Patient Registration

Patient: (This section refers to Patient only)

Name:____________________ Sex:___ Age:___ D.O.B.:____________

Address: ____

City:____________ State:__________ Zip:________ SSN:______________

Home Phone: (___)________ Work Phone: (___)________ Cell Phone: (___)________

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Employer:____________________ Address:____________________

City:____________________ State:__________ Zip:__________

Please Supply the Following Information:

Spouse's Name:____________________ Phone: (___)____________

SSN:__________ Employer:______________________________

Employer Address: __________________________ City:____________

State:____________ Zip: __________ Phone: (___)____________

Please give us all pertinent information regarding your insurance coverage.

Carrier's Name:________________ Address:____________________

City:____________________ State:__________ Zip:__________

Phone: (___)________________ Name of Insured:____________________

Relationship to you:______________ Policy Holder:____________________

Policy/Certificate #:____________________ Group #:________________

Policy Statement

Patients who carry health insurance understand all health services furnished are charged directly to the patient and that he/she is responsible for payment of all physician services. This office will help prepare the patient's insurance forms to assist in making reimbursements from insurance companies. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I have read the above and understand the office policy. I hereby authorize treatment.

Patient's Signature: ______________________________ Date:__________

Signature of Guardian for patient's under 21:______________________________

For Women only: To the best of my knowledge I am not pregnant and authorize treatment.

Signature:____________________________________ Date:__________

Privacy Policy

I do hereby affirm that I have received a copy of the privacy policy of Kauffman Chiropractic Clinic. If I have any questions or wish to exercise my rights regarding my personal health information I will contact the privacy officer.

____________________________ ________________

Signature Date

Confidential Health History

Please write **C** if you **currently** have any of the following or **P** if you have had any of the following in the **past**.

____	Allergies	____	Nervousness/Depression	____	Chest Pain
____	Arthritis	____	Dizziness	____	Difficult Breathing
____	Cancer/Tumor	____	Ear Problems	____	Pleurisy/Pneumonia
____	Diabetes	____	Eye problems	____	Chronic Cough
____	Liver problems	____	Headaches	____	Hoarseness
____	Hepatitis	____	Head Injury	____	Varicose Veins
____	Kidney Problems	____	Fractures/Dislocations	____	Constipation
____	Gall bladder problems	____	Foot Trouble	____	Abnormal Stools
____	Ulcers	____	Paralysis	____	Blood in Urine
____	Thyroid problems	____	High/Low Blood Pressure	____	Urinary Problems
____	Lumps on Breast	____	Heart problems	____	Menapausal Problems

Other conditions:____

____

Medications:____

____

Vitamins:____

List all surgeries and year:____

____

Have you ever been hospitalized (Non-surgery)?____________________________

Do you have any metal implants?: ( ) Yes ( ) No Where?:____________________

Do you have a pacemaker?: ( ) Yes ( ) No

Are you pregnant?: ( ) Yes ( ) No Date of last menstrual period:____________________

Number of children: ____________ Number of pregnancies: ______________

Do you/Did you smoke?: ____

Family History

__ Cancer __ Diabetes __ Heart Disease __ Kidney Disease __ Other:____________________

What is your area of complaint? (I.E. neck, low back, ETC.):

____

Have you had this or a similar problem in the past?: ( ) Yes ( ) No

If yes, explain: ____

Did the Accident/Injury occur at work:_____________ Date:______________ Time:______________

Dates of work missed due to this condition: ____

Involved in Auto Accident:____________________ Date:______________ Time:______________

Have you ever been treated by a chiropractic physician before: ( ) Yes ( ) No

His/Her name:____

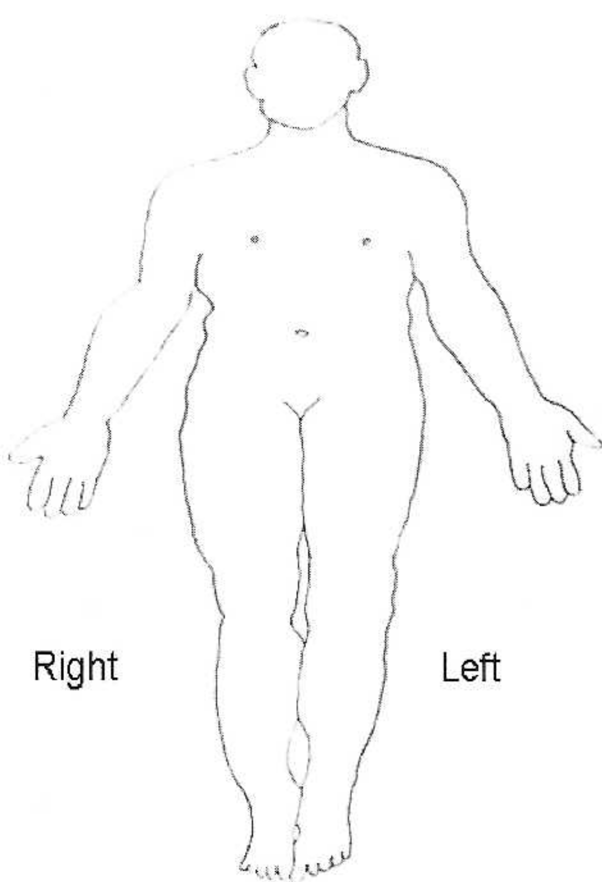
Other doctors seen for this condition:____

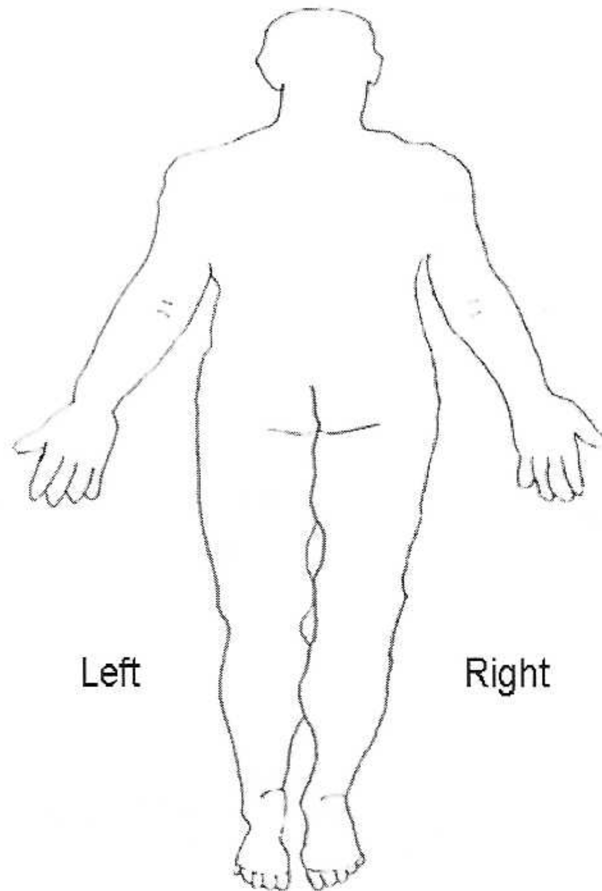
Name: ______________________________ Date: ____________

Pain Chart

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols and include all affected areas. Mark all areas of radiation.

Numbness	Pins/Needles	Burning	Aching	Stabbing
- - - - - -	000000	xxxxx	*****	/////





Visual Analog Scale

Low Back Pain

The line below represents the intensity of low back pain. Please mark an X at the position on the scale which indicates how much pain you feel in your low back **at this time**.

|--|

No Pain Worst Pain Imaginable

Pain Other Than Low Back Pain

The line below represents the intensity of your pain. Please mark an X at the position on the scale which indicates how much pain you feel **at this time**.

|--|

No Pain Worst Pain Imaginable

Name: ______________________ Date: ____________

Oswestry Disability Questionnaire (LOWER BACK)

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box, which most closely describes your current condition**.

Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I can manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me with moderate relief from pain.
- ☐ Pain medication provides me with little relief from pain.
- ☐ Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)

- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Lifting

- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. 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 only very light weights.
- ☐ I can not lift or carry anything at all.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk with crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

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 for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than ½ hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Sleeping

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

Social Life

- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Traveling

- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ My pain restricts travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My pain restricts my travel to short necessary journeys under ½ hour.
- ☐ My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking

- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pan prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Score: ________

Name: ____________________________ Date: ___________

Neck Disability Index

This questionnaire has been designed to give your therapist information as to how your neck pain has affected you in your everyday activities. Please answer each section, marking only **ONE** box which best describes your status **today**.

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 me 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 I stay in bed.

Section 3 – 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, 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 positioned conveniently.
- ❑ I can only 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 to with moderate pain in my neck.
- ❑ I can't read as much as I want to 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 – Headache

- ❑ I have no headache at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all of the time.

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 as I want.
- ❑ 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 cannot do any work at all.

Section 8 – Driving

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want to, with slight pain in my neck.
- ❑ I can drive my car as long as I want to, with moderate pain in my neck.
- ❑ I cannot drive my car as long as I want to because of moderate pain in my neck.
- ❑ I can hardly drive my car at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

Section 9 – Sleeping

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

Section 10 – Recreation

- ❑ I am able to engage in all my recreational activities with no neck pain at all.
- ❑ I am able to engage in all my recreational activities with some pain in my neck.
- ❑ I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- ❑ I am able to engage in only a few of my usual recreational activities because of pain in my neck.
- ❑ I can hardly do any recreational activities because of pain in my neck.
- ❑ I cannot do any recreational activities at all.

Score: _________