



CONSULTATION HISTORY

Name: _____ Date: _____

Have you ever received chiropractic care: Yes or No
If yes, was your experience: Good or Bad, explain?

I. Reasons for seeking chiropractic care?

1. Primary _____

2. Secondary _____

3. Tertiary _____

II. Chief Complaint:

1. Location _____

2. When did this begin? _____

3. How did this begin? _____

4. Circle all that apply to the quality of complaint/pain?
Dull Ache Sharp Shooting Burning Throbbing Deep Nagging Other _____
Futher description if necessary: _____

5. Does this complaint/pain radiate or travel to other areas of the body? Yes or No
If yes, where? _____

6. Do you have any numbness or tingling associated with this complaint/pain: Yes or No
If yes, where? _____

7. Grade the intensity /severity (1 best – 10 worst) 1 2 3 4 5 6 7 8 9 10

8. How frequent is the complaint/pain (circle all that apply): daily weekly monthly other _____

9. How long does it last (circle all that apply): seconds minutes hours

10. What activity makes it worse (circle all that apply): Home Work Exercise Diet Personal
 Walking Standing Squatting Twisting Laying Down Reading
 Sitting Bending Lifting Running Driving Other _____

11. What activity makes is better (circle all that apply): Home Work Exercise Diet Personal
 Walking Standing Squatting Twisting Laying Down Reading
 Sitting Bending Lifting Running Driving Other _____

III. Previous Intervention: What have you tried to fix the problem?

1. Medications: _____ 3. Other Physicians: _____
 2. Surgery: _____ 4. Treatments: _____

IV. All Past Health History:

1. Previous Illness: MEDICAL HISTORY
 Please check all that apply.

Headaches	Neck Pain	Hip Pain	High Blood Pressure
Fatigue	Thyroid Trouble	Elbow Pain	Low Blood Pressure
Sinus Problems	Throat Problems	Wrist Pain	Anemia
Fainting/Dizziness	Shoulder Tension	Ankle/Foot Pain	Stomach Problems
Arthritis/Joint Pain	Chest Pain	Slipped Disc	Weight Trouble
Loss of Smell	Shortness of Breath	Pinched Nerve	Depression
ringing in ears	Mid Back Pain	Diabetes	Sciatic Pain
Menstrual irregularity	Tingling in legs/feet	Tingling in arms/hands	Pain btwn shoulder blades
Memory loss	Lower Back Pain	Constipation	Other

2. Previous Trauma/ Injury CAR ACCIDENT FALLS WORK ACCIDENTS OTHER _____
 3. Any broken bones? YES /NO: What bone? _____ When did this occur? _____
 4. Allergies POLLEN DUST MOLD FOOD MEDICATIONS OTHER _____
 5. List all current medications _____
 6. Surgeries Date _____ Type _____
 7. Females: Pregnancy _____ How many? _____ Vaginal or C Section
 Any complications, explain _____

V. Family Health History (circle all that apply)

Mother Side		Father Side	
Heart Disease	Diabetes	Heart Disease	Diabetes
Cancer	Arthritis	Cancer	Arthritis
Autoimmune Disorders		Autoimmune Disorders	
Other _____			

VI. Social Occupation

1. Job Description: _____

2. Work Schedule: mornings afternoons evenings 8hours 9hours 10hours 12hours other_____

3. Recreational Activities: _____

4. Hobbies: _____

5. Do you exercise? Yes or No How often? _____ How long? _____

6. Do you drink? Yes or No How often? _____ How much? _____

7. Do you smoke? Yes or No How often? _____ How much? _____

8. Describe your daily diet and food intake, on an average day?

9. Do you drink water? Yes or No How often? _____ How much? _____

What concerns do you have that could prevent you from accepting treatment in this office?

Money Time Schedule Other _____

I, have the read the above information and certify it to be true and correct to the best of my knowledge, hereby authorize this office of chiropractic to provide me with my consultation to determine my eligibility to receive treatment in this office.

Signature _____ Date _____

Parent or Guardian _____ Date _____

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Doctor: Dr Tammy Costello Dr Tiffany Butler

Patient is: Accepted for care Denied for care

Current Recommendations:

Cervical Exam	X-rays /Area _____
Lumbar Exam	Hydrotherapy
Thoracic Exam	Ice/ Stim
Upper / Lower Extremity Exam	Adjust today
Massage Therapy	Aqua Chi
Other _____	

_____ I, hereby accept the recommendations set forth by the doctor and wish to peruse chiropractic treatment. I further understand that this portion of the health consultation is over and that there may be additional charges for further treatment.



Informed Consent Document

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 that I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands, a special table, therapy tools or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles you may or may not feel a sense of movement.

Analysis/Examination/Treatment:

As part of the analysis, examination, and treatment, you are consenting to the following:
Spinal manipulative therapy, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, vital signs, basic neurology, hot/cold therapy, EMS/Tens therapy, rehabilitation, radiographic studies, and any other protocol that may be deemed fit for your case by the Doctors of Chiropractic.

The material risks inherent in chiropractic adjustment

As with any 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, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. To the best of my knowledge I have never had a patient suffer with any complications from 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, it is your responsibility to inform me. If treatment is not showing success within a reasonable amount of time for your case then other further recommendations shall be made.

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, examination, radiographic views, and further evaluation of the radiographs from Spinal Imaging, a diagnostic over read group. 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. You may be at risk just by driving a car; getting your hair washed, sleeping with multiple pillows and playing sports. We take great strides to protect our clients and their safety.

The availability and nature of other treatment options:

Other treatment options for your condition may include but are not limited to and will be discussed as deemed necessary for the further progress of your case:

- Self administered, over the counter analgesics and rest, that you may deem necessary
- Massage Therapy
- Rehabilitation Therapy
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Pain Management referral
- MRI or CAT Scan referral
- Hospitalization
- Surgery

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

The risks 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 reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read () or I have had this read to me () along with verbal explanation of the treatment plan and options set forth by this clinic for my case. The above explanation of the chiropractic treatment and related treatment has been discussed by Doctor _____ and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Dated: _____

Patients Name: _____

Doctor Name: _____

Signature: _____

Doctor Signature: _____

Signature of Parent or Guardian: _____

AUTHORIZATION FORM

Patient Name _____ SSN: _____-_____-_____

RELEASE OF INFORMATION

I hereby authorize *Life Line Chiropractic* to release medical and financial data to my insurance carriers and attorney. INITIALS _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. *Life Line Chiropractic* cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or precertification procedures. I also understand that if I suspend or terminate my care and treatment, the fees for services rendered me will be immediately due and payable. In the event that of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection. INITIALS _____

CONSENT FOR TREATMENT OF MINOR CHILD

Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of *Life Line Chiropractic*. The undersigned states that he/she is the patient's legal guardian. INITIALS _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to *Life Line Chiropractic* professional services rendered. NO OTHER THIRD PARTY, including attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office. INITIALS _____

SUBROGATION AND RIGHTS OF REIMBURSEMENT AGREEMENT

If I, or one of my covered dependents receive benefits under my health insurance carrier, hereinafter referred to as Carrier, due to an injury or illness as a result of the acts of a third party. I agree to repay the Carrier any amount of money that I receive from third party or its insurer as compensation for such injuries up to the amount paid out by the Carrier. I understand that this includes the insurer or other agent or if I enter into any form of settlement regarding an accident which I or my covered dependents are injured as a result of the acts of a third party. I will do whatever is reasonably needed to secure the Carriers rights and shall do nothing to damage such rights. I will abide by this agreement only if my health insurance policy contains language that gives the health insurance carrier subrogation and rights of reimbursement. INITIALS _____

UNKEPT MASSAGE APPOINTMENT NOTIFICATION

I understand that I am required to give at least one business days notice to cancel and/or reschedule my massage appointment, unless I have a documented emergency. If I do not give this notice, I understand it will be necessary to charge \$25.00 to my account. I also understand that this charge may not be filed with my insurance carrier and that I am responsible for the charge, which is due on/or before my next appointment. **INITIALS**_____

BOUNCED CHECK FEES

I understand that the fee for any bounced check or return check for insufficient funds, closed accounts or any other ancillary concerns will be an additional \$35.00 charge and will be required to be paid by credit card, money order, or cash. **INITIALS**_____

Please check the following boxes to inform us that you are in compliance with our office standards of operation. Any questions or concerns please feel free to talk with us.

- Permission to treat with open treatment rooms
- Permission to use you as a source of testimonial letters
- Permission to use or take photos for marketing or website
- Permission to call you for updates regarding your care or finances
- Permission for open rehabilitation

Permission can always be revoked, but this must be done in writing

Sign _____

Date _____

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

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

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights

Office Use Only

Name _____

Date _____

- I cannot lift or carry anything

Section 4: Reading

- I can read as much as I want to with no pain in my neck
- I can read as much as I want to with slight pain in my neck
- I can read as much as I want with moderate pain in my neck
- I can't read as much as I want because of moderate pain in my neck
- I can hardly read at all because of severe pain in my neck
- I cannot read at all

Section 5: Headaches

- I have no headaches at all
- I have slight headaches, which come infrequently
- I have moderate headaches, which come infrequently
- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all the time

Section 6: Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7: Work

- I can do as much work as I want to
 - I can only do my usual work, but no more
 - I can do most of my usual work, but no more
 - I cannot do my usual work
 - I can hardly do any work at all
 - I can't do any work at all
- ### Section 8: Driving
- I can drive my car without any neck pain
 - I can drive my car as long as I want with slight pain in my neck
 - I can drive my car as long as I want with moderate pain in my neck
 - I can't drive my car as long as I want because of moderate pain in my neck
 - I can hardly drive at all because of severe pain in my neck
 - I can't drive my car at all

Section 9: Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- I am able to engage in all my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities, with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- I am able to engage in a few of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all

Score: ___/50 Transform to percentage score $\times 100 =$ %points

Scoring For each section the total possible score is 5; if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

$$\begin{array}{l} \text{Example: } \underline{16} \text{ (total scored)} \\ 50 \text{ (total possible score)} \times 100 = 32\% \\ \underline{16} \text{ (total scored)} \\ 45 \text{ (total possible score)} \times 100 = 35.5\% \end{array}$$

Minimum Detectable Change (90% confidence): 5 points or 10 %points

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

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

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Walking*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 2 kilometres
- Pain prevents me from walking more than 1 kilometre
- Pain prevents me from walking more than 500 metres
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment

Score: $I \times 100 = \%$

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example:

$$\frac{16 \text{ (total scored)}}{50 \text{ (total possible score)}} \times 100 = 32\%$$

If one section is missed or not applicable the score is calculated:

$$\frac{16 \text{ (total scored)}}{45 \text{ (total possible score)}} \times 100 = 35.5\%$$

Minimum Detectable Change (90% confidence): 10%points (Change of less than this may be attributable to error in the measurement)

Source: Fairbank JCT & Pynsent, PB (2000) The Oswestry Disability Index. *Spine*, 25(22): 2940-2953.
Davidson M & Keating J (2001) A comparison of five low back disability questionnaires: reliability and responsiveness. *Physical Therapy* 2002;82:8-24.

*Note: Distances of 1mile, ½ mile and 100 yards have been replaced by metric distances in the Walking section.

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

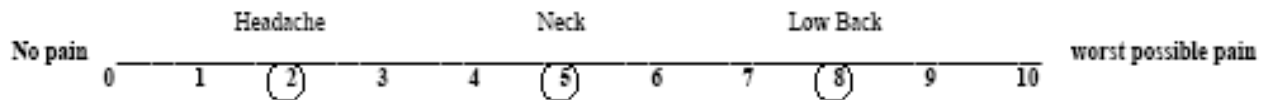
Date _____

Please read carefully:

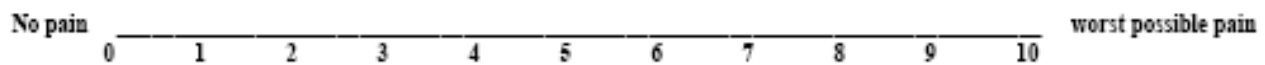
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

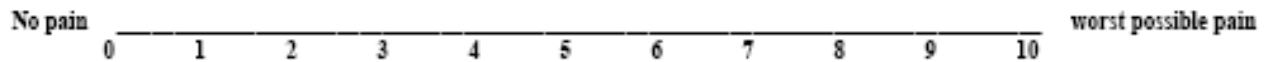
Example:



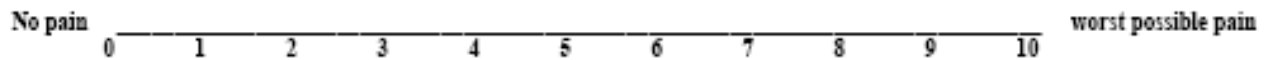
1 – What is your pain RIGHT NOW?



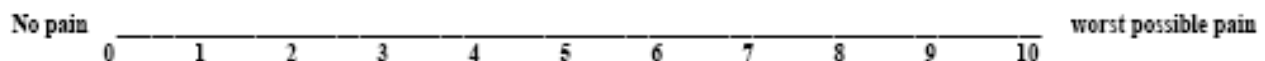
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Chackin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.