

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____
Address: _____ Home Phone: _____
City: _____ Zip: _____ Cell Phone: _____
SS#: _____ Email: _____
Date of Birth: _____ Marital Status: M S W D
Occupation: _____ Employer: _____
Relationship to Insured: _____ Employer Phone _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___ No

Ins. Company: _____ Ins. Phone #: _____
ID#: _____ Group #: _____
Name of Policy Holder: _____ Policy Holder DOB: _____
Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N

Have you ever had any Hip or Knee Replacements Y / N

What medications or drugs are you taking? (check those that apply): Pain Killers ___ Insulin ___ Cholesterol Meds ___
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Dr. James J. Krumpak** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date

CASE HISTORY

Name: _____

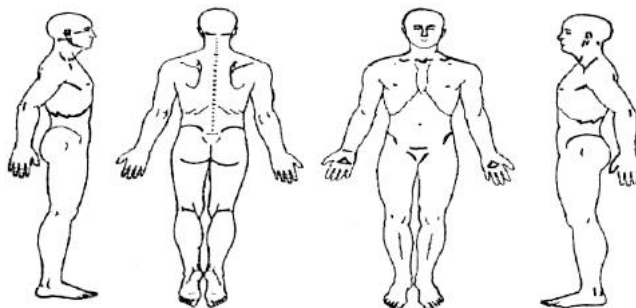
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					Occasional					Constant						
a. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
d. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
e. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain.)

2. Symptoms are worse in the (circle what applies)

- morning -Increase during the day
- afternoon -same all day
- night -decrease during the day



3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? _____

6. How did your symptoms begin? _____

7. Have you experienced these before? _____

8. Do your symptoms radiate? _____

9. Has your condition? ___ Improved ___ Gotten Worse ___ Stayed the same since it began

10. Circle the things that make your problems worse:

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

11. Is there anything you can do to relieve the problems? ___ No ___ Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ___ No ___ Yes How long ago? _____

13. What treatment did you receive? _____

14. Results of previous treatment? ___ Good ___ Poor Comments _____

15. Were you referred to our office by anyone? _____

16. Is this condition interfering with ___ Work ___ Sleep ___ Daily Routine ___ Recreation

17. List any other major injuries you have had, other than those mentioned above: _____

18. Any other Musculoskeletal problems? ___ No ___ Yes ...Neurological problems? ___ No ___ Yes

_____ Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____

Date: _____

James J. Krumpak, DC., DABCO
1714 Boardman-Poland Rd. Ste. 1 Poland, OH 44514
Ph. (330) 757-1151~ Fax (330) 757-6687

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 Western Reserve Chiropractic, 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.

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.
(Circle one above) (Circle one above)

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

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Neck Index

ACN Group, Inc. - Form NI-100

ACN Group, Inc. Use Only rev 11/13/02

Patient Name _____

Date _____

Pain Intensity

- ⑤ I have no pain at the moment.
- ④ The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ② The pain is fairly severe at the moment.
- ① The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

Sleeping

- ⑤ I have no trouble sleeping.
- ④ My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ② My sleep is moderately disturbed (2-3 hours sleepless).
- ① My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⑤ I can read as much as I want with no neck pain.
- ④ I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ② I cannot read as much as I want because of moderate neck pain.
- ① I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

Concentration

- ⑤ I can concentrate fully when I want with no difficulty.
- ④ I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ② I have a lot of difficulty concentrating when I want.
- ① I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

Work

- ⑤ I can do as much work as I want.
- ④ I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ② I cannot do my usual work.
- ① I can hardly do any work at all.
- ⑥ I cannot do any work at all.

Personal Care

- ⑤ I can look after myself normally without causing extra pain.
- ④ I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ② I need some help but I manage most of my personal care.
- ① I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⑤ I can lift heavy weights without extra pain.
- ④ I can lift heavy weights but it causes extra pain.
- 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).
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ① I can only lift very light weights.
- ⑥ I cannot lift or carry anything at all.

Driving

- ⑤ I can drive my car without any neck pain.
- ④ I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ② I cannot drive my car as long as I want because of moderate neck pain.
- ① I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

Recreation

- ⑤ I am able to engage in all my recreation activities without neck pain.
- ④ I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ② I am only able to engage in a few of my usual recreation activities because of neck pain.
- ① I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

Headaches

- ⑤ I have no headaches at all.
- ④ I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ② I have moderate headaches which come frequently.
- ① I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Neck
Index
Score

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Back Index

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____

Date _____

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ 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 very severe.
- Ⓔ The pain is very severe and does not vary much.

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 sleep is reduced by less than 25%.
- Ⓝ Because of pain my normal sleep is reduced by less than 50%.
- Ⓓ Because of pain my normal sleep is reduced by less than 75%.
- Ⓔ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit 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 1/2 hour.
- Ⓓ Pain prevents me from sitting more than 10 minutes.
- Ⓔ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while 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 1/2 hour without increasing pain.
- Ⓓ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓔ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓝ I cannot walk more than 1/2 mile without increasing pain.
- Ⓓ I cannot walk more than 1/4 mile without increasing pain.
- Ⓔ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓝ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓓ 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 without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓝ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓓ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓔ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while travelling.
- Ⓛ I get some pain while travelling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓝ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓓ Pain restricts all forms of travel except that done while lying down.
- Ⓔ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓝ Pain has restricted my social life and I do not go out very often.
- Ⓓ Pain has restricted my social life to my home.
- Ⓔ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓝ My pain is neither getting better or worse.
- Ⓓ My pain is gradually worsening.
- Ⓔ My pain is rapidly worsening.

Back
Index
Score

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QUADRUPLE VISUAL ANALOGUE SCALE



1. What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____ %

NAME: _____ DATE: ____/____/____