**

848 Scioto St, Urbana, Ohio 43078  
(937)484-3400 office, (937)484-3402 fax

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Terms of Acceptance**

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

**Informed Consent:**

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis.

The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated.

Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician.

The chiropractic doctor provides a specialized, non-duplicating health care service.

Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Sertell Chiropractic Clinic, L.L.C.,

I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Women Only:**

To the best of my knowledge I **am / am NOT** pregnant and  
**(give my permission / don't give permission)**  
to x-ray me for diagnostic interpretation.

**Consent to Evaluate and Treat a Minor:**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Communications:**

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Others: \_\_\_\_\_

No one: \_\_\_\_\_

May we leave messages regarding your personal healthcare information on any answering device?  
I.e. home answering machines or voicemails? Yes [ ] No [ ]

May we contact you at work? Yes [ ] No [ ]

May we leave a message at work? Yes [ ] No [ ]

**Patient Acknowledgement and  
Receipt of Notice of Privacy Practices  
Pursuant to HIPAA and  
Consent for Use of Health Information**

Patients Name \_\_\_\_\_

Date \_\_\_\_\_

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By \_\_\_\_\_

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By \_\_\_\_\_

Signature of Parent/Guardian (circle one)

# 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