

Central Chiropractic & Rehab

A patient in coming to the Doctor of Chiropractic gives the Doctor permission and authority to care for the patient in accordance with the chiropractor's assessment of tests, diagnostic impressions, and conclusions. The Chiropractic adjustment, as well as other clinical procedures are usually beneficial pathologies may render the patient susceptible to injury. The Doctor, of course, will not give a contraindicated.. It is the patient's responsibility to make known any pathological defects, illnesses, or deformities that would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed as a specialist and is available to work with other types of procedures in your health care regime.

Usually, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control of other health care providers. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have listed all known medical conditions above. I understand that there will be no liability on the practitioner's part for any aggravation of conditions which were present, but not disclosed, at the time of the massage and which maybe affected by the massage.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services are rendered to be are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, all fees for professional services rendered to me will be immediately due and payable.

Please discuss any questions or problems with the Doctor before signing this statement.

Patient's Signature Witness's Signature Witness's Printed Name Date

CONSENT TO TREAT A MINOR

_____,
(Printed Name of Guardian) hereby authorize Dr. _____ whomever he

or she may designate as assistants to administer care as deemed necessary to _____
(Name of Minor)

My relationship to this minor is _____

PATIENT HEALTH QUESTIONNAIRE - PAGE 1

PATIENT NAME: FIRST _____ MIDDLE _____ LAST _____ BIRTH DATE _____ TODAY'S DATE _____

CHIEF SUBJECTIVE COMPLAINT: _____
(Briefly describe)

HISTORY OF PRESENT ILLNESS

When did your pain begin? _____ **Is this work related?** Yes No

Condition is due to: Work Injury Illness Other Auto Accident (please ask for and fill out Auto Accident Form)

How did your pain begin? No apparent reason Bending Lifting Fall Motor Vehicle Accident

Other, describe: _____

Have you had a similar episode before? No Yes **What have you been told is wrong?** _____

PAIN SPECIFICS

Please indicate the location of your pain on the pain diagram below.

Use these symbols to best describe the type(s) of pain:

D = Dull Ache **N** = Numbness **T** = Tingling (Pins & Needles)
B = Burning **S** = Stabbing/Cutting **C** = Numbness



WHEN DID THIS PAIN BEGIN:

FREQUENCY OF PAIN:

- Constantly (76%–100% of the day)
- Frequently (51%–75% of the day)
- Occasionally (26%–50% of the day)
- Intermittently (0%–25% of the day)
- Other

PAIN MEDICATION AND/OR MUSCLE RELAXERS:

ON THE SCALES BELOW, PLEASE DRAW A VERTICAL LINE REPRESENTING YOUR PAIN OR DISCOMFORT:

Rate the pain you have NOW:

NO PAIN _____ UNBEARABLE PAIN

Rate your pain at its BEST in the past week:

NO PAIN _____ UNBEARABLE PAIN

Rate your AVERAGE pain in the past week:

NO PAIN _____ UNBEARABLE PAIN

Rate your WORST pain in the past week:

NO PAIN _____ UNBEARABLE PAIN

PAIN BETTER:

- AM
- Mid-Day
- PM
- At Rest
- Does Not Change
- Other

PAIN WORSE:

- AM
- Mid-Day
- PM
- At Rest
- Does Not Change
- Other

PATIENT HEALTH QUESTIONNAIRE – PAGE 2

SUBJECTIVE SYMPTOMS		
SYMPTOM	TIMING	
	PAST	PRESENT
PROBLEMS		
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Cold sweats	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
SENSORY	PAST	PRESENT
Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Buzzing or ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>
Eyes sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>
Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
EMOTIONAL	PAST	PRESENT
Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Depression or crying spells	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Anxious	<input type="checkbox"/>	<input type="checkbox"/>
DYSFUNCTION	PAST	PRESENT
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart irregularities	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Liver/gall bladder disorder	<input type="checkbox"/>	<input type="checkbox"/>
DISEASE	PAST	PRESENT
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>

(ADL)	ACTIVITY OF DAILY LIVING (ADL)				
	ABILITY TO PREFORM ADL				
	Unable	Painful	Difficult	Limited	Other
SLEEP					
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying flat on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side with knees bent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning over in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEATED	Unable	Painful	Difficult	Limited	Other
Supine to sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting at a table	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting to standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STANDING	Unable	Painful	Difficult	Limited	Other
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing for more than 1 hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending sideways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WALKING	Unable	Painful	Difficult	Limited	Other
Walking short distances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair/10 yards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VOCATIONAL	Unable	Painful	Difficult	Limited	Other
Operate car/machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gripping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMESTIC	Unable	Painful	Difficult	Limited	Other
Feeding self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress upper body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress lower body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of perineum/clothing at toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wash or bathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward to brush teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing or sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRANSFER	Unable	Painful	Difficult	Limited	Other
Transfer – toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer – tub or shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer – automobile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR PAIN SPECIFICS

PRIOR TESTS FOR YOU PAIN – TEST/RESULTS:

- X-ray _____
- MRI _____
- CT _____
- Lab _____
- Other _____

PRIOR TREATMENT FOR YOUR CURRENT PROBLEM:

- Anti-inflammatory:** Ibuprofen Celebrex Vioxx
 Bextra Other, Results: _____

- Steroids:** Cortisone Pills Cortisone Injections

- Other, Results: _____

Other Medications: _____

Results: _____

- Injections:** Epidural Facer Other, Results: _____

Spinal Surgery: Year/Procedure/Results: _____

Physical Therapy: Year/Procedure/Results: _____

Chiropractic: Year/Procedure/Results: _____

Other Treatments: Year/Type/Results: _____

FOR PROVIDER USE ONLY:

PERSONAL MEDICAL HISTORY

SURGERIES/HOSPITALIZATIONS:

- _____ Year: _____
- _____ Year: _____
- _____ Year: _____
- _____ Year: _____

INJURIES/FRACTURES/DISLOCATIONS:

- _____ Year: _____
- _____ Year: _____
- _____ Year: _____
- _____ Year: _____

Have you had problems with anesthesia, infection, bleeding, or other surgical complications? No Yes Explain: _____

PAST PERSONAL HEALTH HISTORY

PLEASE CHECK ITEMS THAT APPLY TO YOUR PAST MEDICAL HISTORY:

- | | | |
|---|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Other, _____ |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Pacemaker | _____ |

FAMILY MEMBER HEALTH HISTORY

PLEASE CHECK ITEMS THAT APPLY TO YOUR FAMILY MEDICAL HISTORY:

	FATHER	MOTHER	BROTHER	SISTER	OTHER
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other, _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT HEALTH QUESTIONNAIRE – PAGE 4

LIST ALL MEDICATIONS/SUPPLEMENTS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION	DOSAGE	STARTING DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: No Yes _____

PATIENT WORK STATUS

Current Work Status:

- Regular Duty
- Limited/Light Duty, Date Light Duty Began: _____
- Off Work, Date Taken Off Work: _____

Occupation:

HOURS PER DAY SPENT SITTING

- Domestic/Home maker _____
- Office _____
- Truck Driver _____
- Labor _____
- Construction _____
- Sales (Standing Most of the Day) _____
- Public Service (Mail Carrier/Fireman/Policeman) _____
- Military _____
- Other _____

FEMALE PATIENTS PERSONAL MEDICAL HISTORY

Are you possibly pregnant? No Yes Due Date: _____

Date of last menstrual cycle? Begin _____ End _____

PLEASE CHECK ITEMS THAT APPLY TO YOUR MEDICAL HISTORY:

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Lack of Bladder Control
- Menopause/Hot Flashes
- Number of Children _____
- Complications During Pregnancy or Delivery? _____

PERSONAL LIFE STYLE

Exercise:

DURATION

TIMES PER WEEK

- Walk _____
- Jog _____
- Run _____
- Aerobic _____
- Pilates _____
- Yoga _____
- Sports _____
- Weight Lifting _____
- Swimming _____
- Elliptical _____
- Core Training _____
- Other _____

MALE PATIENTS PERSONAL MEDICAL HISTORY

PLEASE CHECK ITEMS THAT APPLY TO YOUR MEDICAL HISTORY:

- Prostate Problems
- Pain in Penis
- Painful Urination
- Lack of Bladder Control
- Sexual Problems

Interests/Other Activities:

HOURS PER DAY SPENT SITTING

- Crafts/Creative Hobbies _____
- Garage/Shop _____
- Sports Fan _____
- Social Events _____
- Hunting/Fishing _____
- Shopping _____
- Family Time _____
- Other _____

PATIENT SLEEP PATTERNS

Sleep Position:

Sleep Description:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Back | <input type="checkbox"/> Deep & Recuperative | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Restless & Recuperative | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Side | <input type="checkbox"/> Deep & Unrecuperative | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> All | <input type="checkbox"/> Restless & Unrecuperative | <input type="checkbox"/> Night Terrors |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Awakened Several Times | <input type="checkbox"/> Pain/Stiffness |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Other _____ |

PATIENT DIET

Diet Type:

Diet Consistency:

- | | |
|--|--|
| <input type="checkbox"/> Typical Western | <input type="checkbox"/> 3 Meals a Day with Snacks |
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Inconsistent |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> 2 Meals a Day with Snacks |
| <input type="checkbox"/> Low Fat | <input type="checkbox"/> Constant Snacking |
| <input type="checkbox"/> Low Carb | <input type="checkbox"/> Specialized |
| <input type="checkbox"/> Low Calorie | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetic | |
| <input type="checkbox"/> Other _____ | |

PATIENT STRESS

Stress Factors:

Domestic Violence:

- Work _____
- Home _____
- Relationship _____
- Other _____

Yes No

Support System:

- Family _____
- Relationship _____
- Church _____
- Therapist _____
- Other _____

PATIENT HEALTH QUESTIONNAIRE – PAGE 5

PATIENT BOWEL HABITS

- Infrequent
- Incomplete
- Hard
- Straining During Defecation
- Does not Defecate Everyday
- Each Night
- Constipation
- Diarrhea
- Other _____
- Painful–Hemorrhoids
- Painful–Anal Fissu
- Painful–Perianal A
- Spinal Cord Injuries
- Scleroderma
- Hirschsprung's Disease
- Secretory
- Osmotic
- Exudative
- Motility Disorder

PATIENT URINARY HABITS

- Stop & Go
- Going
- Stopping
- Incontinence
- Retention
- Blood in Urine
- Painful
- Other _____

PATIENT TREATMENT GOAL EXPECTATIONS

- Return to General Health
- Decrease Pain
- Decrease Inflammation
- Decrease Muscle Tension
- Decrease Compensatory Patterns
- Increase Mobility
- Increase Strength
- Restore Function
- Restore Posture
- Patient Education
- All of the Above

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all services rendered. I also understand that as a courtesy to me, _____ will bill my insurance company directly. I further understand that I am financially responsible for any services rendered that are not covered by my insurance company.

SIGNED _____

DATE _____

CONSENT TO TREAT A MINOR

I hereby authorize the doctor to render chiropractic care as deemed necessary to my _____ (relationship to child).

NAME OF CHILD _____

GUARDIAN SIGNATURE _____

DATE _____