Beaumont Chiropractic Case History/Patient Information

Date: ___________________ Patient #___________ **Doctor:** ____________________

Name: ___________________________________ SSN #__________________ Home Phone: ___________________

Address: ____ City: ____________________ State: ______ Zip: __________

E-mail address: ____ Cell Phone: _______________________________

Age: ______ Birth Date: ____________________ Race: ________________________ Marital: M S W D (circle one)

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: _______________________ Clinic Name: _____________________ Phone: ________________

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No (circle one)

HISTORY OF PRESENT 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: ________________

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Dizziness	__Circulatory
__Circulatory Problems	__Epilepsy	__Alcoholism	__Backaches	__Hypertension
__Arthritis	__Pace Maker	__Drug Addiction	__Heart Trouble	__Neuritis
__Rheumatoid Arthritis	__Strokes	__HIV Positive	__Diabetes	__Anemia
__A Congenital Disease	__Seizures/Convulsions	__Gall Bladder	__Sinus Trouble	__Hernia
__Excessive Bleeding	__Ruptures	__Depression	__Headaches	__Cancer
__High/Low Blood Pressure	__Coughing Blood	__Ulcers	__Nervousness	
__Numbness	__Asthma	__ Rheumatic Fever	__Digestive Disorders	

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

____

Has a physician treated you for any health condition in the last year? Yes No (circle one)

If yes, describe: ____

What medications or drugs are you taking? ____

____

Do you have any allergies to any medications? Yes No (circle one)

If yes, describe: ____

Do you have any allergies of any kind? Yes No (circle one)

If yes, describe: ____

Please list any other health problems you have, no matter how insignificant they may be: ____

____

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 take vitamin supplements? ________ If so, please list: ________________________________
Do you consume caffeine? ________ If so, how much per day: ________________________________
Do you exercise? ________ If yes, what is the frequency and type of exercise? ______________________
What are your hobbies? ____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting _____% Sitting _____% Bending _____% Working at a computer_____%

FAMILY HISTORY:

Parents:
Father: living____ deceased____ (check one) Current age if still living: ______
Cause of death and age at death if deceased: ______________________________________
Mother: living____ deceased____ (check one) Current age if still living: ______
Cause of death and age at death if deceased: ______________________________________

Check if applicable to you: ____ As an adopted child, little is known of my birth parents or family.

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

FAMILY DISEASES (if applicable, 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____________	

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

__Major Medical Insurance __Worker's Compensation Insurance __Medicaid __Medicare __Medicare Supplement Plan

__Auto Accident Insurance __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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:____ Date:________________

Guardian's Signature Authorizing Care:________________________________ Date:________________

SUMMARY:

1. What is your major symptom? ______________________________
2. What does this prevent you from doing or enjoying?______________________________
3. If this is a recurrence, when was the first time you noticed this problem?______________________________
   How did it originally occur?______________________________
   Has it become worse recently? Yes No Same Better Gradually Worse (circle one) Other ____________
   If yes, when and how? ______________________________
4. How frequent is the condition? Constant Daily Intermittent Night Only (circle one) Other ____________
   How long does it last? All Day Few Hours Minutes (circle one) Other______________________________
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes No (circle one) If yes, describe: ______________________________
   Are there other unrelated health problems? Yes No (circle one) If yes, describe ____________________
   ____
6. Describe the pain: (circle all that apply) Sharp Dull Numbness Tingling Aching Burning Stabbing Other
   If Other, discribe:______________________________
7. Is there anything you can do to relieve the problem? Yes No (circle one) If yes, describe ____________
   ____________________. If no, what have you tried to do that has not helped? ____________________
   ____
8. What makes the problem worse? (circle all that apply) Standing Sitting Lying Bending Lifting Twisting Other
   If Other, describe:______________________________
9. List any major accidents you have had other than those that might be mentioned above: ____________
   ____
10. Remarks: ______________________________
    ____
    ____

NO SYMPTOMS ______________________________ EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

11. **WOMEN ONLY:** Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____

Doctor's Signature ______________________________ Date ________________

BEAUMONT CHIROPRACTIC CLINIC
INFORMED CONSENT FOR CHIROPRACTIC CARE

In coming to the Chiropractic Physician, a patient gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if a physician at Beaumont Chiropractic Clinic accepts me as a patient, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: ______________________________ Date: __________________

FINANCIAL POLICY FOR YOUR FIRST VISIT

Welcome to our office! We're happy you have chosen Chiropractic for your health care needs. Your health is your greatest asset and therefore one of the best things you can invest in financially.

YOUR FIRST VISIT:

All services rendered during the first visit **must** be paid for at that time. Patients without insurance coverage may pay by cash, check, electronic debit or credit card. Patients with insurance can pay for their deductible and/or co pay by cash, check, electronic debit or credit card provided their coverage has been verified. Patients with insurance that has not been verified are on a cash basis until coverage is confirmed. If this results in an overpayment, **we will credit your account or reimburse you when our office receives final payment from the carrier and care has been completed.**

I have read, understood and agree to abide by the terms of this office's Financial Policy for my first visit. Any portion of this agreement that is found to be void or invalid will have no effect on other portions of this agreement.

Patient's Printed Name: ______________________________

Patient's Signature: ______________________________

Date: ______________________________

Beaumont Chiropractic

Patient Name: Date:

HEADACHE DISABILITY INDEX

NAME: ______________________ DATE: ________ AGE: ________ Scores Total: ______; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. **I have headache: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than one per week**
2. **My headache is: [1] mild [2] moderate [3] severe**

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	☐	☐	☐
F2. Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
E3. No one understands the effect my headaches have on my life.	☐	☐	☐
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	☐	☐	☐
E5. My headaches make me angry.	☐	☐	☐
E6. Sometimes I feel that I am going to lose control because of my headaches.	☐	☐	☐
F7. Because of my headaches I am less likely to socialize.	☐	☐	☐
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel I am going to go insane.	☐	☐	☐
E10. My outlook on the world is affected by my headaches.	☐	☐	☐
E11. I am afraid to go outside when I feel that a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14. My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15. I avoid being around people when I have a headache.	☐	☐	☐
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
F17. I am unable to think clearly because of my headaches.	☐	☐	☐
F18. I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
F19. I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20. I feel irritable because of my headaches.	☐	☐	☐
F21. I avoid traveling because of my headaches.	☐	☐	☐
E22. My headaches make me feel confused.	☐	☐	☐
E23. My headaches make me feel frustrated.	☐	☐	☐
F24. I find it difficult to read because of my headaches.	☐	☐	☐
F25. I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital headache disability inventory (HDI). Neurology 1994;44:837-842.

Beaumont Chiropractic

Patient Name: Date:

NECK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing,Dressing,etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration/

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

NECK DISABILITY QUESTIONNAIRE

Pain Severity Scale: Rate the severity of your pain by checking one box on the following scale

No pain	1	2	3	4	5	6	7	8	9	10	Extreme Pain

Beaumont Chiropractic

425 North 4th St., Beaumont, TX 77701

Patient Name: Date:

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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

SECTION 1 - Pain Intensity **A The pain comes and goes and is very mild.** **B The pain is mild and does not vary much.** **C The pain comes and goes and is moderate.** **D The pain is moderate and does not vary much.** **E The pain comes and goes and is severe.** **F The pain is severe and does not vary much.**	*SECTION 6 - Standing* **A I can stand as long as I want without pain.** **B I have some pain while standing, but it does not increase with time.** **C I cannot stand for longer than one hour without increasing pain.** **D I cannot stand for longer than 1/2 hour without increasing pain.** **E I cannot stand for longer than ten minute without increasing pain.** **F I avoid standing, because it increases the pain straight away.**
SECTION 2 - Personal Care **A I would not have to change my way of washing or dressing in order to avoid pain.** **B I do not normally change my way of washing or dressing even though it causes some pain.** **C Washing and dressing increases the pain, but I manage not to change my way of doing it.** **D Washing and dressing increases the pain and I find it necessary to change my way of doing it.** **E Because of the pain, I am unable to do some washing and dressing without help.** **F Because of the pain, I am unable to do any washing or dressing without help.**	*SECTION 7 - Sleeping* **A I get no pain in bed.** **B I get pain in bed, but it does not prevent me from sleeping well.** **C Because of pain, my normal night's sleep is reduced by less than one than one quarter.** **D Because of pain, my normal night's sleep is reduced by less than one-half.** **E Because of pain, my normal night's sleep is reduced by less than three-quarters.** **F Pain prevents me from sleeping at all.**
SECTION 3 - Lifting **A I can lift heavy weights without extra pain.** **B I can lift heavy weights, but it causes extra pain.** **C Pain prevents me from lifting heavy weights off the floor.** **D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.** **E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.** **F I can only lift very light weights, at the most.**	*SECTION 8 - Social Life* **A My social life is normal and gives me no pain.** **B My social life is normal, but increases the degree of my pain.** **C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.** **D Pain has restricted my social life and I do not go out very often.** **E Pain has restricted my social life to my home.** **F I have hardly any social life because of the pain.**
SECTION 4 - Walking **A Pain does not prevent me from walking any distance.** **B Pain prevents me from walking more than one mile.** **C Pain prevents me from walking more than 1/2 mile.** **D Pain prevents me from walking more than 1/4 mile.** **E I can only walk while using a cane or on crutches.** **F I am in bed most of the time and have to crawl to the toilet.**	*SECTION 9 - Traveling* **A I get no pain while traveling.** **B I get some pain while traveling, but none of my usual forms of travel make it any worse.** **C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.** **D I get extra pain while traveling which compels me to seek alternative forms of travel.** **E Pain restricts all forms of travel.** **F Pain prevents all forms of travel except that done lying down.**
SECTION 5 - Sitting **A I can sit in any chair as long as I like without pain.** **B I can only sit in my favorite chair as long as I like.** **C Pain prevents me from sitting more than one hour.** **D Pain prevents me from sitting more than 1/2 hour.** **E Pain prevents me from sitting more than ten minutes.** **F Pain prevents me from sitting at all.**	*SECTION 10 - Changing Degree of Pain* **A My pain is rapidly getting better.** **B My pain fluctuates, but overall is definitely getting better.** **C My pain seems to be getting better, but improvement is slow at present.** **D My pain is neither getting better nor worse.** **E My pain is gradually worsening.** **F My pain is rapidly worsening.**

LOW BACK DISABILITY QUESTIONNAIRE

Pain Severity Scale: Rate the severity of your pain by checking one box on the following scale

No pain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Extreme Pain**

Beaumont Chiropractic

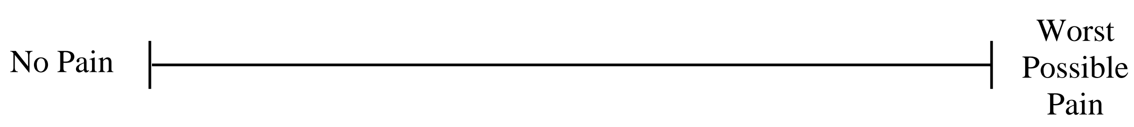
PAIN DRAWING

Name ______________________________ **Date** ____________________

Using the following descriptive symbols, draw the location of your pain on body outlines below. In addition, mark the level of your pain on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
	====	OOOO	…………….	///////////	XXX

No Pain



Worst Possible Pain

Please make a slash through this line as to the level of your pain.

____

Patient Signature