

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient _____ Age _____

Check ONE: _____ INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

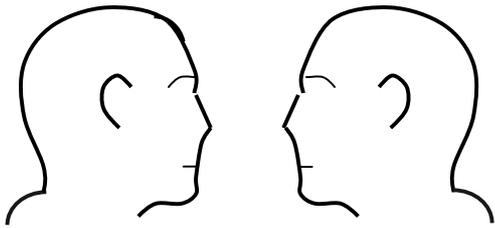
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right

Left

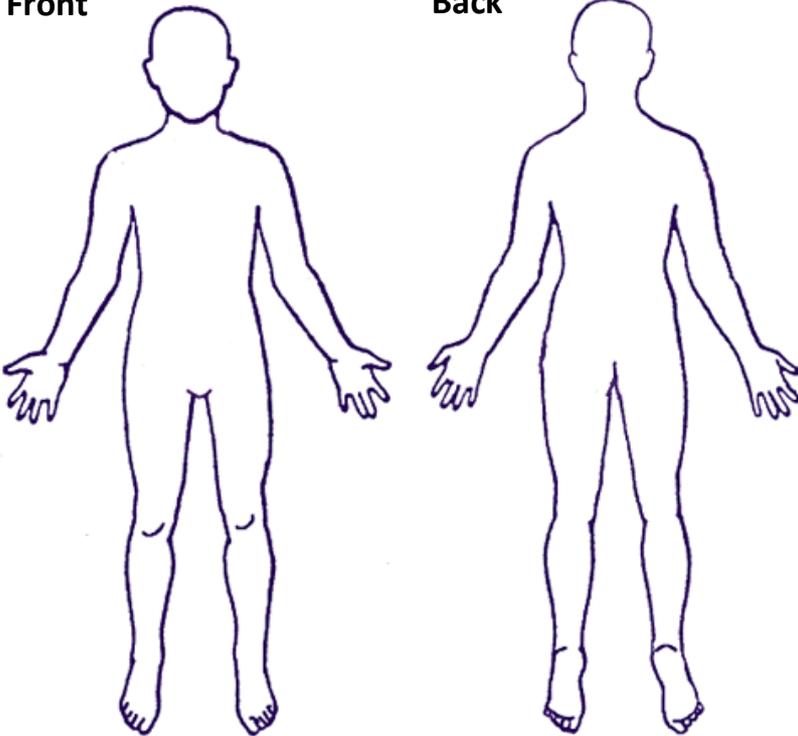


RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

Front

Back



- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

DATE

Chiropractic Case History/Patient Information

Date: _____ **Patient #** _____ **Doctor:** Stacey Myint, D.C.

Name: _____ **Social Security #** _____ **Home Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-mail address: _____ **Fax #** _____ **Cell Phone:** _____

Age: _____ **Birth Date:** _____ **Race:** _____ **Marital:** M S W D

Occupation: _____ **Employer:** _____

Employer's Address: _____ **Office Phone:** _____

Spouse: _____ **Occupation:** _____ **Employer:** _____

How many children? _____ **Names and Ages of Children:** _____

Name of Nearest Relative: _____ **Address:** _____ **Phone:** _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office if necessary? _____

Please check any and all insurance coverage that may be applicable in this case:

- Major Medical Worker's Compensation Medicaid Medicare Auto Accident
 Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. **The following person(s) have my permission to receive my personal health information:**

 Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

PATIENT NAME _____

DATE _____

Doctor: Stacey Myint, D.C.

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work___ Other_____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant? _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now

P = Previously

Headaches_____ Frequency _____
 Neck Pain _____
 Stiff Neck _____
 Sleeping Problems _____
 Back Pain _____
 Nervousness _____
 Tension _____
 Irritability _____
 Chest Pains/Tightness _____
 Dizziness _____
 Shoulder/Neck/Arm Pain _____
 Numbness in Fingers _____
 Numbness in Toes _____
 High Blood Pressure _____
 Difficulty Urinating _____
 Weakness in Extremities _____

Loss of Balance _____
 Fainting _____
 Loss of Smell _____
 Loss of Taste _____
 Unusual Bowel Patterns _____
 Feet Cold _____
 Hands Cold _____
 Arthritis _____
 Muscle Spasms _____
 Frequent Colds _____
 Fever _____
 Sinus Problems _____
 Diabetes _____
 Indigestion Problems _____
 Joint Pain/Swelling _____
 Menstrual Difficulties _____

PATIENT NAME _____

DATE _____

Doctor: Stacey Myint, D.C.

- | | | | |
|------------------------|-------|----------------------|-------|
| Breathing Problems | _____ | Weight Loss/Gain | _____ |
| Fatigue | _____ | Depression | _____ |
| Lights Bother Eyes | _____ | Loss of Memory | _____ |
| Ears Ring | _____ | Buzzing in Ears | _____ |
| Broken Bones/Fractures | _____ | Circulation Problems | _____ |
| Rheumatoid Arthritis | _____ | Seizures/Epilepsy | _____ |
| Excessive Bleeding | _____ | Low Blood Pressure | _____ |
| Osteoarthritis | _____ | Osteoporosis | _____ |
| Pacemaker | _____ | Heart Disease | _____ |
| Stroke | _____ | Cancer | _____ |
| Ruptures | _____ | Coughing Blood | _____ |
| Eating Disorder | _____ | Alcoholism | _____ |
| Drug Addiction | _____ | HIV Positive | _____ |
| Gall Bladder Problems | _____ | | |
| Ulcers | _____ | | |

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

- | | |
|----------------------------|-----------------------------|
| _____ Vigorous Exercise | _____ Family Pressures |
| _____ Moderate Exercise | _____ Financial Pressures |
| _____ Alcohol Use | _____ Other Mental Stresses |
| _____ Drug Use | _____ Other (specify)_____ |
| _____ Tobacco Use | _____ |
| _____ Caffeine | _____ |
| _____ High Stress Activity | |

PATIENT NAME _____

DATE _____

Doctor: Stacey Myint, D.C.

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
HighBlood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

**Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent
for Use of Health Information**

Name _____

Date _____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20____

By _____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____

Signature of Parent/Guardian (circle one)

Neck Index

Form N1-100

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 car 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

Back Index

Form B1100

rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back 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

- Ⓐ 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 very severe.
- Ⓡ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓡ Pain prevents me from sleeping at all.

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 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓡ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while 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 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓡ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓡ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases 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.

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.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓟ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓡ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓡ Pain restricts all forms of travel.

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 affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓡ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓡ My pain is rapidly worsening.

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

Back
Index
Score