Case History

Date: _____ # _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: (Street #) _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (Home) _____ (Work) _____ BEST TIME TO CALL: ___AM ___PM

EMAIL ADDRESS: _____

TEXT REMINDERS: YES___ NO___ BEFORE VISIT: 1hr 4hrs 1 day CELL PROVIDER: _____

SS#: _____ SPOUSES NAME: _____ No. OF CHILDREN _____

YOUR OCCUPATION: _____ EMPLOYER: _____ TYPE OF WORK: _____

NAME OF EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

REFERRED TO THIS OFFICE BY: _____ (Website/Google, Friend, Dr., Etc.)

HAVE YOU RECEIVED CHIROPRACTIC CARE BEFORE? YES___ NO___ WHEN? _____ WHERE? _____

DO YOU HAVE HEALTH INSURANCE? YES___ NO___ NAME OF INSURANCE: _____

NAME OF INSURED: _____ RELATIONSHIP: _____

SPOUSES INSURANCE CO. NAME: _____ MEDICAID: YES___ NO___ MEDICARE: YES___ NO___

ARE YOUR PRESENT PROBLEMS, COMPLAINTS, INJURIES DUE TO:

____ AUTO RELATED ACCIDENT/ ____ ON THE JOB INJURY/ ____ PERSONAL INJURY (fall, etc.) DATE OF INJURY _____

PLEASE LIST YOUR HEALTH COMPLAINT(S)/SYMPTOMS:

A _____
B _____
C _____
D _____

DR'S COMMENTS

PLEASE CIRCLE (Y) FOR <u>YES</u> or (N) FOR <u>NO</u>:

Have you seen any doctors for your current problems? Y N

Have you been hospitalized for any current problems? Y N

Has there been any changes in your bodily functions (urination, bowel habits, respiration, digestion, vision, sexual function, other)? Y N;
If yes, explain: _____

Have you found anything that makes your problem <u>better</u> (rest, morning, evening, certain positions...)? Y N;
If yes, explain: _____

Have you found anything that makes your problem <u>worse</u> (positions, activities, morning, evening, coughing, sneezing, straining when moving your bowels, other)? Y N; If yes, explain: _____

_____

Does your condition / pain awaken you from sleep? Y N; If yes, explain: _____

Does your condition affect work activities in any way? Y N; If yes, explain: _____

Have you had <u>time</u> loss from work or school? Y N; If yes, explain: _____

Do you have any congenital (born with) factors which relate to your condition? Y N; If yes, explain: _____

_____

Are you suffering from any conditions and/or disabling conditions other than those you are consulting us for? Y N;
If yes, explain: _____

What medications or drugs are you taking and why? _____

_____

Do you have any family history of the following conditions (please circle)

Diabetes Heart Kidney Cancer Back Stroke Arthritis Other _____

Place a "**B**", if you have experienced any of the following BEFORE, a "**N**" if you are experiencing any NOW, or "**B&N**" if both apply. Circle R for right and L for left, when appropriate.

___ Headache
___ Behind the Eyes
___ Forehead
___ Temples
___ Migraine
___ Pressure
___ Head Feels Heavy
___ Loss of Memory
___ Light-Headedness
___ Fainting
___ Dizziness
___ Fatigue
___ Weakness
___ Blurred Vision
___ Light Bothers Eyes
___ Loss of Consciousness
___ Loss of Smell
___ Loss of Taste
___ Loss of Balance
___ Loss of Hearing
___ Ear Problems
___ Ringing in Ears
___ Poor Vision

___ Eye Problems
___ Sinus Problems
___ Nasal Problems
___ Thyroid Problems
___ Throat Problems
___ Frequent Colds
___ Low Resistance
___ Nervousness
___ Depression
___ Convulsions/Seizures
___ Epilepsy
___ Nausea
___ Vomiting
___ Speech Problems
___ Abnormal Weight Loss
___ Chest Pain
___ Rib Pain
___ Heart Problems
___ High Blood Pressure
___ Low Blood Pressure
___ Respiratory (Breathing) Problems
___ Asthma

___ Stroke
___ Breast Problems
___ Stomach Problems
___ Ulcers
___ Digestive Problems
___ Hernias (Hiatal, Inguinal, etc.)
___ Gall Bladder Problems
___ Liver Problems
___ Colon Problems
___ Constipation
___ Diarrhea
___ Kidney Problems
___ Urinary Problems
___ Hemorrhoids
___ Female Organ Trouble
___ Menstrual Problems
___ Prostrate Problems
___ Tailbone Problems
___ Sacroiliac Problems
___ Poor Circulation
___ Cold Hands R/L
___ Cold Feet R/L

___ Loss of Grip Strength R/L
___ Swelling
Where?_____
___ Swollen Joint(s)
Where?_____
___ Leg Cramping R/L
___ Foot Cramping R/L
___ Arthritis
Where?_____
___ Rheumatoid Arthritis
___ Psoriatic Arthritis
___ Osteoporosis
___ Bursitis
___ Psoriasis
___ Muscle Disease
What type?_____
___ Diabetes/Insulin Dependent? Y/N
or Diet Controlled? Y/N
___ Cancer
Where?_____
What Type?_____
_____

___ Polio
___ Alcoholism
___ AIDS
___ Syphilis
___ Sexually Transmitted Diseases (What Type?)
_____
___ Mental Disorder
___ Bone Disease
___ Arteriosclerosis
___ Pacemaker
___ Breast Alteration
___ Plastic Surgery
___ Hip Replacement
___ Artificial Joints

Any chance of Pregnancy AT THIS TIME? Y/N

Pain in:			Numbness in:			Pins and Needles in:			Neck:	Midback:	Lowback:
___ Arms	R	L	___ Arms	R	L	___ Arms	R	L	___ Pain	___ Pain	___ Pain
___ Hands	R	L	___ Hands	R	L	___ Hands	R	L	___ Spasm	___ Spasm	___ Spasm
___ Knee	R	L	___ Legs	R	L	___ Legs	R	L	___ Stiffness	___ Stiffness	___ Stiffness
___ Legs	R	L	___ Feet	R	L	___ Feet	R	L	___ Grinding	___ Grinding	___ Grinding
___ Feet	R	L							___ Popping	___ Popping	___ Popping
___ Hips	R	L							___ Pinched Nerve	___ Pinched Nerve	___ Pinched Nerve

Please bring in past health records and x-rays so they may be reviewed.

PLEASE EXPLAIN AND GIVE DATES

List any **recent** and/or **past:**

Accidents, falls, or injuries: _____

_____

Broken Bones/ Dislocations: _____

a) Fractures of the spine/vertebrae: _____

Sprains or Strains: _____

Spinal Surgeries: _____

Any other surgeries / operations: _____

Spinal Injections: _____

Spinal (Back) Treatment: _____

Illnesses/Diseases: _____

Specialized Tests Performed, i.e. (E.MG., EEG, EKG, M.R.I., CAT SCAN, BONE SCAN, MYELOGRAM, BLOOD TESTS, OTHER...)

_____

Physical Therapy Treatment: _____

X-Rays Performed: _____

Doctor Visits: _____

Hospital Visits or Stays: _____

Please list any additional comments you wish to make regarding your condition: _____

_____

It is understood and agreed that the amount paid Radix Chiropractic for x-rays is for evaluation only and the x-ray negatives will remain the property of this office.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement of charges incurred.

2. I authorized the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, **and by any insurance company** obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to correctly set forth under pertinent date below) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claims as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.

4. By signing below, you acknowledge that you understand the information above and you agree to be responsible for payments of all costs, including collection fees.

PATIENT SIGNED: _____ DATE: _____

WITNESS SIGNED: _____ DATE: _____

Radix Chiropractic

4347 Integrity Center Point
Colorado Springs, CO 80917
(719) 573-1007 phone
(719) 573-1006 fax
www.radixchiro.com

AUTHORIZATION FOR MEDICAL INFORMATION

DATE: _____

I, _____, AUTHORIZE THE RELEASE OF MY X-RAYS AND OTHER RELATED HEALTH RECORDS TO RADIX CHIROPRACTIC.

PATIENT SIGNATURE: _____

PATIENT ADDRESS: _____

PATIENT DATE OF BIRTH: _____

THIS AUTHORIZATION OR PHOTOCOPY THEROF WILL AUTHORIZE A PHYSICIAN, HOSPITAL, CLINIC OR OTHER MEDICAL INSTITUTION TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND ANY PHYSICAL FINDINGS, DIAGNOSIS, AND PROGNOSIS. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH PUBLIC STATUTE.

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Automobile Accident History

Today's Date:_____
Patient Name: _____ Date of Birth: _____

Road conditions at the time of accident:
❑ Wet ❑ Dry ❑ Icy ❑ Snow ❑ Other:_____
You were the: ❑ Driver ❑ Passenger ❑ Pedestrian
Passenger position: ❑ Front ❑ R rear ❑ L rear
The impact was from: ❑ Front ❑ Right side ❑ Left side ❑ Rear
At impact the trunk of your body was facing: ❑ Straight-ahead ❑ Right ❑ Left
At impact your head was looking: ❑ Straight-ahead ❑ Right ❑ Left
What were you doing at the time of impact: _____
Were you aware of the approaching collision prior to impact or were you surprised?
❑Aware ❑ Surprised
Were you braced for impact? ❑Yes ❑ No
Did you experience a flash of light or a feeling of explosion in your head?
❑ Yes ❑ No ❑ Can't remember
Immediately following the accident, did you become:
❑ Confused ❑ Disoriented ❑ Light-headed ❑ Dizzy ❑ Nauseous ❑ Blurred vision
❑ Ring in ears ❑ Lose consciousness, if so, how
long?_____
❑Other_____

Were your hands on steering wheel? ❑ Yes ❑ No
Foot on Brake? ❑ Yes ❑ No
Seat belts on? ❑ Yes ❑ No
Seat belt type? ❑ Shoulder-Lap ❑ Lap Only
Did you receive any injury or bruise from the seatbelt? ❑ Yes ❑ No
If yes, describe: _____
If you have an airbag in your car, did it inflate on impact? ❑ Yes ❑ No ❑ N/A
Was the position of the top of the headrest:
❑ Above your head ❑ Even to head ❑ Below head ❑ N/A
Did you strike anything in vehicle at impact?
❑Yes, specify_____❑No
Name(s) of other people in your car:
1._____2._____3._____

What type of clothing were you wearing at the time of the accident_____
What type of fabric was the clothing made of_____
Were the seats of car you in have: ❑ Leather ❑ Cloth ❑ Other_____

Any other comments about accident or injuries:_____

Date of Accident:_____ Time:_____❑am❑pm
Who was issued at fault? ❑ You ❑Other Party

Was there a police investigation at the scene? ❑Yes ❑No
Citation issued? ❑Yes ❑No To whom?_____
Did you go to a hospital/emergency center? ❑Yes ❑No
If yes, where:_____when:_____
How did you get to hospital? _____
Treatment rendered:_____
Release same day? ❑Yes ❑No If no, when:_____
Doctor's recommendations, if any:_____
Have you seen any other doctor as a result of this accident? ❑ Yes ❑ No
Doctor's name and Specialty:_____

Have you lost anytime from work because of this accident?❑Yes❑No
Dates: From_____to_____
Totally disabled from _____to_____
Partially disabled from _____to_____

List the year, make and model of the vehicle you were in:
Year: _____Make:_____Model: _____
Was your car stopped at the time of impact? ❑ Yes ❑ No
If no, estimated speed of vehicle you were in:____MPH
If your vehicle was moving at the time of impact, was it:
❑ Slowing down ❑ Speeding up ❑ Maintaining speed
Estimated damage to the vehicle you were in: $_____

List the year, make, and model of the other vehicle involved in the accident:
Year: _____Make:_____Model: _____
Was the other vehicle moving at time of impact? ❑ Yes ❑ No
If yes, what was approximate speed?___MPH
Was the other car: ❑ Slowing down ❑ Speeding up ❑ Maintaining steady speed

Your auto insurance company:_____Claim #_____
Other driver's insurance co._____Claim #_____
Have you been contacted by an insurance adjustor or company representative on this claim? ❑ Yes ❑ No

Do you have an attorney who has advised you in this case?❑ Yes ❑ No
Name:_____

I hereby authorize Rādix Chiropractic to release medical information necessary to process this claim.

Patient Name: _____

Signature_____ Date_____

PATIENT DESCRIPTION OF AUTO ACCIDENT

DATE: _____

Patient Name: _____ Date of Birth: _____

Please use this space to explain all details of the auto accident. How did it happen, how did you feel during or directly after the accident, and how have you felt since the accident? Please also include emergency help from bystanders, paramedics, or police that may have assisted. No detail is too small, so be as specific as possible.

PATIENT SIGNATURE: _____

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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**.**

Office Use Only

Name _____

Date _____

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
☐ 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 x 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:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

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

16 (total scored)
45 (total possible score) x 100 = 35.5%

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

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NDI developed by: Vernon, H. & Mior, S. (1991). The Neck Disability Index: A study of reliability and validity. Journal of Manipulative and Physiological Therapeutics. 14, 409-415

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us 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 the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. 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 manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. 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 lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

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 one 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

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. 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, i.e. dancing, etc.
- ☐ 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

9. TRAVELLING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

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www.radixchiro.com

Chiropractic Reports and Doctor's Lien

I do hereby authorize the doctor named below to furnish you, my attorney, with a full report of examination, care, etc. I received in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for chiropractic service rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctor.

And I hereby further give a lien on my case to you, my attorney, or myself as the result of the injuries for which I have received care of injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by said doctor for service rendered on me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment.

I understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. Please acknowledge this letter by signing below and returning to the doctor's office.

_____ _____

Patient's Name Doctor's Name

_____ _____

Patient's Signature Doctor's Signature

_____ _____

Date Date

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect the above-named doctor.

Please sign, date and return one copy to the office of the doctor named above. Keep one copy for your records. A photocopy of this form shall be considered as valid as the original.

_____ _____

Attorney's Signature Attorney's Name

_____

Date