Patient Health Care History:

Name____ Date______________

Referred by_______________________________________

Number of Children/Ages_____________________________

Have you ever received Chiropractic Care? Yes No

Include dates and doctors' names, if not applicable write N/A

Family/Primary Care Physician: ______________________ Phone #: __________________

Current and Previous Health Habits:

Drugs, prescription, OTC, recreational? Y N ______________________________

Surgery? Y N ______________________________

Hospitalizations? Y N ______________________________

Sports or other physical activities Y N ______________________________

Injuries during sports? Y N ______________________________

Auto accidents? Y N ______________________________

Did you have other traumas? Y N ______________________________

Did you ever break any bones? Y N ______________________________

Did/do you smoke? Y N __________< 1 2 3 > packs/day ______years

Did/do you drink alcohol? Y N ________________________drinks/day

Diet, do you eat healthy foods? Y N ______________________________

Dental problems? Y N ______________________________

Eye problems? Y N ______________________________

Hearing problems? Y N ______________________________

Exercise regularly? Y N ______________________________

Did/do you have occupational stress? Y N ______________________________

Drive? Daily time spent driving Y N ______________________________

Physical stress? Y N ______________________________

Emotional/Mental stress? Y N ______________________________

Hobbies/Sports injuries? Y N ______________________________

Do you sleep well, hours of sleep? Y N ________________________hrs/day

Sleeping posture? O side O stomach O back ______________________________

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office: ____

Pain or Problem started on (date)____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other________________

Does this pain shoot, radiate, or travel in your body?

Where?____

Are you experiencing numbness or tingling in any area of your body?

Where?____

Since it began, is it: O Same O Better O Worse

What activities aggravate your condition/pain?

____

What activities lessen your _______condition/pain?

____

Is this condition worse during certain times of the day?____

Is this condition interfering with Work?____________Sleep?____________Routine?________Other?____

Is this condition progressively getting worse?____

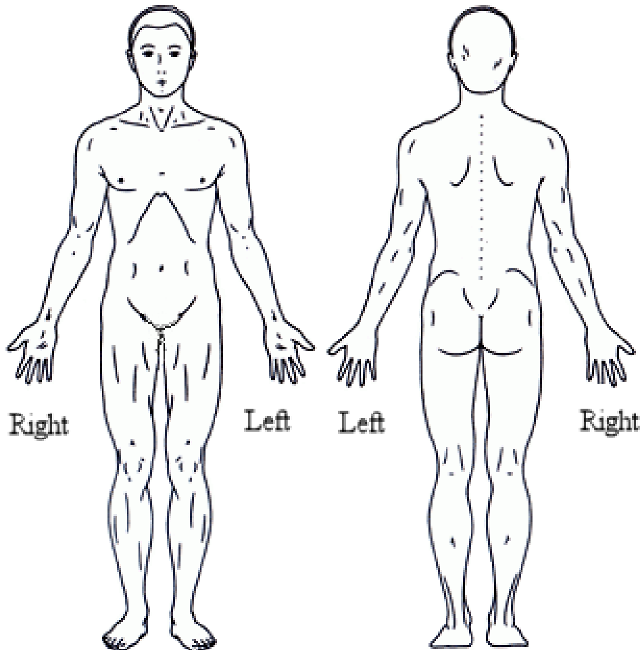
Other Doctors seen for this condition____

Any home remedies?

____

Please Circle where you are: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible /Pain)

Using the symbols below, mark on the pictures where you feel pain.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _______	^ ^ ^

____

____

____

____

____

Please mark any of the following conditions or symptoms that you have now or have experienced:

Other Symptoms:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Are you under medical care for any condition? ____

What Medications are you taking? ____

____

How long?______________Have you had surgery?___________What?_________________ When?___________

What side effects have you experienced from the drugs and surgery? ______________________________

Females Only – Date last Menstrual Period began on__________________ Are you possibly pregnant?________

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other______________
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient

Signature____Date_________________________

If patient is under 18 years of age, parent or guardian must sign: ____________________________________

Neck Disability Questionnaire:

Please answer every section, and mark only the ONE box which applies to you in each. If two apply to you, choose the ONE which most closely resembles 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 I've experienced

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ I t is painful to look after myself and I'm 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 mangae 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 with no pain in my neck
- ☐ I can read as much as I want with slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☐ 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 because of the pain

Section 5 – Headaches

- ☐ I have no headaches 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 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 concentrating when I want to
- ☐ I have a lot of difficulty concentrating when I want to
- ☐ I have a great deal of difficulty 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 can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight neck pain
- ☐ I can drive my car as long as I want with moderate neck pain
- ☐ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive 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 mildly 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 my recreation activities with no neck pain
- ☐ I am able to engage in 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 neck pain
- ☐ I am able to engage in a few of my usual recreation activities because of neck pain
- ☐ I can hardly do any recreation activities because of neck pain
- ☐ I can't do any recreational activities

Patient Signature: ____________________________ Print Name: ____________________________________

Date:____________________

If patient is under 18 years of age, parent or guardian must sign: __________________________

Release of Records Authorization:

I hereby authorize the use or disclosure of the Protected Health Information(P.H.I.) described below to be provided to, or obtained by the following:

Name of individual/facility to RECEIVE P.H.I.	**Name of individual/facility to DISCLOSE P.H.I.**
Manadero Chiropractic__________________	Name: _________________________________
727 J. Clyde Morris Blvd._________________	Date: __________________________________
Suite B__________________________________	Fax: ___________________________________
Newport News, VA 23601_________________	____

Information authorized for use or disclosure, or to be obtained:

☐ All medical information concerning this patient

☐ Medical information of this patient compiled between __________________ to ________________

☐ Only: ____

Dates of treatment, if known: ____

The information will be obtained, used, or disclosed for the following purpose(s) only:

☐ All necessary purposes ☐ Insurance ☐ Continued treatment ☐ Legal

☐ At the request of the patient/patient's representative ☐ Other (specify)_______________

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event: ________________________
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

I understand that my medical information may indicate that I have a communicable/venereal disease which may include but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

NOTICE of RIGHTS: Information in your medical record pursuant that you have, or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk of exposure, disclosure pursuant to an order of the court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

____ ___________________
Signature of Patient/Legal Representative (if under 18, parent/guardian) Date

____ ___________________
Describe if Legal Representative's Authorization Expires Date of expiration

Patient Name: ____Birth: _____/___/________

SS#: ______________________________

Roland Morris LOW BACK DISABILITY QUESTIONNAIRE:

When your back hurts, you may find it difficult to do some things you normally do. This list contains some sentences that people use to describe their back pain. If you read some that describe yourself TODAY, check the box next to it.

Remember, ONLY check the box if you feel that way TODAY.

- ☐ 1. I stay at home most of the time because of my back
- ☐ 2. I change position frequently to try and get my back comfortable
- ☐ 3. I walk more slowly than usual because of my back
- ☐ 4. Because of my back, I am not doing ANY of the jobs I usually do around the house
- ☐ 5. Because of my back, I use a handrail to get upstairs
- ☐ 6. Because of my back, I lie down to rest more often
- ☐ 7. Because of my back, I have to hold onto something to get out of an easy chair
- ☐ 8. Because of my back, I try to get other people to do things for me
- ☐ 9. I get dressed more slowly than usual because of my back
- ☐ 10. I only stand up for short periods of time because of my back
- ☐ 11. Because of my back, I try not to bend or kneel down
- ☐ 12. I find it difficult to get out of a chair because of my back
- ☐ 13. My back is painful almost all of the time
- ☐ 14. I find it difficult to turn over in bed because of my back
- ☐ 15. My appetite is not very good because of my back
- ☐ 16. I have trouble putting on my socks (stockings) because of the pain in my back
- ☐ 17. I only walk short distances because of my back pain
- ☐ 18. I sleep less well because of my back pain
- ☐ 19. Because of my back pain, I get dressed with help from someone else
- ☐ 20. I sit down for most of the day because of my back
- ☐ 21. I avoid heavy jobs around the house because of my back
- ☐ 22. Because of my back pain, I am more irritable and bad tempered with people than usual
- ☐ 23. Because of my back, I go upstairs more slowly than usual
- ☐ 24. I stay in bed most of the time because of my back

Patient Signature: ___________________________ Print Name: _________________________

Date: ______________________

If patient is under 18 years of age, parent or guardian must sign: ________________________________