DIB Chiropractic & Wellness

Chiropractors are doctors of the nervous system and our purpose is to remove any dysfunction by correcting the misalignments in your spine with an adjustment. When this dysfunction is removed it decreases pain and allows your body to function at 100%.

Don't wait until you are in pain to seek care, get your nervous system back on the road to maximum potential today!

Name: _____ **Preferred name:** _____

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

Home #: _____ **Cell #:** _____ **Work #:** _____

Email: _____ Preferred method of contact: □ Call cell □ Home □ Work □ Email

Birth Date: _____ **Age:** _____ **Sex:** □ **M** □ **F** □ Single □ Married □ Widowed □ Divorced □ Separated

Whom may we thank for referring you? _____

Occupation: _____ Employer: _____

Spouse/Guardian's Name: _____ Spouse/Guardian's Employer: _____

How many children? _____ Names & ages of Children: _____

Emergency contact and phone number: _____

Have you ever had Chiropractic Care? □ Y □N When? _____ How was your experience? _____

Please list any surgeries you have had and approximate dates: _____

_____

Medications you take now: □ Pain killer □ Anti-depressant □Insulin □ Birth Control □ Blood pressure □ Cholesterol

□ Other (please list): _____

_____

_____

Who is your Primary Care Physician (PCP): _____

When was your last visit with your PCP: _____

Please list any health concerns that you have had in the past, or you are having today that may or may not be related to the problem: _____

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____

Do you use any tobacco products?_____ Do you smoke?_____If so, packs per day: _____

Do you exercise?_____ If yes, what is the frequency and type of exercise?_____

What are your hobbies?_____

FAMILY HISTORY:

Do you have any family members who suffer from the same condition you do? If so, please list:_____

Do any of your family members suffer from? (Indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):
Tuberculosis____ Cancer____ Mental Illness____ Diabetes ____ Asthma____ Heart Disease ____

Stroke ____ Kidney Disease____ Lung Disease____ Arthritis_____ Liver Disease ____ Other _____

Patient Consent to X-ray

I, _____ authorize the performance of diagnostic x-ray examination of myself which the doctor may consider necessary or advisable in the course of my examination and treatment.

I, _____ authorize the performance of diagnostic x-ray examination of **my child** which the doctor may consider necessary or advisable in the course of my examination and treatment. The patient is a minor, _____ years of age. My relationship to the minor is _____.

Signature: _____ **Date:** _____

For all female patients: This is to certify that to the best of my knowledge I am NOT pregnant and the doctor has my permission to perform an x-ray evaluation. I am aware that x-ray can be hazardous to an unborn child.

Date of the first day of your last menstrual cycle: _____

□ Hysterectomy date: _____

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. By signing below you verify you have received a copy of the HIPAA Privacy Policy. If there is anyone you do not want to receive your medical records, please inform our office.

Signature: _____ **Print Name:** _____

Minor's Name: _____ **Date:** _____

ACCIDENT QUESTIONNAIRE

Name: _____ **Preferred name:** _____

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

Home #: _____ **Cell #:** _____ **Work #:** _____

Birth Date: _____ **Age:** _____ **Sex:** □ **M** □ **F**

Date of accident: _____ Time of accident: _____ Claim #: _____

Insurance contact name: _____ Phone number: _____

Insurance fax number: _____

Attorney name: _____ Phone number: _____

Attorney fax number: _____

City and state of accident: _____ Street of accident: _____

Road conditions at the time of accident: Wet Dry Icy Other

Were you taken to the hospital? _____ If yes, what hospital? _____

What type of treatment was received at hospital? _____

Have you had MRIs, CT scans or X-rays since accident? _____ If yes, what test was performed, what parts were studied, and where were they taken _____

1. Please describe, to the best of your knowledge, what happened during this accident.

   _____

   _____

   _____

   _____

2. Where were you seated in the vehicle? _____
3. What direction were **you** traveling? _____ On (name of street): _____
4. What direction was the **other** vehicle traveling? _____ On (name of street): _____
5. Where was impact on **your** vehicle? Front Back Left Side Right Side
6. Where was impact on the **other** vehicle? Front Back Left Side Right Side
7. Were you aware of the approaching collision or did it take you by surprise? _____

8. Did you lose consciousness or black out upon impact? Yes No How long? _____

9. Were you wearing a seatbelt? Yes No If yes, was it a shoulder-lap seatbelt or lap seatbelt? _____

10. Did the airbags deploy? Yes No If yes, did any body part hit the airbag? _____

11. Please describe if and how any body part hit any part of the vehicle? (ex: head hit steering wheel) _____

_____

12. Did you have any physical complaints **BEFORE THE ACCIDENT**? Yes No If yes, describe in detail _____

_____

13. Please describe how you felt:

    a. **During** the accident: _____

    b. **Immediately After** the accident: _____

    c. **Later** that day: _____

    d. The **Next** day: _____

    e. **Present** complaints and symptoms: _____

    _____

    f. Is the pain getting better, getting worse, or staying the same since it began? _____

    g. Please rate the pain on a scale from 1-10, where 1 is least severe and 10 is the most severe: _____

The following questions pertain to the vehicles involved in the accident:

1. Year, make and model of **your** vehicle: Year _____ Make _____ Model _____

2. Was **your** vehicle stopped at the time of impact? Yes No

   If yes, was your foot on the brake? Yes No

   If no, then estimate the speed of the vehicle you were in _____MPH

3. Were **you**: Slowing down? Yes No Gaining speed? Yes No Traveling steady? Yes No

4. Year, make and model of the **other** vehicle: Year _____ Make _____ Model _____

5. Was the **other** vehicle moving at the time of the collision? Yes No Approximate speed _____MPH

6. Was the **other** vehicle: Slowing down? Yes No Gaining speed? Yes No Traveling steady? Yes No

Have you notice any of the following symptoms **SINCE** the accident?

- ☐ Allergies/sinus problems
- ☐ Anxiety
- ☐ Asthma
- ☐ Blackouts
- ☐ Bladder troubles
- ☐ Blood Pressure problems
- ☐ Breathing difficulties
- ☐ Chest pain
- ☐ Clicking jaw
- ☐ Cold hands
- ☐ Cold feet
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty hearing
- ☐ Difficulty chewing
- ☐ Dislocations
- ☐ Dizziness
- ☐ Earaches
- ☐ Excessive sweating
- ☐ Eye strain
- ☐ Fatigue (tiredness)
- ☐ Fever
- ☐ Fractures
- ☐ General aches, pain or tension
- ☐ General stiffness
- ☐ Head and neck pain
- ☐ Headaches
- ☐ Heartburn
- ☐ Heaviness of head
- ☐ Inability to concentrate
- ☐ Increased reactions to drugs
- ☐ Insomnia (can't sleep)
- ☐ Irregular heartbeat
- ☐ Joint pain
- ☐ Light headedness
- ☐ Loss of balance
- ☐ Loss of hearing
- ☐ Loss of normal spinal contours
- ☐ Loss of smell
- ☐ Low back pain
- ☐ Mood swings or irritability
- ☐ Muscle atrophy (wasting or dying)
- ☐ Muscle spasms
- ☐ Muscle swelling
- ☐ Nausea
- ☐ Neck and shoulders feel tired
- ☐ Nervousness
- ☐ Night blindness
- ☐ Numbness or tingling of (Lt, Rt, B) arms
- ☐ Numbness or tingling of (Lt, Rt, B) feet
- ☐ Numbness or tingling of (Lt, Rt, B) hands
- ☐ Numbness or tingling of (Lt, Rt, B) legs
- ☐ Numbness or tingling of (Lt, Rt, B) shoulders
- ☐ Pain between the shoulders
- ☐ Pallor (pale, cold, and clammy)
- ☐ Palpitations (rapid heart beating)
- ☐ Pinched nerve
- ☐ Poor memory
- ☐ Restriction of neck motion
- ☐ Ringing in the ears
- ☐ Sensitivity to light
- ☐ Shortness of breath
- ☐ Stiff neck
- ☐ Stress
- ☐ Tension
- ☐ TMJ (jaw) pain
- ☐ Tremors (shaking)
- ☐ Other (describe below)

_____

_____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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.

Neck Index Score

Oswestry Low Back Pain Scale

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 circle the **ONE NUMBER** in each section which 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 severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
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 increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase 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 gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me 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 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 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ 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 sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

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 1 hour without increasing pain.
3. I cannot stand for longer than ½ 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 immediately.

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 nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
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 it 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 when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____