Spine By Design | Chiropractic
www.spinebydesign.net
Patient Health Information

Name: Todays Date:
Address: Home Phone:
Mobile:
Date of Birth: Referred By:
Marital Status:
Gender: ◯ M ◯ F
Email: Occupation:
Emergency Contact: Student Status:
Emergency Contact Phone:

Insurance Information:
◯ Private Insurance ◯ Medicare ◯ Workers Comp ◯ Auto Accident ◯ Self Pay / Cash ◯ Medicaid
Insurance Carrier:
Insurance ID:

Primary Care Doctor: Primary Care Tel:
Would you like us to communicate the results of your exam to your primary care team? ◯ Yes ◯ No

## Financial Policy

- Payment for services is due at the time services are rendered.
  - We accept Cash, Checks, and all Major Credit Cards.
- All charges are your responsibility whether your insurance company pays or not.
  - Not all services are a covered benefit. Benefits may vary by plan. We work hard to ensure you are aware ahead of time what services may be covered or not covered. *All services are subject to your deductible*.
  - Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.
  - Covered charges may be your responsibility because of your Copay, Coinsurance, and Deductible.
  - Some services in this office may not be covered by your plan. If they are non covered services, they will be your responsibility. We will endeavor to identify these prior to rendering care, but it is not always possible due to the considerable number of plans. Please ask the Dr. if you have any questions regarding finances.
- Do you need a referral to this office under your plan? If so, please contact your primary care provider. Should your plan require a referral, and you do not have one, charges incurred will be your responsibility.
- This office does not routinely send paper invoices for balances due. We will send electronic invoices via email should a balance come due after you have concluded your care in this office.

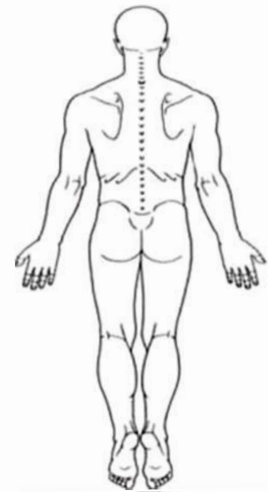
Patient's Signature: (parent if minor) ______________________________ Date: _____________

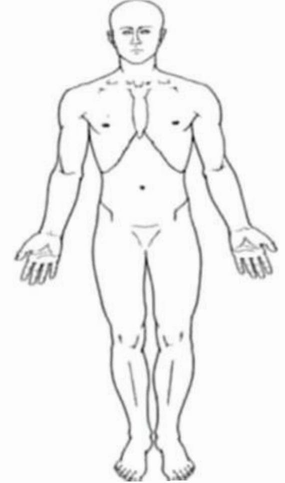
Primary Complaint:
Refers/Radiates into:
This problem is preventing me from:
Getting: ◯ Worse ◯ Better ◯ No Change How Long?:
Began by: ◯ Fall ◯ Trauma ◯ Work ◯ Other (describe):
Past Treatment to this area:
◯ Surgery ◯ Injections ◯ Chiropractic ◯ Other (describe):
Current Pain Level – ◯1 (least) ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (worst)

Secondary Complaint:
Refers/Radiates into:
This problem is preventing me from:
Getting: ◯ Worse ◯ Better ◯ No Change How Long?:
Began by: ◯ Fall ◯ Trauma ◯ Work ◯ Other (describe):
Past Treatment to this area:
◯ Surgery ◯ Injections ◯ Chiropractic ◯ Other (describe):
Current Pain Level – ◯1 (least) ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (worst)

Additional Complaint:
Refers/Radiates into:
This problem is preventing me from:
Getting: ◯ Worse ◯ Better ◯ No Change How Long?:
Began by: ◯ Fall ◯ Trauma ◯ Work ◯ Other (describe):
Past Treatment to this area:
◯ Surgery ◯ Injections ◯ Chiropractic ◯ Other (describe):
Current Pain Level – ◯1 (least) ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (worst)

Indicate your symptoms:





Current Medications: ◯ None

Current Allergies: ◯ None

Past Surgeries: ◯ None

Current Illnesses: ◯ None

Major Injuries / Trauma: ◯ None

Illnesses of Immediate Family:

Deaths of Immediate Family:

Level of Education Completed:
Smoking: ◯ Current ◯ Former ◯ Never
How Much?
Alcohol: ◯ Current ◯ Former ◯ Never
How Much?
Rec. Drugs: ◯ Current ◯ Former ◯ Never
Which Ones?

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet)*

| Musculoskeletal | | |
|---|---|---|
| NOW | Past | |
| ○ | ○ | Back Pain |
| ○ | ○ | Sciatica |
| ○ | ○ | Neck Pain |
| ○ | ○ | Headaches |
| ○ | ○ | Migraines |
| ○ | ○ | Knee Pain |
| ○ | ○ | Hip Pain |
| ○ | ○ | Elbow Pain |
| ○ | ○ | Ankle Pain |
| ○ | ○ | Other: |
| | | |
| General | | |
| ○ | ○ | Lethargy / Weakness |
| ○ | ○ | Recurring Fever |
| ○ | ○ | Weight Loss |
| ○ | ○ | Weight Gain |
| ○ | ○ | Dizziness |
| ○ | ○ | Fever / Chills |
| ○ | ○ | Other: |
| Respiratory | | |
| ○ | ○ | Persistent Cough |
| ○ | ○ | Spitting Up Blood |
| ○ | ○ | Asthma / Wheezing |
| ○ | ○ | Shortness of Breath |
| ○ | ○ | Sleep Apnea |
| ○ | ○ | Emphysema |
| ○ | ○ | Pneumonia |
| ○ | ○ | Other: |
| Blood /Lymph | | |
| ○ | ○ | Anemia |
| ○ | ○ | Bleeding |
| ○ | ○ | Bruising |
| ○ | ○ | Blood Clots |
| ○ | ○ | Transfusions |
| ○ | ○ | Leukemia |
| ○ | ○ | Lymphoma |
| ○ | ○ | HIV / AIDS |
| Urinary | | |
| ○ | ○ | Painful / Frequent |
| ○ | ○ | Incontinence |
| ○ | ○ | Blood in Urine |
| ○ | ○ | Kidney Stones |
| ○ | ○ | Urinary Infections |
| Male | | |
| ○ | ○ | Dribbling |
| ○ | ○ | Prostate Disease |
| ○ | ○ | Erectile Dysfunction |
| ○ | ○ | Other: |
| Female | | |
| ○ | ○ | Menstrual Pain / Irreg. |
| ○ | ○ | Infertility |
| ○ | ○ | Menopause |
| ○ | ○ | Pregnancy |
| ○ | ○ | Discharge |
| ○ | ○ | Other: |
| | | |

| Head / Ears / Nose / Throat | | |
|---|---|---|
| NOW | Past | |
| ○ | ○ | Headaches |
| ○ | ○ | Migraines |
| ○ | ○ | Vision Problems |
| ○ | ○ | Glasses/Contacts |
| ○ | ○ | Cataracts |
| ○ | ○ | Glaucoma |
| ○ | ○ | Nosebleeds |
| ○ | ○ | Sinus Problems |
| ○ | ○ | Hoarseness |
| ○ | ○ | Hearing Problems |
| ○ | ○ | Swollen Glands |
| ○ | ○ | Dental Problems |
| ○ | ○ | TMJ |
| ○ | ○ | Other: |
| Gastro Intestinal | | |
| ○ | ○ | Loss of Appetite |
| ○ | ○ | Nausea / Vomiting |
| ○ | ○ | Diarrhea |
| ○ | ○ | Constipation |
| ○ | ○ | Abdominal Pain |
| ○ | ○ | Ulcer |
| ○ | ○ | Bloating / Cramping |
| ○ | ○ | Heartburn |
| ○ | ○ | GERD / Reflux |
| ○ | ○ | Hemorrhoids |
| ○ | ○ | Hepatitis |
| ○ | ○ | Cirrhosis |
| ○ | ○ | Liver Disease |
| ○ | ○ | Gallbladder Prob. |
| ○ | ○ | Blood in the stool |
| ○ | ○ | Colon Cancer |
| ○ | ○ | IBS |
| ○ | ○ | Chron’s |
| ○ | ○ | Colitis |
| ○ | ○ | Other: |
| Allergies | | |
| | | |
| | | |
| ○ | ○ | Medication |
| ○ | ○ | Food |
| ○ | ○ | Other: |
| Skin / Hair | | |
| | | |
| ○ | ○ | Flushing |
| ○ | ○ | Eczema |
| ○ | ○ | Skin Cancer |
| ○ | ○ | Easily Bruised |
| ○ | ○ | Other: |
| Psychiatric | | |
| | | |
| ○ | ○ | Parkinsons |
| ○ | ○ | Insomnia |
| ○ | ○ | Concentration Diff. |
| ○ | ○ | Memory Loss |
| ○ | ○ | Depression |
| ○ | ○ | Suicidal Thoughts |
| ○ | ○ | Other: |

| Neurological | | |
|---|---|---|
| NOW | Past | |
| ○ | ○ | Freq. Headache |
| ○ | ○ | Migraines |
| ○ | ○ | Dizziness |
| ○ | ○ | Fainting |
| ○ | ○ | Poor Balance |
| ○ | ○ | Numbness |
| ○ | ○ | Tingling |
| ○ | ○ | Seizures |
| ○ | ○ | Stroke |
| ○ | ○ | Tremors |
| ○ | ○ | Sleep Problems |
| ○ | ○ | Weak Muscles |
| ○ | ○ | Loss of smell |
| ○ | ○ | Loss of Vision |
| ○ | ○ | Other: |
| | | |
| Cardiovascular | | |
| ○ | ○ | Chest Pain |
| ○ | ○ | Heart Attack |
| ○ | ○ | Shortness of Breath |
| ○ | ○ | Palpitation |
| ○ | ○ | Swelling of Hands / Feet |
| ○ | ○ | High Blood Pressure |
| ○ | ○ | High Cholesterol |
| ○ | ○ | Murmur |
| ○ | ○ | Blood Clots |
| ○ | ○ | Valve Prolapse |
| ○ | ○ | Stent |
| ○ | ○ | Pacemaker |
| ○ | ○ | Heart Disease |
| ○ | ○ | Vascular disease |
| ○ | ○ | Other: |
| Endocrine | | |
| ○ | ○ | Diabetes |
| ○ | ○ | Thyroid Dz. |
| ○ | ○ | Sweating |
| ○ | ○ | Heat Intolerant |
| ○ | ○ | Cold Intolerant |
| ○ | ○ | Weight Loss |
| ○ | ○ | Weight Gain |
| ○ | ○ | Frequent Urination |
| ○ | ○ | Excessive Thirst |
| ○ | ○ | Change in appetite |
| ○ | ○ | Hair Changes |
| ○ | ○ | Hair falling out |
| ○ | ○ | Hyperthyroid |
| ○ | ○ | Hypothyroid |
| ○ | ○ | Hormonal imbalance |
| ○ | ○ | Steroid Treatment |
| ○ | ○ | Hormone Replacement |
| | | |
| | | |

# Patient Disclosures and Consent:

**Appointment Reminders Preferences:**

- ☐ I would like to receive appointment reminders via automated email / text the day before my appointment.
  - Email Address for Reminders: ________________________________________
  - Cell Phone for Text Reminders: ________________________________________

**Contact from This Office:**

- ☐ As part of your care you may receive occasional telephone, mail and email correspondence.
- ☐ We do not make calls regarding upcoming appointments. Should you wish to receive a reminder, please sign up for email reminders.
- ☐ We do not routinely send out statements via mail. This office uses electronic invoicing, should a balance be due at a time when you are not in the office personally. Payment may be made via the link in the email.

Patient's Signature: (parent if minor) ________________________________________ Date: ____________

**HIPAA Notice:**

I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operation, 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 a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for 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: (parent if minor) ________________________________________ Date: ____________

**Informed Consent for Chiropractic Treatment:**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by Spine By Design Chiropractic, and Dr. Thomas White. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, however remote, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature: (parent if minor) ______________________________________ Date: ______________

# Neck Index

**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.

### 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.

### 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).

### 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.

### 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.

### 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.

### 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.

### 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.

### 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.

### 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

**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*