Lakeside Chiropractic Clinic

Confidential Patient Data **This information will become part of your Electronic Health Records**
(If you need more space for an answer, please use back of page)

PATIENT INFORMATION Today's Date: _____

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security # last 4: _____ Age: _____ Male Female
Home Phone: _____ Work Phone: _____
E-Mail: _____ Cell Phone: _____
Marital Status: Married Single Divorced Separated Other _____
Name of Spouse or Nearest Relative: _____ Phone: _____
Your Occupation _____ Your Employer: _____
Referred to this Office by: Friend/Family Member - Name? _____
Payment for Services will be by: Cash Check Credit Card
Automobile Insurance Worker's Compensation Health Insurance
Name of Insurance Co.: _____ Insured's Employer: _____
Insured's ID number#: _____ Employer's Phone #: _____
Are you covered by more than one insurance company? Yes No Name _____

CURRENT HEALTH CONDITION

Purpose of this appointment: _____
When did this condition begin: l_____/_____/_____ _____
If disabled from work please give date: _____/_____/_____ _____

_____
Job related; Auto related; Sports related; Personal; Other _____
Drugs you now take: Nerve Pills: Pain Killers; Muscle Relaxers; Blood Pressure Medicine; Insulin; Other

_____
Other Doctors seen for this _____
condition: Dates & Describe: _____

_____

_____
Have you been treated for any health condition by a physician in the last year? Y N
Date:_____ Describe _____
Patient's Weight: _____lb; Height: ____ ft _____ in; Are you pregnant? ☐ Y ☐ N Remarks and additional information you would like the Doctor to know: _____

PAST HEALTH HISTORY

Please check or describe:
Major Surgery/Operations: ☐ Appendectomy; ☐ Broken Bones, ☐ Gall Bladder; ☐ Heart, ☐ Hernia; ☐ Hysterectomy
☐ Tonsillectomy; ☐ Other _____
Major Accidents or Falls dates: (include all auto accidents): _____
Hospitalizations (other than above): _____

_____
Previous Chiropractic Care: ☐ Yes ☐ No
Doctor's name: _____ approximate date of last visit: ____/____/____

VACCINATIONS & INJECTIONS:

☐ Smallpox ☐ Mumps ☐ Swine Flu ☐ D.P.T. ☐ Polio ☐ Spinal tap injection
Other: _____

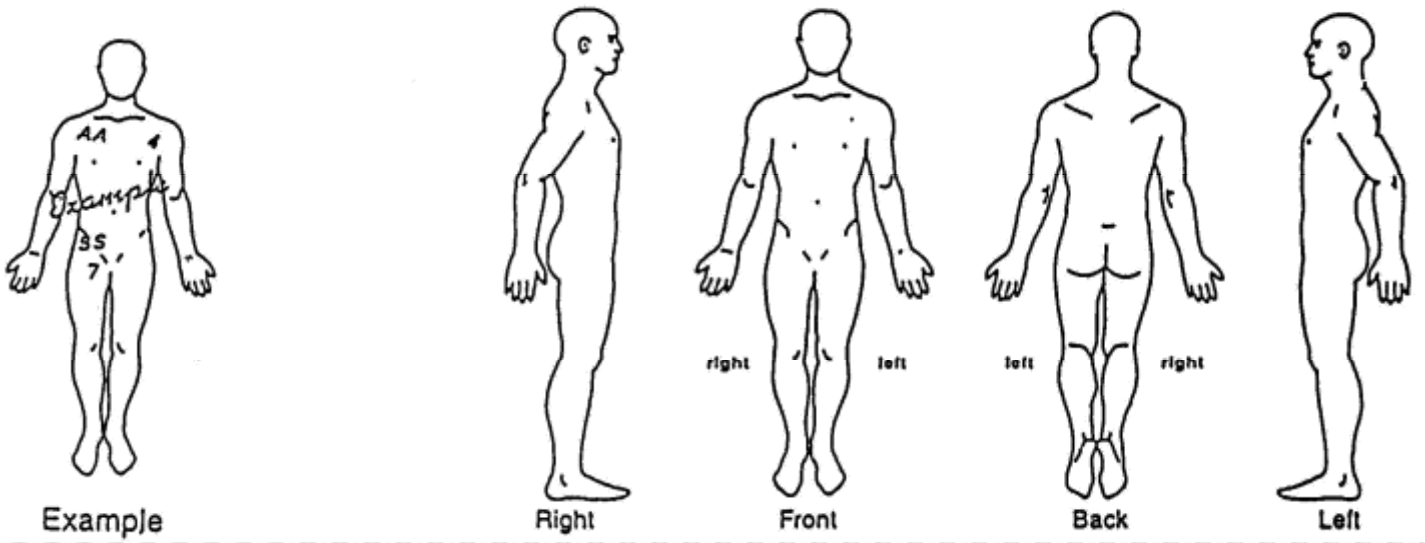
LSCC PATIENT SUBJECTIVE REVIEW

INSTRUCTIONS: Please **Check** the most appropriate response. Sign and date when sides completed.

1. The problem is the result of: a long time condition personal injury auto accident work injury other ____

2. It began on (date) __ / ___ / ___ with a sudden or gradual onset. Worse in the Morning Afternoon Night

3. On the diagram below indicate where your symptoms are located as shown in the **EXAMPLE**. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from **1** (discomfort) to **10** (extreme pain)
NN = Numbness **PP** = Pin & Needles **BB** = Burning **AA** = Aching **SS** = Stabbing



4. Currently my symptoms are aggravated by? Coughing Sneezing Straining at Stool Reaching Lifting Bending Sitting Standing Walking Movement Other _____

5. Currently my symptoms are relieved by? Nothing Rest Ice Stretching Sitting Standing Heat Lying Exercising Walking Other _____

6. Since my symptoms began, I have noticed a change in; Bowel Function Bladder Function Sexual Function

7. I feel limited in moving my neck arms low back legs other _____

8. I feel weakness in my arms hands legs feet other _____

9. I avoid certain activities because of my symptoms Yes No What _____

10. My symptoms interfere with my a) work Always Sometimes Never b) sleep Always Sometimes Never

11. I regularly sleep a) on my back side stomach b) on a waterbed Yes No c) on the sofa Yes No
d) I regularly watch TV or read in bed yes no e) I sleep on # _____ pillows

13. PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

blurred vision	diarrhea	insomnia	numbness in fingers
buzzing /ringing in ears	dizziness	light bothers eyes	numbness in toes
cold feet	fatigue	loss of balance	pins and needles in arms
cold hands	fever	loss of smell	pins and needles in legs
cold sweats	face flushed	loss of taste	shortness of breath
constipation	fainting	low resistance to colds	stiff neck
concentration loss /confusion	head seems too heavy	muscle jerking	stomach upset
depression /weeping spells	headaches		

Neck Pain Disability Index Questionnaire

INSTRUCTIONS: This questionnaire is designed to enable us to understand how much your neck pain affected your ability to manage your everyday activities. In each section **MARK** the statement that **BEST** describes you.

1.PAIN INTENSITY
1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

2.PERSONAL CARE
1. I can look after myself normally without causing extra pain.
2. I can look after myself normally, but it causes extra pain.
3. It is painful to look after myself and I am slow and careful.
4. I need some help, but manage most of my personal care. 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.

3. LIFTING
1. I can lift heavy weight, without extra pain
2. I can lift heavy weight, but it gives extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, i.e. on a table.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently position.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

4. READING
1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want with moderate pain in my neck.
4 I cannot read as much as I want because of moderate pain in my neck
5. I cannot read as much as I want because of severe pain in my neck
6. I cannot read at all because of the pain in my neck.

5. HEADACHES
1. I have no headaches at all.
2. I have slight headaches which come infrequently.
3. I have moderate headaches which come infrequently.
4. I have moderate headaches which come frequently.
5. I have severe headaches which come frequently.
6. I have headaches almost all the time.

6. CONCENTRATION
1. I can concentrate fully when I want to with no difficulty.
2. I can concentrate fully when I want to with slight difficulty.
3. I have a fair degree of difficulty in concentrating when I want
4. I have a lot of difficulty in concentrating when I want to.
5. I have a great deal of difficulty in concentrating when I want
6. I cannot concentrate at all.

7. WORK
1. I can do as much work as I want to.
2. I can only do my usual work, but no more.
3. I can do most of my usual work, but no more.
4. I cannot do my usual work.
5. I can hardly do any work at all.
6. I cannot do any work at all.

8. DRIVING
1. I can drive my car without any neck pain.
2. I can drive my car as long as I want with slight pain in my neck.
3. I can drive my car as long as I want with moderate pain in my neck.
4 I cannot drive my car as long as I want because of moderate pain in my neck.
5. I can hardly drive at all because of severe pain in my neck.
6. I cannot drive my car at all.

9. SLEEPING
1. I have no trouble sleeping.
2. My sleep is slightly disturbed (less than 1 hour sleepless).
3. My sleep is mildly disturbed (1-2 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless)
5. My sleep is greatly disturbed (3-5 hours sleepless).
6. My sleep is completely disturbed (5-7 hours sleepless)

10. RECREATION
1. I am able to engage in all of my recreational activities, with no neck pain at all.
2. I am able to engage in all of my recreational activities, with pain some pain in my neck.
3. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
4. I am able to engage in a few of my usual recreational activities because of pain in my neck.
5. I can hardly do any recreational activities because of pain in my neck.
6. I cannot do any recreational activities at all

Patient Signature _____ Date _____

Score _____ Doctor/Staff Signature _____

REVISED OSWESTRY LOW BACK PAIN DISABLITY QUESTIONNAIRE

INSTRUCTIONS: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. MARK one answer in each section which BEST describes you.

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

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

3. LIFTING
1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights off the floor ,but I can manage if they are conveniently positioned, e.g. on a table
5. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
6. I can only lift very light weights, at the most.

4. Walking
1. Pain does not prevent me walking any distance.
2. Pain prevents me walking more than 1 mile.
3. Pain prevents me walking more than 1/2 mile.
4. Pain prevents me walking more than 1/4 mile.
5. I can only walk using a cane or crutches.
6. I am in bed most of the time and have to crawl to the toilet.

5. Sitting
1. I can sit in any chair as long as I like without pain.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me sitting more than 1 hour.
4. Pain prevents me from sitting more than 1/2 hour.
5. Pain prevents me from sitting more than 10 minutes.
6. Pain prevents me from sitting at all.

6. STANDING
1. I can stand as long as I want without extra pain.
2. I can stand as long as I want but it gives me extra pain.
3. Pain prevents me from standing for more than 1 hour.
4. Pain prevents me from standing for more than 30 minute.
5. Pain prevents me from standing for more than 10 minute.
6. Pain prevents me from standing at all

7. SLEEPING
1. I get no pain in bed.
2. I get pain in bed, but it does not prevent me from sleeping well.
3. Because of pain, my normal night's sleep is reduced by less than one-quarter.
4. Because of pain, my normal night's sleep is reduced by less than one-half
5. Because of pain, my normal night's sleep is reduced by less than three-quarters.
6. Pain prevents me from sleeping at all.

8. SOCIAL LIFE
1. My social life is normal and gives me no extra pain.
2. My social life is normal but increases the degree of pain
3. Pain has no significant effect on my social life apart from limiting my more energetic interest e.g. dancing etc.
4. Pain has restricted my social life and I do not go out as often.
5. Pain has restricted my social life to my home.
6. I have no social life because of pain.

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

10. CHANGING DEGREE OF PAIN
1. My pain is rapidly getting better.
2. My pain fluctuates, but overall is definitely getting better.
3. My pain seems to be getting better, but improvement is slow at present.
4. My pain is neither getting better nor worse.
5. My pain is gradually worsening.
6. My pain is rapidly worsening.

Patient Signature _____ Date _____

Score _____ Doctor's Signature _____

"GEORGE'S TEST" QUESTIONNAIRE

INSTRUCTIONS: Please "CHECK" the correct response.

I. HISTORICAL INFORMATION

Have you ever been diagnosed or told you had any of the following.

1. High blood pressure (Hypertension) ..... Yes No
2. Hardening of the arteries (Arteriosclerosis)? ..... Yes No
3. Diabetes? ..... Yes No
4. Heart or blood vessel disease? ..... Yes No
5. Bone spurs on the neck bones (cervical spondylosis/osteoarthritis/degenerative joint disease)? ..... Yes No
6. Whiplash injury (flexion-extension injury/cervical sprain)? ..... Yes No
7. Have any of your relatives ever suffered a stroke? ..... Yes No
8. Were you ever a smoker? ..... Yes No
9. Do you take any medication on a regular basis? ..... Yes No

   What? (Coumadin, Hepanin, Aspirin, Antihypertensive medicine, etc.) .....

10. (Women only) Have you ever taken oral contraceptives? Yes No

    From _____ to _____

Have you ever experienced any of the following, (even short, temporary attacks)?

11. Blurred vision? ..... Yes No

    Double vision? ..... Yes No
12. Complete, partial-loss or diminished vision in one or both eyes? ..... Yes No
13. Ringing, buzzing or any noise in the ear(s)? ..... Yes No
14. Hearing loss in one or both ears? ..... Yes No
15. Slurred speech or other speech problems? ..... Yes No
16. Difficulty swallowing? ..... Yes No
17. Dizziness? ..... Yes No
18. Temporary lack of understanding? ..... Yes No
19. Loss of consciousness, even momentary blackouts? ..... Yes No
20. Numbness or loss of sensation in the face. fingers, hands, arms, legs, or other parts of your body? Yes No
21. Any other abnormal sensations in any part of your body? ..... Yes No
22. Weakness, clumsiness or loss of strength in the face, fingers, hands, arms or legs? ..... Yes No
23. Sudden collapse without loss of consciousness? ..... Yes No

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PLEASE READ:

I hereby state that the information on all pages of this form is true and correct to best of my knowledge and belief. I authorize **Lakeside Chiropractic Clinic/Dr William Howell, DC** to examine, do appropriate tests, treat me and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me by **Lakeside Chiropractic Clinic/Dr William Howell DC** will be immediately due and payable. In the event that the Clinic must take any action to collect an outstanding balance on my account, I acknowledge and agree to be liable to reimburse the Clinic for all costs incurred, including collection cost, court cost, expert witness fees, travel cost, and reasonable attorneys' fees.

Patient's Signature: _____ **Date:** _____

Guardian or Spouse's Signature Authorizing Care: **Date:**

DO NOT WRITE BELOW THIS LINE

Patient accepted YesNo Dr. Signature: _____

INFORMED CONSENT

PATIENT NAME:_____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic spinal is manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", such as you may have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/examination/treatment.

As part of the analysis, examination, and treatment, you are consenting to the following procedures:
Patient should initial each procedure they are consenting to.

___ Spinal manipulative therapy	___ palpation	___ vitals signs
___ range of motion testing	___ orthopedic testing	___ basic neurological testing
___ muscle strength testing	___ postural analysis	___ ultrasound
___ hot/cold therapy	___ EMS	___ radiographic studies (x-rays)

The material risks inherent in chiropractic adjustment.

As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

Self-administered, over-the-counter analgesics and rest.
Medical care and prescription drugs such as anti-inflammatory, muscle relaxers and painkillers.
Hospitalization.
Surgery.

If you choose to use one the above noted "other treatment" options, you should be aware that there are risk and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further the reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

INFORMED CONSENT (con't)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or I have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Bill Howell, DC and have had my questions answered to my satisfaction. By signing below I state that I will have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)

Dated: _____

Dr. William Howell, D.C.
Doctor's Name

_____
Signature