GLOCESTER FAMILY CHIROPRACTIC

Patient Information & Health History

Date: _____

First Name: _____ MI: _____

Last Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Date Of Birth: _____

Age: _____

Marital Status: □Single □Married □Divorced □Widowed □Other

Spouse's Name: _____

Home Phone: _____

Cell Phone: _____

Cell Phone Carrier: _____

EMAIL: _____

Work Phone: _____

Occupation: _____

□Unemployed □Full Time □Part Time □Student

Employer: _____

Emergency Contact: _____

Relationship: _____

Primary Care Provider: _____

Primary Care Phone:

Insurance Information:

PRIMARY INSURANCE

Insurance Name:

Policy Number:

Subscriber Name:

Subscriber DOB:

SECONDARY INSURANCE

Insurance Name:

Policy Number:

Subscriber Name:

Subscriber DOB:

I certify that I and/or my dependents have insurance coverage with the above company and assign directly to Glocester Family Chiropracitc Inc, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission.
The above named facility may use my healthcare information and disclose such information to the above named insurances and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services. This consent will end when my current treatment plan has ended or one year from date signed below.

Print Name: _____

Signature: _____

Is your condition a result of an accident ☐ NO ☐ Yes

Type of Accident ☐ AUTO ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Work Comp.

Attorney name (if applicable): _____

Have you Chiropractic Care previously? □ Yes □ No

If so who? _____ How long ago? _____

Medication Name	Dosage	Frequency	Prescribing Provider

Allergies		
Food	**Environmental**	**Medications**

Date	Surgeries and Hospitalizations	Date	Surgeries and Hospitalizations

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Patient Information & Health History

Please CIRCLE "NO" or "YES" to indicate if you have had any of the following:

Aids/HIV	NO	YES	Chicken Pox	NO	YES	Liver Disease	NO	YES	Rheumatoid Arthritis	NO	YES
Diabetes	NO	YES	Measles	NO	YES	Rheumatic Fever	NO	YES	Alcoholism	NO	YES
Stroke	NO	YES	Migraines	NO	YES	Scarlet Fever	NO	YES	Allergy shots	NO	YES
Anemia	NO	YES	Epilepsy	NO	YES	Miscarriage	NO	YES	Emphysema	NO	YES
Anorexia	NO	YES	Fractures	NO	YES	Mononucleosis	NO	YES	Suicide Attempt	NO	YES
Tonsillitis	NO	YES	Glaucoma	NO	YES	Multiple Sclerosis	NO	YES	Thyroid Problems	NO	YES
Arthritis	NO	YES	Goiter	NO	YES	Mumps	NO	YES	Appendicitis	NO	YES
Asthma	NO	YES	Gonorrhea	NO	YES	Osteoporosis	NO	YES	Tuberculosis	NO	YES
Ulcers	NO	YES	Gout	NO	YES	Pacemaker	NO	YES	Bleeding Disorders	NO	YES
Bronchitis	NO	YES	Hepatitis	NO	YES	Pinched Nerve	NO	YES	Typhoid Fever	NO	YES
Bulimia	NO	YES	Hernia	NO	YES	Pneumonia	NO	YES	Vaginal Infections	NO	YES
Cancer	NO	YES	Herniated Disc	NO	YES	Polio	NO	YES	Venereal Disease	NO	YES
Prosthesis	NO	YES	Herpes	NO	YES	Prostate Disease	NO	YES	Whooping Cough	NO	YES
Tumors	NO	YES	Kidney Disease	NO	YES	Psychiatric Care	NO	YES	High Cholesterol	NO	YES
Cataracts	NO	YES	Heart Disease	NO	YES	Breast Lump	NO	YES	Parkinson's Disease	NO	YES
Lyme Disease	NO	YES	Fibromyalgia	NO	YES	Other Not Listed:					

Please CIRCLE "NO" or "YES" to all items you feel are applicable to you:

Have you had any unexplained weight loss?	NO	YES	Do you frequently feel fatigued?	NO	YES
Do you have any fever or chills?	NO	YES	Had any recent Infections?	NO	YES
Have you had any changes in your appetite?	NO	YES	Do you feel Depressed?	NO	YES
Do you have shortness of breath?	NO	YES	Do you frequently feel anxious?	NO	YES
Do you have palpitations (Fast Heart)?	NO	YES	Have severe nighttime pain?	NO	YES
Numbness in arms or legs	NO	YES	have difficulties with sleep?	NO	YES
Numbness in your genital area?	NO	YES	Paralysis or muscle weakness?	NO	YES
Do you have abdominal pain?	NO	YES	Have you had any trouble walking?	NO	YES
Have you had diarrhea?	NO	YES	Do you have nausea?	NO	YES
Problems controlling your bowels?	NO	YES	Have any pain with urination?	NO	YES
Problems controlling your bladder?	NO	YES	Have any recurrent headaches?	NO	YES
Problems with dizziness/keeping balance?	NO	YES	Do you have chest pain?	NO	YES
Does Pain limit your current sexual activity?	NO	YES	Do you have joint pain?	NO	YES

Please List any previous studies you have had done

STUDY	DATE (Approximate)	BODY PART i.e.: Neck/Low back/Head/Shoulder	Ordering Physician (Last Name)	Facility Name (Location/Town)
X-Ray				
MRI				
CT Scan				
Other				

GLOCESTER FAMILY CHIROPRACTIC

Patient Information & Health History

Family History Of:	Mother	Father
Heart Disease	☐	☐
Diabetes	☐	☐
Cancer	☐	☐

Please Circle All That Apply To You

Smoking History:	**Current**	**Former**	**Never**	
Do you Drink Alcohol?	**NO**	**Social**	**Moderate**	**Heavy**
Drink Caffeine?	**NO**	**1-2 Cups**	**3-6 Cups**	**More than 6 Cups/Day**
Use of NON Prescription Drugs?	**NO**	**OTC**	**Recreational Drugs**	
Do you Exercise?	**NO**	**Rarely**	**Daily**	**Weekly**

Reason for Today's Visit? _____ **Height:** _____ **Weight:** _____

When did your symptoms begin?_____ How did your problem begin? _____

How often do you have these symptoms ?

☐ Constant 100% of time ☐Frequent 50-75% of time ☐ Occasional 25-50% of time ☐ Intermittent 0-25% of time

Rate your symptoms on a scale : 0 (no symptoms/pain) to 10 (severe pain/symptoms) **AT WORST**_____ **Now**_____

Quality of your symptoms? Check all that Apply

□ Discomfort	□ Deep	□ Intolerable	□ Stabbing	□ Tingling
□ Aching	□ Diffuse	□ Pulling	□ Stiffness	□ Other
□ Annoying	□ Dull	□ Sharp	□ Throbbing	
□ Burning	□ Heavy	□ Shock Like	□ Tightness	

What Alleviates the Symptoms?

□ Nothing □ Chiropractic □ Cold □ Exercise/ Stretch □Heat □ Massage □ Medication □ PT □ Rest □ Movement

What Increases the Symptoms?

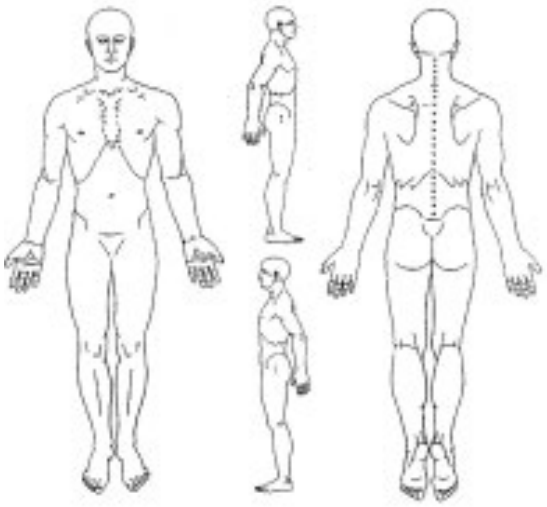
□ Nothing □ Driving □ Lifting □ Exercise/ Stretch □Sleeping □ Sitting □ Standing □ Walking □ Rest □ Movement

Have you ever had these symptoms before? ☐ NO ☐ YES (How long ago?) _____

Have you seen anyone else for these symptoms? NO or Who/When _____

Have you had any recent Diagnostic tests i.e. X-Ray / Blood Work/ MRI / Other_____

Please Mark Location of Your Pain in Diagram Below



MOVEMENTS

Are you having any trouble with the following actions?

Looking:	left	right	up	down
Bending:	Forward	Backward	Right	Left

HEADACHES

Are you currently having Headaches? □Yes □ No

Have you had Headaches in the Past? □Yes □No

Have you seen a medical provider for Headaches? □Yes □No

Have the Headaches been diagnosed? Tension / Migraines

Location of Headache □Front □Back □Right Side □Left Side

Timing of Headache? □AM □ Afternoon □ PM □As day goes on

How often do Headaches occur? □Constant □daily □Weekly

How long do they last?_____ Minutes/Hours

How Intense? Worst _____ Now _____

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

BACK COMPLAINTS ONLY

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

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

2. PERSONAL CARE (e.g. Washing, Dressing)

- ☐ 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 don't get dressed, I was with difficulty and stay in bed

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, i.e. 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

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ 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

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

6. STANDING

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

7. SLEEPING

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

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, i.e. dancing, etc.
- ☐ 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

9. TRAVELLING

- ☐ 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 restricts me to journeys of 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

10. 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 (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Neck Index

ACN Group, Inc. Form NI-100

For Neck Complaints Only

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

GLOCESTER FAMILY CHIROPRACTIC, INC.
712 PUTNAM PIKE, UNIT 4
CHEPACHET, RI 02814
(401) 568-2200

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscle strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been describes as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

  Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

  Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

  Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment; I hereby give my full consent to treatment.

Printed Name	Signature	Date

Witness:

Printed Name	Signature	Date

GLOCESTER FAMILY CHIROPRACTIC, INC.
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Office Policies

- In order to allow low volume scheduling and minimize patient wait times, there will be a $20.00 fee applied to missed appointments or appointments cancelled without 24 hours notice. This fee is not covered by insurance and will be billed directly to the patient. I agree to contact Glocester Family Chiropractic 24 hours prior to my appointment to cancel or reschedule.
- I understand that it is my responsibility to pay Glocester Family Chiropractic directly for services not covered by my health insurance plan and that all co-payments and deductibles are due at the time of service.
- I acknowledge that Glocester Family Chiropractic verifies my chiropractic benefits and bills my health insurance plan directly as a courtesy, and that it is in my best interest to understand my insurance plan's current benefit and coverage rules, including but not limited to co-payments, deductibles and visit limits. I am responsible for contacting my insurance plan directly with questions regarding my coverage.
- I acknowledge that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) as amended, I have certain rights to privacy regarding my protected health information. I understand that at any time I may request a more detailed Provider PHI Privacy Policy containing a more complete and updated description of the uses and potential disclosures of my health information.
- I give Glocester Family Chiropractic permission to provide information regarding my chiropractic care to the person(s) listed below.

_____

_____

_____

_____

Signature: _____ Date: _____