Prior Lake Chiropractic center

Patient Information & History

Date:______________

1 PATIENT INFORMATION

Name: ____
(First) (Initial) (Last) (Name called by)

Address: ____

City:________________State:____Zip:____________

Birthday:______________Age:_____ ☐ Male ☐ Female

Occupation: ________________________________

Employer: __________________________________

Parents Name(if a minor):__________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Spouse's Name: ______________________________

# of Children: __Name(s)________________________

2 INSURANCE

Who is responsible for this account?___________

Relationship to patient______________________

Insurance company____________________________

Insurance ID number__________________________

Group / Claim number_________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance company____________________________

Subscriber # and name________________________

Birthdate____________Group #_______________

Please present insurance card(s) so we can put a copy in your file.

3 ACCIDENT INFORMATION

Is your condition due to an accident? ☐ No ☐ Yes Date: _____

Type of accident? ☐ Automobile ☐ Work ☐ Home ☐ Other

To whom have you reported the accident?

Insurance ☐ Worker's Comp ☐ Employer ☐ Other______

Attorney Name (If applicable)___________________

4 CONTACT INFORMATION

Home phone___________________________________

Cell phone___________________________________

Work Phone______________________Ext_______

Email____

Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email

IN CASE OF EMERGENCY, CONTACT

Name_________________Relationship_______

Home Phone______________Cell____________

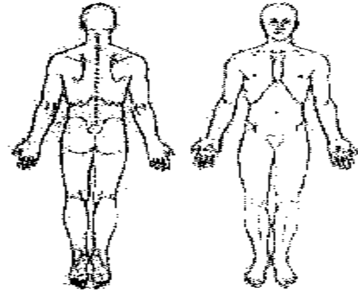
5 PATIENT CONDITION

Patient Completes This Section

(Please fill in selections completely)

Symptoms began on: [ ] [ ] [ ]

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms: ________________________________

____

2. How did your symptoms start? ________________________________

____

3. Average pain Intensity:

Last 24 hours: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

Past week: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X ________________________________ **Date:** ______________

6 HEALTH HISTORY

What other treatments have you had for this condition?

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery

Name of other doctors who have treated you for this condition ____________

Describe the other doctor's treatment for your condition ____________

Previous Chiropractic care? ☐ No ☐ Yes Date ________ ☐ Local ☐ Out of state ________

Date of Last: Physical Exam ________ Spinal x-ray ________ MRI ________

Spinal Exam ________ Dental x-ray ________ CT- Scan ________

List any Medications you are taking ____________

Vitamins / Herbs / Minerals ____________

Females: Are you Pregnant ☐ Yes ☐ No Beginning of last menstrual cycle ________

Check any of the following conditions you have had:

☐ AIDS/HIV
☐ Allergies
☐ Anxiety/Depression
☐ Arm/shoulder pain
☐ Arthritis
☐ Asthma
☐ Bladder problems
☐ Cancer
☐ Chronic fatigue
☐ Deafness
☐ Diabetes
☐ Digestion problems
☐ Earache
☐ Ear ringing
☐ Epilepsy
☐ Headaches
☐ Headaches - Migraine
☐ Heart Disease
☐ Hemorrhoids
☐ Herniated disk
☐ High blood pressure
☐ Insomnia
☐ Irregular cycle
☐ Kidney problems
☐ Leg pain
☐ Low back pain
☐ Neck pain
☐ Osteoporosis
☐ Poor circulation
☐ Prostate problems
☐ Rheumatoid Arthritis
☐ Sciatica
☐ Shingles
☐ Sinus infection
☐ Stroke
☐ Thyroid problems
☐ TMJ
☐ Venereal disease
☐ Vertigo/Dizziness

STRESSORS

☐ Smoking — Packs/Day ________
☐ Alcohol — Drinks/Week ________
☐ Coffee/ Caffeine Drinks — Cups/Day ________
☐ High Stress Level — Reason ________

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Have you had any:	**Description**	**Date**
Automobile accidents		
Surgeries		
Broken bones		
Falls/Head injuries		

7 AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize PLCC.Ltd / Prior Lake Chiropractic Center to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

________ Signature ________ Date ________ Parent (if patient is a minor)

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-names procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____

Printed Name

______________________________ ____________________

Signature Date

WITNESS: **PLCC, Ltd, DBA Prior Lake Chiropractic Center**

____

Printed Name

______________________________ ____________________

Signature Date

PLCC, Ltd, DBA Prior Lake Chiropractic Center

Privacy Practices Acknowledgement: HIPPA

As of April 2003, all health care providers are required by law to provide you the patient with a Notice of Privacy Practices. The privacy of your protected health information (PHI) is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. You are being provided a Notice of Privacy Practices which explains how we may use and share PHI about you. If, at any time, you have questions or concerns related to your protected health information, please feel free to speak with any one of our staff.

Signature on file form

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all insurance companies related to my care at Prior Lake Chiropractic Center.
- I authorize release of all medical / health information from any other provider I have used previously to Prior Lake Chiropractic Center and any agent working on their behalf.
- I authorize Prior Lake Chiropractic Center Chiropractic and any agent working on their behalf to obtain payment from my insurance company and / or attorney.
- I authorize payment to be made directly to Prior Lake Chiropractic Center.
- I permit a copy of this authorization to be used in place of the original.
- I permit Prior Lake Chiropractic Center and any agent working on their behalf to contact me by means of the home, work and / or cell phone number(s) I have provided on the patient information form.
- I permit Prior Lake Chiropractic Center and any agent working on their behalf to contact me via written communication to my home address given on the patient information form.

I have received the Notice of Privacy Practices and have reviewed it and I have reviewed the signature on file form.

Signature: ______________________________ Date: ________________

Name printed: ____

NAME:______________________________ DATE: ______________________________

Oswestry Neck Pain Questionnaire

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please circle the one choice which closely describes your problem *right now*.**

Section 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate
D. The pain moderate and does not vary much.
E. The pain is severe, but comes and goes.
F. The pain is severe and does not vary much.

Section 2 – Personal Care

A. I can look after myself without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get undressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor, But I can manage if they are conveniently positioned (e.g on a table)
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift only very light weights.
F. I cannot lift or carry anything at all.

Section 4 – Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with slight pain in my neck.
C. I can read as much as I want to with moderate pain in my neck.
D. I cannot read as much as I want to because of moderate pain in my neck.
E. I cannot read as much as I want to because of severe pain in my neck
F. I cannot read at all.

Section 5 – Headache

A. I have no headaches at all.
B. I have slight headaches that come infrequently.
C. I have moderate headaches that come infrequently.
D. I have moderate headaches that come frequently.
E. I have severe headaches that come frequently.
F. I have headaches almost all the time.

Section 6 – Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

Section 7 – Work

A. I can do as much work as I want to.
B. I can do my usual work but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

Section 8 – Driving

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

Section 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

A. I am able to engage in all my recreational activities, with no neck pain at all.
B. I am able to engage in all of my recreational activities, with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D. I am able to engage in only a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

Section 11 – Numeric Rating Scale (NRS)

Try and assign a number from 0 to 10 to your current pain level. If you have no pain, use a 0. As the numbers get higher, they stand for pain that is getting worse. A 10 means the pain is as bad as it can be.

0	1 2 3	4 5 6	7 8 9	10
No pain Absent	Mild Present, Functional	Moderate Uncomfortable	Severe Nonfunctional	Worst Possible Unbearable

OSW-SCORE:_____%

P-SCORE:________

NAME:______________________________ DATE: ______________________________

Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please circle the one choice which closely describes your problem *right now*.**

Section 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate
D. The pain moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing)

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting

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

Section 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than 1 hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

Section 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

Section 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well. (less than 1 hour sleepless).
C. Because of pain, my normal night's sleep is reduced by less than one-quarter. (1-2 hours sleepless).
D. Because of pain, my normal night's sleep is reduced by less than one-half. (2-3 hours sleepless).
E. Because of pain, my normal night's sleep is reduced by less than three-quarters. (3-5 hours sleepless).
F. Pain prevents me from sleeping at all.

Section 8 – Social Life

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

Section 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts me to short necessary journeys under ½ hour.
F. Pain prevents all form of travel.

Section 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Section 11 – Numeric Rating Scale (NRS)

Try and assign a number from 0 to 10 to your current pain level. If you have no pain, use a 0. As the numbers get higher, they stand for pain that is getting worse. A 10 means the pain is as bad as it can be.

0	1 2 3	4 5 6	7 8 9	10
No pain Absent	Mild Present, Functional	Moderate Uncomfortable	Severe Nonfunctional	Worst Possible Unbearable

OSW-SCORE:_____%

P-SCORE:________

OPTUM

MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free. (800) 873-4575 | Telephone. (763)595-3200 | Fax (763) 595-3333

The Keele STarT Back Screening Tool

Patient name: ______________________________ Date: ____________

Thinking about the **last 2 weeks** tick your response to the following questions:

		No 0	Yes 1
1	Has your back pain spread down your leg(s) at some time in the last 2 weeks?	☐	☐
2	Have you had pain in the shoulder or neck at some time in the last 2 weeks?	☐	☐
3	Have you only walked short distances because of your back pain?	☐	☐
4	In the last 2 weeks, have you dressed more slowly than usual because of back pain?	☐	☐
5	Do you think it's not really safe for a person with a condition like yours to be physically active?	☐	☐
6	Have worrying thoughts been going through your mind a lot of the time?	☐	☐
7	Do you feel that your back pain is terrible and it's never going to get any better?	☐	☐
8	In general have you stopped enjoying all the things you usually enjoy?	☐	☐

9. Overall, how **bothersome** has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): __________________ Sub Score (Q5-9): ____________

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