Patient Health History

Name: _____

Address: _____

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

Home Phone: _____-_____-_____ **Work Phone:** _____-_____-_____

Cell Phone: _____-_____-_____

Email Address: _____ ☐ I opt out of electronic access

What is your preferred method of communication? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Date of Birth: _____ **Social Security #:** _____-_____-_____ **Gender:** Male - Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Occupation: _____

Employer: _____

Employer Address: _____

Emergency Contact Name: _____ **Relation:** _____

Emergency Contact Phone Number: _____ - _____ - _____

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Island ☐ White ☐ Decline to Provide

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Provide

Preferred Language: _____

Security Question: Please select and mark a question. Answer accordingly (*Answer must be at least 6 characters long)

Question:	**Answer:**
☐ What is your mother's maiden name?	
☐ What is your pet's name?	_____
☐ In what city were you married?	
☐ In what city did you go to school?	
☐ In what city were you born?	
☐ What is your favorite car?	
☐ Where were you on 9/11?	

Name of Insurance Company: _____

Policy #: _____ **Group #:** _____

Policy Holders Name: _____ **DOB:** _____

Social Security #: _____ - _____ - _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to O'Keefe Chiropractic Center all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Do you smoke? ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never Smoker

Do you drink alcohol? ☐ No ☐ Yes – How many per day? _____

Do you drink caffeine? ☐ No ☐ Yes – How many per day? _____

Do you have a high stress level? ☐ No ☐ Yes – Why? _____

Do you exercise? ☐ No ☐ Yes (what forms and how often): _____

What is your level of activity at work? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bee Stings ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex
☐ Molds ☐ Penicillin ☐ Ragweed/Pollen ☐ Rubber ☐Seasonal ☐ Shellfish ☐ Soaps ☐ Wheat
☐ X-Ray Dye ☐ Other:

List any **Surgeries:**	**Broken Bones:**	**Head Injuries:**	**Falls:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please Select **ALL Past Medical History** conditions:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Ankle Pain	☐ Anorexia
☐ Appendicitis	☐ Arm Pain	☐ Arthritis	☐ Asthma	☐ Back Pain
☐ Bleeding Disorders	☐ Broken Bones	☐ Bulimia	☐ Cancer	☐ Cataracts
☐ Chest Pain	☐ Chicken Pox	☐ Depression	☐ Diabetes	☐ Dizziness
☐ Elbow Pain	☐ Emphysema	☐ Epilepsy	☐ Eye Problems	☐ Fainting
☐ Fatigue	☐ Foot Pain	☐ Fractures	☐ Glaucoma	☐ Genetic Spinal Condition
☐ Gout	☐ Hand Pain	☐ Headaches	☐ Hearing Problems	☐ Heart Disease
☐ Hepatitis	☐ Hernia	☐ Herniated Disk	☐ Hypertension	☐ High Cholesterol
☐ Hip Pain	☐ HIV	☐ Jaw Pain	☐ Joint Stiffness	☐ Knee Pain
☐ Kidney Disease	☐ Leg Pain	☐ Liver Disease	☐ Measles	☐ Mid-Back Pain
☐ Migraines	☐ Miscarriage	☐ Mononucleosis	☐ Multiple Sclerosis	☐ Mumps
☐ Neck Pain	☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's	☐ Pinched Nerve
☐ Pneumonia	☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care
☐ Rheumatoid Arthritis	☐ Rheumatic Fever	☐ Scarlet Fever	☐ Shoulder Pain	☐ Significant Weight Change
☐ Spinal Cord Injury	☐ Sprain/Strain	☐ Stroke	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors, growths	☐ Ulcers	☐ Whooping Cough	☐ Other

List all **Medications** you are currently taking and the reason: (Example: Ibuprofen – Pain)

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any medications: ☐ No ☐ Yes _____

List your **Family History:**

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer

☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition

☐ High Blood Pressure ☐ Heart Problems ☐ Multiple Sclerosis ☐ Neurological Problems

☐ Parkinson's ☐ Polio ☐ Prostate Problems ☐ Stroke/Heart Attack

Please list all family members who had/has any of the problems above: Example: Mother – High blood pressure

_____ _____

_____ _____

_____ _____

Is your condition due to an <u>Accident</u>? ☐ No ☐ Yes Date: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable): _____

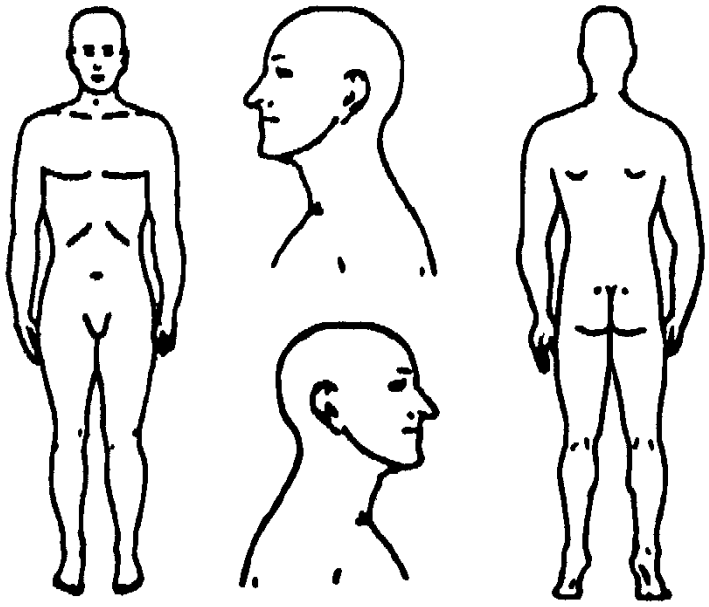
What was the date of your last physical examination: _____

Have you ever had chiropractic care? ☐No ☐ Yes – Where? _____

Why? _____ When was your last visit?_____

Were X-Rays taken? ☐ Yes ☐ No

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

What is your **CHIEF** complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)?_____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

If present, what is your **SECOND** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

If present, what is your **NEXT** complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Signature of Patient: _____ **Date:** _____

----------**To Be Completed by Office Staff**----------

Vitals:

Height: _____ Weight: _____ Blood Pressure: _____/_____ Arm Used: **L** or **R**

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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

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 very severe and does not vary much.

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 sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

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 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while 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 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 pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 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.

Personal Care

⓪ I do 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.

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

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect 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.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall 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.

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

Back Index Score

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.

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

Neck Index Score _____