# PERSONAL HISTORY

Date_____
Name_____ Address_____
City_____State_____Zip_____
Age _____ Sex_____ Birth Date _____S.S.#_____
Height _____Weight _____ Married/Partner – Separated – Single – Divorced – Widow
Ages of your children _____Referred to this office by_____
Occupation_____ Employer_____
Medical Doctor:_____ If needed, may we contact your doctor? Yes No
Name and phone number of person to contact in case of emergency other than your spouse or partner:
Name: _____ Phone: _____

**The United States Congress requests you answer these 3 questions:**
Race: _____ Hispanic: yes no Primary language:_____

**Please circle your 2 preferred contact choices:** Text Message to cell phone ? Yes No
**Email**: home _____work_____
**Phone** :home_____ cell _____work_____

Spouse or Partner or Parent: _____
S.S. #: _____ Birth Date:_____
Employer: _____work phone:_____

Who is responsible for your bill? **[ ]** Self **[ ]** Spouse **[ ]** Insurance Other:_____

## CHECK TYPE OF INSURANCE COVERAGE FOR THIS CONDITION:

**[ ]** Health Insurance (Group Policy) **[ ]** Personal Policy
**[ ]** Medicare **[ ]** Workman's Compensation
**[ ]** Automobile Insurance **[ ]** Other _____
If dually insured, which insurance is primary? _____

## REASON FOR CONSULTING THIS OFFICE:

**[ ]** I have no problem. I need to maintain my good health with regular Chiropractic treatments.
**[ ]** I have a problem now, and I need Chiropractic to help me reach my maximum health potential.
**[ ]** I have a problem now that I need help with. I want to learn how to prevent it in the future.
**[ ]** I have a problem, and I need help only with this specific problem.

## OPERATIONS: (Please date!)

Spinal _____ Heart_____ Appendectomy_____
Female Organs _____ Gall Bladder_____ Hernia_____
Others _____

## ACCIDENTS AND FALLS: (Please date and describe!) _____

_____

_____

## BROKEN BONES AND DISLOCATIONS: _____

_____

Patient: _____date of birth: _____

**Are you taking any medications? (Please name)** _____

_____

## PLEASE CIRCLE IF YOU EVER HAVE HAD……

Alcoholism
Anemia
Cancer
Diabetes
Dizziness
Epilepsy
Goiter
Heart disease
Hepatitis B
Implants
Mental disorder
Nervous breakdown
Osteoporosis
Pacemaker
Pleurisy
Pneumonia
Polio
Recent fractures
Rheumatic fever
Scarlet fever
Seizures
Spinal injection
Spinal tap
Stroke
T.I.A.
Tuberculosis
Rheumatoid arthritis
Joint replacements
Sexually transmitted disease
Plastic or metal plates

## PLEASE CIRCLE ALL THAT APPLY TO YOU……

### UPPER SPINE:

Neck Problems
Shoulder Problems
Elbow Problems
Wrist Problems
Hand Problems
Headaches Frequently
Headaches Occasionally
Eye Problems
Sinus Trouble
Ear Problems
Noises in Ears
Hay Fever
T.M.J. Problems

### MIDDLE SPINE:

Back Pain (problems)
Side Pain (ache)
Chest Pain (problems)
Abdominal Pain
Digestive Problems
Breathing Problems
Nausea
Constipation
Diarrhea
Anxiety Attacks
Gall Bladder Trouble
Colon Problems
Compression Fracture

### LOWER SPINE:

Low Back Problems
Hip Problems
Tail Bone Pain
Abdominal Pain
Groin Pain
Muscle Spasms
Kidney Problems
Urination Problems
Bed Wetting
Leg Problems
Knee Problems
Ankle/Foot Trouble
Sciatica
Spinal Disc Problems
Neuropathy
Foot Drop

### FOR WOMEN ONLY

Menstrual Problems
Excessive Flow
Hot Flashes
Irregular Cycle
Fertility Problems
Pregnant? Yes No

### PAIN DESCRIPTION:

Sharp pain on motion (joint)
Constant pain (joint or nerve)
Burning or Hot pain (nerve)
Sharp pain at rest (nerve)
Stabbing or shooting (nerve)
Tingling or numbness (nerve)
Cramp or knot pain (muscle)
Spasm pain (muscle)
Dull ache (muscle)
Throbbing pain (vascular)

Radiating dull or deep ache (referred ligament or muscle)

Deep burning or dull pain (bone/ligament)

Pin point or spot pain (myofascial trigger-point)

Crawling sensation (myofascitis)

**Date:** _____

_____

PATIENT'S OR GAURDIAN'S SIGNATURE

# REITER/GRAND CHIROPRACTIC OFFICES
# Consent for Chiropractic Services

## CONSENT FOR CHIROPRACTIC CARE:

I hereby request and consent to chiropractic treatment including physical examination, diagnostic x-rays, manipulations, meridian therapy (acupuncture) and various physical therapy by the doctors and staff of Reiter or Grand Chiropractic offices. I shall have the opportunity to discuss the nature, the purpose, and the cost of procedures before they are administered. I understand that results can never be guaranteed. I understand that in the practice of chiropractic, as in the practice of medicine, there are some risks which include sprains, disc injuries, dislocations, strokes, and fractures. I do not expect my doctor to be able to anticipate or explain all risks or complications. I wish to rely on the doctor to use judgment during my course of treatment which he/she believes is in my best interest. I have read or have had read to me this consent and may take the opportunity to ask questions whenever I choose. It is my intention that this consent apply to treatment at any time in the future when I decide to take treatment at Reiter or Grand Chiropractic offices.

_____ _____

**Patient's or Guardian's signature** **Date**

## CONSENT TO TREATMENT OF A MINOR (17 years old or less):

I authorize the doctors and staff at Reiter/Grand Chiropractic offices to administer chiropractic treatment as deemed necessary to

_____my_____(relationship to patient).

_____ _____

**Parent or guardian signature** **Date**

**Please note, the parent or guardian must accompany the minor for the first visit.**

## INSURANCE AUTHORIZATION and RELEASE:

Name of primary Insurance Company:_____

Secondary Insurance Company (if any): _____

I authorize payment of insurance benefits directly to the chiropractor or the office. I authorize the doctor to release all information to communicate with insurance personnel and other healthcare providers in order to secure the payment of benefits and/or the coordination of care. I understand that I am ultimately responsible for all costs of chiropractic treatment, regardless of insurance coverage. **I hereby promise to assist collections at this office by completing, signing, and mailing insurance forms when necessary.**

In so much as I have agreed to allow the use of my patient health information for the purpose of insurance payment and coordination of care, I am still entitled to privacy. I understand my rights to privacy are detailed in the "HIPPA NOTICE" which describes the policy and procedures of this office. This manual is available for my review at the receptionist desk.
**(If you want us to discuss your condition with a family member or friend, we need your permission to do so.)**

_____ _____

**Patient's or Guardian's signature** **Date**

# Oswestry Disability Index

This questionnaire has been designed to give the doctor information as to how your pain or condition has affected your ability to manage everyday life. Please answer every section and circle in each section **only the ONE number** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just circle the number that most closely describes your problem.

## Section 1: Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is very severe.
5. The pain is severe and does not vary much.

## Section 2: Personal Care

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain, I am unable to do some washing and dressing without help.
5. Because of the pain, I am unable to do any washing and dressing without help.

## Section 3: 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 manage if they are conveniently positioned (e.g., on a table).
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at the most.

## Section 4: Walking

0. I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than one mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than 1/4 mile without increasing pain.
5. I cannot walk at all without increasing pain.

## Section 5: Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than 1/2 hour
4. Pain prevents me from sitting more 10 minutes.
5. I avoid sitting because it increases pain right away.

**0-10 Minimal disability**

**11-20 Moderate disability**

**21-30 Severe disability**

**31-40 Crippled (incapacitated)**

**40-50 Bed-bound**

## Section 6: Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing, but it does not increase with time.
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain right away.

## Section 7: Sleeping

0. I get no pain in bed.
1. I get pain in bed, but it does not prevent me from sleeping well.
2. Because of pain, my normal night's sleep is reduced by less than 1/4.
3. Because of pain, my normal night's sleep is reduced by less than 1/2.
4. Because of pain, my normal night's sleep is reduced by less than 3/4.
5. Pain prevents me from sleeping at all.

## Section 8: Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal, but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

## Section 9: Traveling

0. I get no pain while travelling.
1. I get some pain while travelling, but none of my usual forms of travel makes it any worse.
2. I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while travelling, which compels me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

## Section 10: Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitively getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

**Patient's Signature:**

_____

**Date:**_____