Edmond Chiropractic Center
Bruce J. Heng D.C., M.Ed.
1700 S. Boulevard Suite A
Edmond, OK 73013
(405) 340-1086

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential.
We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes When?

Whom may we thank for referring you?

If so, whom?

Gender
○ Male ○ Female

Your Last Name

Your Social Security Number

Your First Name | Your Middle Name (or Initial) | Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City | State/Province | ZIP/Postal Code | Home Phone | Spouse's Name

Email Address | Cell Phone | Child's Name and Age

Emergency Contact | Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Address

City | State/Province | ZIP/Postal Code | Work Phone

Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Last Name

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name | Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

Patient name _____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

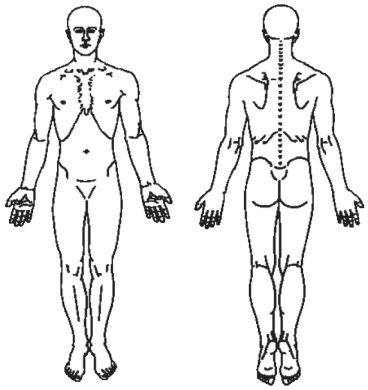
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0 ◯—◯—◯—◯—◯—◯—◯—◯—◯—◯—◯ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Come and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?)
Circle the area (s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptons?)
◯ Prescription medication ◯ Surgery ◯ Other _____
◯ Over-the-counter drugs ◯ Acupuncture _____
◯ Homeopathic remedies ◯ Chiropractic _____
◯ Physical therapy ◯ Massage

11. What else should Dr. Heng know about your current condition? _____
_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household resposibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders	
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness	Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising	Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia	Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea	Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste	Initials ____

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ◯
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash	Initials ____

Consultation Notes

Doctor's Initials _____

Edmond Chiropractic Center
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(Contiued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight change	○	○	Weakness	Initials ____

Patient name

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Sexually transmitted disease
○	○	Alcoholism	○	○	Stroke
○	○	Allergies	○	○	Tuberculosis
○	○	Arteriosclerosis	○	○	Typhoid fever
○	○	Arthritis	○	○	Ulcer
○	○	Cancer	○	○	Other: _____
○	○	Chicken pox			
○	○	Diabetes			
○	○	Eczema			
○	○	Emphysema			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Pneumonia			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional Supplements
○	○	Medications (prescription and over-the-counter):

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Heng about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
_____		○	○			○	○

19. Are there any other hereditary health issues that you know about? _____

20. Social History

Tell Dr. Heng about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much?	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much?	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much?	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much?	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much?	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much?			

Hobbies: _____

Doctor's Initials

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21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

Signature _____ Date (MM/DD/YYYY) _____

Patient name _____

Consultation Notes

Doctor's Initials _____

Edmond Chiropractic Center
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Low Back Disability Questionnaire (Modified Oswestry)

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Name_____ **Date**_____

Instructions: Please check ***only*** **ONE BOX** in each section which **most closely** describes your problem.

Section 1 – Pain Intensity

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is severe.
- ❑ The pain is severe and does not vary much.

Section 2 – Personal Care (Wash, Dress, etc)

- ❑ I don't have to change my way of washing or dressing to avoid pain.
- ❑ I don't normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain I am unable to do some washing and dressing without help.
- ❑ Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it causes extra pain.
- ❑ Pain prevents me lifting heavy weights off the floor.
- ❑ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ❑ Pain prevents me lifting heavy weights but I manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at most.

Section 4 - Walking

- ❑ I have no pain on walking.
- ❑ I have some pain on walking but can still walk my normal distances.
- ❑ Pain prevents me from walking long distances.
- ❑ Pain prevents me from walking intermediate distances.
- ❑ Pain prevents me from walking even short distances.
- ❑ Pain prevents me from walking at all.

Section 5 – Sitting

- ❑ Sitting doesn't cause me any pain.
- ❑ I can sit as long as I need provided I have my choice of sitting surfaces.
- ❑ Pain prevents me from sitting more than 1 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.

PLEASE COMPLETE OTHER SIDE

Section 6 – Standing

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than 1 hour without increasing pain.
- ❑ I cannot stand for longer than ½ hour without increasing pain.
- ❑ I cannot stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain immediately.

Section 7 – Sleeping

- ❑ I have no pain while in bed.
- ❑ I have pain in bed but it does not prevent me from sleeping well.
- ❑ Because of pain I sleep only ¾ of normal time.
- ❑ Because of pain I sleep only ½ of normal time.
- ❑ Because of pain I sleep only ¼ of normal time.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but it increases the degree of pain.
- ❑ Pain prevents me from participating in more energetic activities e.g. sports, dancing.
- ❑ 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 the pain.

Section 9 – Traveling

- ❑ I get no pain while traveling.
- ❑ I get some pain when traveling, but none of my usual forms of travel make it any worse.
- ❑ I get some pain while traveling, but it does not compel me to seek alternate forms of travel.
- ❑ I get extra pain while traveling that requires me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

- ❑ My normal job / homemaking duties do not cause pain.
- ❑ My normal job / homemaking duties cause me extra pain, but I can still perform all that is required of me.
- ❑ I can perform most of my job / homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
- ❑ 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 chore.

Total _____ / 50 x 100 = _____% **File # _____**

Neck Pain & Disability Index (Vernon-Mior)

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Name_____ **Date**_____

Instructions: Please check ***only ONE BOX*** in each section 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 the **worst imaginable** at the moment.

Section 2 - Personal Care (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 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 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 to with **moderate** pain in my neck.
- ❑ I can't read as much as I want to because of moderate neck pain.
- ❑ 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 **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.

PLEASE COMPLETE THE OTHER SIDE

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 only 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** 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 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** hour sleepless).
❑ My sleep is **mildly** disturbed (**1-2** hours sleepless).
❑ My sleep is **moderately** disturbed (**2-3** hours sleepless).
❑ My sleep is **greatly** disturbed (**3-5** hours sleepless).
❑ My sleep is **completely** disturbed (**5-7** hours sleepless).

Section 10 - Recreation

❑ I am able to engage in all my recreation activities with **no** neck pain.
❑ 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.

Total_____ / 50 x 100 = _____% **File # _____**

Edmond Chiropractic Center **FINANCIAL POLICY**

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

PRIVATE PAY: (please initial one)

A_____ As I **have no insurance,** I agree to assume all responsibility to keep my account current by paying for services by cash, check or credit card when they are rendered.

B_____ I **have insurance,** but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time the services are rendered. I am requesting however that a "Super Bill" be provided to me which includes the diagnosis in order that I can submit it to my insurance company.

HEALTH INSURANCE: (please initial)

C_____ I would like this office to **bill my insurance company.** I understand I am responsible for the costs of treatment should my insurance company deny coverage for all or part of the claim submitted on my behalf. I understand that I will be required to pay all co-pays or co-insurance percentages as stated in my insurance plan contract. I also understand that when I have reached the maximum number of visits or dollar amount allowed by my insurance plan, I will be personally responsible for payment of any and all services rendered for the remainder of the year. I understand that all payments including deductibles, co-pays, co-insurance, and non-covered services are due at the time the service is rendered. (please be aware that our contract status with any insurance company is subject to change and you are advised to call your insurance company directly to determine your chiropractic benefits for this office.)

By accepting option (C), I assign all benefits for coverage with payment to be paid directly to this office and any checks received from my insurance company will be immediately endorsed over to this office for payment of service rendered to me. In the event of an overpayment by me, that amount will be refunded to me within 30 days.

By my signature, I request option _____ as the method by which I will pay for my services performed in this office.

Print Name:_____ **HR#** _____

Signature:_____ **Date:** _____

Staff Witness:_____ **Date:** _____