

**Patient Data****Date:** \_\_\_\_\_Title:  Mr.  Mrs.  Ms  Miss (check one)

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  FemaleSocial Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  Single  Married  OtherEmployment Status:  Employed  Unemployed  Full Time Student  Part Time Student  Other (check one)**Family Member Data**Do you have a family member that is a patient in the clinic?  Yes  No Relationship: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Employer Data**

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

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Emergency Contact**

Contact Name: \_\_\_\_\_ Contact Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Primary Care Physician**

Name: \_\_\_\_\_ Contact Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**How did you hear about our clinic? Or who referred you?**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney         | <input type="checkbox"/> Internet Website | <input type="checkbox"/> Health Class   |
| <input type="checkbox"/> Friend        | <input type="checkbox"/> Yellow Pages     | <input type="checkbox"/> Billboard        | <input type="checkbox"/> Brochure       |
| <input type="checkbox"/> Physician     | <input type="checkbox"/> Newspaper Ad     | <input type="checkbox"/> TV Commercial    | <input type="checkbox"/> Direct Mail Ad |
| <input type="checkbox"/> Employer      | <input type="checkbox"/> Sign on Building | <input type="checkbox"/> Radio            | <input type="checkbox"/> Other:         |

**If you selected 'Yellow Pages' please indicate which Yellow Pages:**

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**If you selected 'Family Member', 'Friend', or 'Physician' please enter their name below:**

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**If you selected 'Internet Website' please describe**

**Medical Conditions:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Psychiatric Illness        | <input type="checkbox"/> Skin Disorder       | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Abnormal Weight Gain/Loss  | <input type="checkbox"/> Fever               | <input type="checkbox"/> Corticosteroid Use |
| <input type="checkbox"/> Dizziness/Fainting     | <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Pregnancy              | <input type="checkbox"/> Severe Headaches           | <input type="checkbox"/> Aortic Aneurism     | <input type="checkbox"/> Muscle Weakness    |
| <input type="checkbox"/> Other:                 |   |  |   |

**Surgeries:**

- |                                       |   |  |  |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular Procedure | <input type="checkbox"/> Cervical/Lumbar Procedure | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Other:       |   |  |  |

**Social History:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Caffeine used occasionally   | <input type="checkbox"/> Caffeine used often           | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often           |
| <input type="checkbox"/> Drink alcohol occasionally   | <input type="checkbox"/> Drink alcohol often           | <input type="checkbox"/> Exercise not at all       | <input type="checkbox"/> Exercise occasionally        |
| <input type="checkbox"/> Exercise often               | <input type="checkbox"/> Experience stress occasionall | <input type="checkbox"/> Experience stress often   | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Other:                        |  |   |

**Family History:**

- |   |                                      |                                 |  |
|---|--------------------------------------|---------------------------------|--|
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Thyroid        | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Other:      | <input type="checkbox"/>        |  |

**Occupational Activities:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner           | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user         |
| <input type="checkbox"/> Construction   | <input type="checkbox"/> Daycare/childcare        | <input type="checkbox"/> Executive/legal      | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care    | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor   | <input type="checkbox"/> Home services         |
| <input type="checkbox"/> Household      | <input type="checkbox"/> Light manual labor       | <input type="checkbox"/> Manufacturing        | <input type="checkbox"/> Medium manual labor   |
| <input type="checkbox"/> Other:         |   |   |  |

**In general, would you say your overall health right now is:**

- |                                    |                                    |                               |                               |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Very good | <input type="checkbox"/> Good | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Poor      |                                    |                               |                               |

**Who have you seen for your symptoms?**

- |                                 |                                       |   |   |
|---------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> No one | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Other: |                                       |   |   |

**What treatment did you receive for your symptoms?**

- |                                      |   |                                     |                                  |
|--------------------------------------|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Adjustments | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Medication | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Other:      |   |                                     |                                  |

**When did you receive this treatment?**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> In the last month | <input type="checkbox"/> 2 – 3 months ago | <input type="checkbox"/> 3 – 6 months ago | <input type="checkbox"/> 6 months to 1 year ago |
| <input type="checkbox"/> 1 – 2 years ago   | <input type="checkbox"/> 2 – 5 years ago  | <input type="checkbox"/> 5 – 10 years ago |   |

**What tests have you had for your symptoms?**

- X-rays                       MRI                       CT Scan                       Bone Scan  
 Other:

**When were these tests done?**

- In the last month                       2 – 3 months ago                       3 – 6 months ago                       6 months to 1 year ago  
 1 - 2 years ago                       2 – 5 years ago                       5 – 10 years ago

**Have you had similar symptoms in the past?**

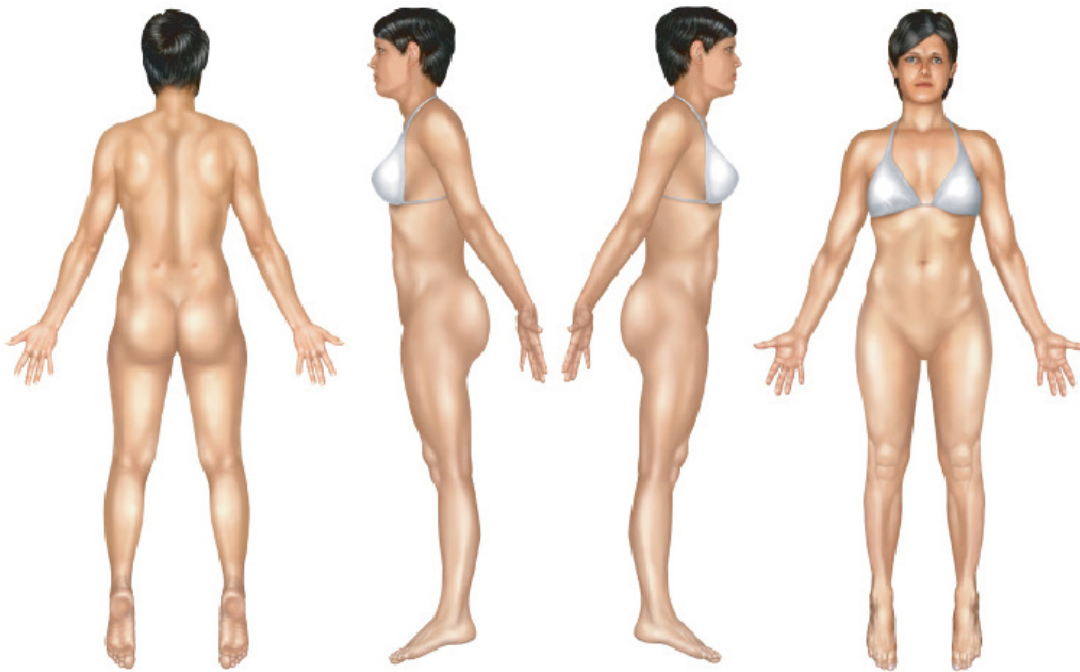
- Yes                       No

**If you have seen treatment in the past for the same or similar symptoms, who did you see?**

- This Office                       Chiropractor                       Medical Doctor                       Physical Therapist  
 Other:

**By using the key below, indicate on the body diagram where you are experiencing the following symptoms:**

**# = Numbness                      X = Burning                      / = Stabbing                      O = Pins & Needles                      + = Dull Ache**



**Describe your symptoms:** \_\_\_\_\_

\_\_\_\_\_

**When did your symptoms start?    Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_**

**How did your symptoms begin?** \_\_\_\_\_

\_\_\_\_\_

# Protecting Your Confidential Health Information is Important to Us

## **For Law Enforcement:**

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of crime or in order to report a crime.

## **Family, Friends and Caregivers:**

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

## **To Coroners, Funeral Directors and Medical Examiners:**

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

## **Medical Research:**

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional review board.

## **Authorization to Use or Disclose health Information:**

Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

## **Patient Acknowledgement:**

Patient Name(s) **Print:**

\_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

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

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

## **Patient Rights**

This new law is careful to describe that you have the following rights related to your health information.

### **Restrictions:**

*You have the right* to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

### **Confidential Communications:**

*You have the right* to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

### **Inspect and Copy Your health Information:**

*You have the right* to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

### **Amend Your Health Information:**

*You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records containing your health information are determined to be accurate and complete.

### **Documentation of Health Information:**

*You have the right* to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

### **Request a Paper Copy of this Notice:**

*You have the right* to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice.

*You have the right* to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

# OSWESTRY REVISED QUESTIONNAIRE

## Section 1 – Pain Intensity

- A. Pain comes and goes and is mild.
- B. Pain is mild and does not vary.
- C. Pain comes and goes and is moderate.
- D. Pain is moderate and does not vary much.
- E. Pain comes and goes and is severe.
- F. Pain is severe and does not vary much.

## Section 2 – Personal Care

- A. Does not change habits to avoid pain.
- B. Does not change habits/Some pain.
- C. Does not change habits/Increases pain.
- D. Changes habits/Increases pain.
- E. Unable to do some personal care without help.
- F. Unable to wash or dress without help.

## Section 3 – Lifting

- A. Lifts heavy weights with no pain.
- B. Lifts heavy weights with pain.
- C. Cannot lift heavy weights off the floor.
- D. Can lift heavy weights from a table.
- E. Can lift light weights from a table.
- F. Can lift only very light weights.

## Section 4 – Walking

- A. Pain does not prevent walking.
- B. Cannot walk more than one mile.
- C. Cannot walk more than 1/2 mile.
- D. Cannot walk more than 1/4 mile.
- E. Can walk only with crutches.
- F. Bedridden and must crawl to the toilet.

## Section 5 – Sitting

- A. Can sit in any chair as long as desired.
- B. Can sit only in the favorite chair as long as desired.
- C. Can sit no more than 1 hour.
- D. Can sit no more than 1/2 hour.
- E. Can sit no more than 10 minutes.
- F. Cannot sit at all due to pain.

## Section 6 – Standing

- A. Can stand for an unlimited time without pain.
- B. Some pain standing/doesn't increase with time.
- C. Cannot stand for more than 1 hour.
- D. Cannot stand for more than 1/2 hour.
- E. Cannot stand more than 10 minutes.
- F. Cannot stand at all.

## Section 7 – Sleeping

- A. No pain in bed.
- B. Gets pain in bed, but sleeps well.
- C. Normal sleep reduced by 1/4.
- D. Normal night's sleep reduced by 1/2.
- E. Normal night's sleep reduced by 3/4.
- F. Cannot sleep at all due to pain.

## Section 8 – Traveling

- A. Travel without pain.
- B. Travel causes some pain, but not made worse.
- C. Causes extra pain/No change in form.
- D. Causes pain/Uses alternative travel.
- E. Pain restricts all forms of travel.
- F. Pain restricts travel except lying down.

## Section 9 - Social

- A. Normal and causes no pain.
- B. Normal but causes extra pain.
- C. Limits energetic interests.
- D. Pain limits/doesn't go out as often.
- E. Pain restricts social life to home.
- F. Pain restricts all social life.

## Section 10 – Changing Degree of Pain

- A. Pain is rapidly improving.
- B. Pain fluctuates but is improving.
- C. Improvement is slow.
- D. Pain level is unchanged.
- E. Pain is gradually worsening.
- F. Pain is rapidly worsening.

DATE:

SCORE: \_\_\_\_\_

A=0

B=2

C=4

D=6

E=8

F=10

Percent Range correlated with disability: \_\_\_\_\_

Additional Notes/Comments: \_\_\_\_\_

\_\_\_\_\_