Shelby Chiropractic

Account #_____

Legal Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name :_____Number of Children: _____

Date Of Birth:_____Age:_____ Sex: ☐ M ☐ F ☐ Gender Pronouns: _____

Mailing Address:_____ City:_____State:_____ Zip:_____

Cell Phone #:_____ Emergency Contact/#:_____

Marital Status: M S W D Occupation: _____ Employer: _____

How were you referred to our office? _____

Describe your condition(s) beginning with the most severe. Please rate each condition on a scale of 1 to 10 (10 being the worse)

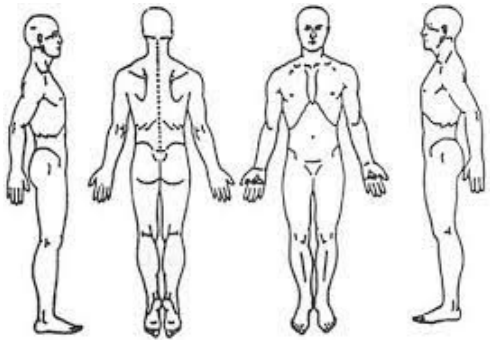
1. _____(___/10) 2. _____(___/10) 3. _____(___/10)

4. _____(___/10) 5. _____(___/10) 6. _____(___/10)

How often do you experience pain?

_____Constantly(75%-100)% _____ Frequently (50%-75%) _____ Occasionally (25%-50%) _____ Intermittently (1%-25%)

How would you describe the type pain? (Please indicate on the diagram below where you have symptoms)



A = ACHE ☐

B= BURN ☐

D= DULL ☐

S= SHARP ☐

S= SHOOTING ☐

How are your symptoms changing with time ? ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

How much has the problem interfered with your work? ☐ Not at all ☐ A little Bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activates? ☐ Not at all ☐ A little Bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for this problem? ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ No One

☐ ER Physician ☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ Other _____

Who: _____ Treatment: _____ Results: _____

Who is your family Physician? _____Name Of Practice: _____

How long have you had this problem? _____

How do you think your problem began ? _____

Do you consider this problem to be severe? ☐ YES ☐ Yes, At Times ☐ NO

What aggravates your problem? _____

What makes it better ? _____

(Over please)

For each of the conditions listed below, place a check mark in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" colum.

PAST	PRESENT	
___	___	HEADACHES
___	___	NECK PAIN
___	___	UPPER BACK PAIN
___	___	MID BACK PAIN
___	___	LOW BACK PAIN
___	___	SHOULDER PAIN
___	___	ELBOW / UPPER ARM PAIN
___	___	WRIST PAIN
___	___	HAND PAIN
___	___	HIP PAIN
___	___	UPPER LEG PAIN
___	___	KNEE PAIN
___	___	ANKLE & FOOT PAIN
___	___	JAW PAIN
___	___	JOINT PAIN/ STIFFNESS
___	___	ARTHRITIS
___	___	RHEUMATOID ARTHRITIS
___	___	CANCER
___	___	TUMOR
___	___	ASTHMA
___	___	CHRONIC SINUSITIS
___	___	HIGH BLOOD PRESSURE
___	___	CHEST PAINS
___	___	EPILEPSY
___	___	DERMATITIS
___	___	HIV/AIDS
___	___	JAW PAIN

PAST	PRESENT	
___	___	STROKE
___	___	ANGINA
___	___	KIDNEY STONES
___	___	KIDNEY DISORDERS
___	___	BLADDER INFECTION
___	___	PAINFUL URINATION
___	___	LOSS OF BLADDER CONTROLL
___	___	PROSTRATE PROBLEMS
___	___	ABNORMAL WEIGHT CHANGE
___	___	LOSS OF APPETTITE
___	___	ABDOMINAL PAIN
___	___	ULCER
___	___	HEPATITIS
___	___	LIVER/GALLBLADDER PROBLEMS
___	___	GENERAL FATIGUE
___	___	MUSCULAR INCORDINATION
___	___	VISUAL DISTURBANCES
___	___	DIZZINESS
___	___	DIABETES
___	___	EXCESSIVE THIRST
___	___	FREQUENT URINATION
___	___	SMOKING/TOBACCO/VAPE USE
___	___	DRUG/ALCOHOL DEPENDENCY
___	___	ALLERGIES
___	___	DEPRESSION
___	___	SLE

		FOR FEMALES ONLY
___	___	BIRTH CONTROLL PILLS
___	___	HORMONAL REPLACEMENT
___	___	Pregnancy

What activities do you do at work?

___ SIT	___ MOST OF THE DAY	___ HALF OF THE DAY	___ A LITTLE OF THE DAY
___ STAND	___ MOST OF THE DAY	___ HALF OF THE DAY	___ A LITTLE OF THE DAY
___ COMPUTER WORK	___ MOST OF THE DAY	___ HALF OF THE DAY	___ A LITTLE OF THE DAY
___ ON THE PHONE	___ MOST OF THE DAY	___ HALF OF THE DAY	___ A LITTLE OF THE DAY
___ DRIVES	___ MOST OF THE DAY	___ HALF OF THE DAY	___ A LITTLE OF THE DAY

What concerns you the most about your problem; what does it prevent you from doing?_____

What is your: Height_____ Weight_____

How would you rate your overall health? ___Very Good ___Good ___Fair ___Poor

What Type of exercise do you do? ___Strenuous ___ Moderate ___ Light ___ None

Family History: Place and "X" if any Apply (Mom, Dad, Brother, Sister)
____ Rheumatoid Arthritis Diabetes____ Lupus____
____ Heart Attacks Cancer____ ALS____

What activities do you do outside of work?_____

List all Prescribed Medications you are currently taken:_____

_____

List all Surgical procedures you have had:_____

_____

Have you ever been hospitalized? ___YES NO___

If yes, why _____

Have You seen a Chiropractor before? ___YES NO___

If yes, who and where?_____

Have You Had significant past trauma? ___YES NO___

If yes, explain what_____

Any thing else pertinent to your visit today?_____

I hereby authorize Shelby Chiropractic to examine me. Including X-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the Doctor from my insurance company and I clearly understand that I am totally responsible for y payment should my insurance company deny payment , or make payment directly to me. First days fees are due and payable at the time of service. BY SIGNING YOU NAME BELOW . YOU CERTIFY THE ACCURACY OF YOU MEDICAL AND HEALTH RELATED CONDITION AND FOR NO OTHER PURPOUSE.

_____ _____
Signature of patient, or of guardian authoring care **DATE**

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 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.

Section 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 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.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, 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 lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 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.

Section 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.

Section 8 – Driving

☐ I 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 my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 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 can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 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 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.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, 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 lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- 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 one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – 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 effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – 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 at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

EHR Certification – Patient Information

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: *(To be entered in EZnotes through "Edit Patient Info")*

Name: (Print clearly) _____ **Today's Date:** _____

Date of Birth: _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other_____

What is your preferred method of contact?

Phone Number: _____

Home	Work	Cell

Phone Call: ☐ Text Message: ☐

E-Mail: _____

Mailing Address: _____

_____

_____

OFFICE USE ONLY

Vitals: *In EZnotes, complete by* 1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: _____ /_____ **Height:** _____ Weight: _____

Smoking Status:	Smokes every day	Smokes some days	Former Smoker	Never Smoked

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued:**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:
Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?

I would like to electronically have access to my health information: (Please initial box) ☐

OFFICE USE ONLY

Timely access: *In EZnotes, complete by* 1) Going to "Edit Patient" section for this patient
3) Select "Asked *Timely Access*" ☐ Completed?

Medications*: In EZnotes, complete by* 1) Going to "Edit Patient"
2) "Edit /View Patient's Data"
3) "Prescriptions/Allergies" ☐ Completed?

Entered into EZnotes by (name): _____ Date & Time: _____