Confidential Health History

Date:_____

Name:_____ SSN:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ M___ F____ Email Address:_____

Home Phone:_____ Cell Phone:_____

It is ok to contact me via (Please select all that apply): ____ Email _____ Phone _____ Text Message ___Carrier Pigeon

Employer:_____ Occupation:_____

Emergency Contact:_____

How did you hear about us?_____

Is this visit due to an auto or work related injury? ____ Yes_____ No *If yes, please ask for a separate injury form.*

List of authorized person(s) for medical information release:_____

Primary reason for seeking care:_____

Date of onset:_____ Most recent aggravation:_____

What makes it worse:_____

What makes it better:_____

Quality of symptoms: ___Aching ___Burning ___ Stabbing ___Dull ___Deep ___Superficial ___Numbness/Tingling

On a scale of 1 to 10, rate your symptoms: 0------1------2------3------4------5------6------7------8-----9-----10

Do symptoms radiate to other areas, if so where?_____

How frequent is your pain?

_____Constant (100%) _____Frequent (75%) _____Intermittent (50%) _____Occasional (25%)

How long does it last? ___24 hrs/day (wakes you at night) ___16 hrs/day ____Other ___hrs/day

List all medications you are currently taking:_____

_____

Other healthcare professionals you currently use:

_____

Previous Chiropractor(s):

_____

List any surgeries and their dates:

_____

Please check any of the following that are relevant to your health history:

General:

__Recent Trauma __Past Trauma __Fatigue __Fever/Chills
__Trouble sleeping/sleep disorder __ Unexplained weight loss/gain

Skin:
__Rashes __Itching __Color Change __Dryness __Lumps
__Hair/Nail changes __New mole/changes in mole

Head/Eyes/Ears/Nose/Throat:

__ Headaches __Head Injury __Vision Changes __Double vision
__ Sinus problems __TMJ/TMD __Ringing in ears __Difficulty swallowing

Cardiovascular:

__High Blood Pressure __Chest Pain __Heart Palpitations __Cold hands/feet
__Poor clotting __Fainting __Heart Disease __Blood clots

Respiratory:
__Cough __Asthma/Wheezing __Tuberculosis
__Sputum __COPD/Emphysema __Coughing blood

Gastrointestinal:
__Abdominal Pain __Vomiting __Diarrhea __Indigestion __Nausea __Constipation

Musculoskeletal:

__Neck pain/Stiffness __Mid back pain/Stiffness __Low back pain/Stiffness
__Shoulder/Elbow pain __Scoliosis __Hip/Knee/Ankle pain
__Joint Pain/Stiffness __Plantar Fasciitis __Foot Pain

Neurologic:
__Dizziness __ Seizures __Weakness __Migraine/Cluster Headache __Numbness/Tingling

Other:
__Diabetes __Fibromyalgia __Nervous/Anxiety __Depression __Cancer __Arthritis __Osteoporosis __Anaphylaxis __Varicose Veins

Women:
__Irregular Cycle __Painful Menstruation __Breast Problems __Menopause Are you pregnant?_____

Doctor's Notes

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if TRILOGY Chiropractic extends credit to me and I understand that if I suspend or terminate my care, fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors of TRILOGY Chiropractic and whomever they may designate as their assistants to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

_____ _____

Name (Please Print) Signature Date

TRILOGY Chiropractic Notices of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY TRILOGY Chiropractic is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. Disclosure of Your Health Care Information Treatment We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example), "On occasion, it may be necessary to seek consultation regarding your treatment from other health care providers associated with TRILOGY Chiropractic" "It is our policy to provide a substitute health care provider, authorized by TRILOGY Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency situation." Due to the nature of TRILOGY Chiropractic's open adjustment areas, others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentially. At any time you may request a private consultation with the doctor. Payment We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example) "As a courtesy to our patients, we will submit an itemized statement to your insurance center for the purpose of payment to TRILOGY Chiropractic for health care services rendered. If you pay for your health care services personally we will, as a courtesy to you, provide and itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the health care services received." Worker's Compensation We may disclose your health information as necessary to comply with State Workers compensation Laws. Emergencies We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or your death. Public Health As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure. Judicial and Administrative Proceedings We may disclose your health information in the course of any administrative or judicial proceeding. Law Enforcement We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order of subpoena, and other law enforcement purposes.

Deceased Persons We may disclose your health information to coroners or medical examiners. Organ Donation We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues. Research We may disclose your health information to researchers conducting research that has been approved by the Institutional Review Board. Public Safety It may be necessary to disclose your health information to appropriate persons in order to prevent or lesson a serious and imminent threat to the health or safety of a particular person or to the general public Specialized Government Agencies We may disclose your health information for military, national security, prisoner and government benefits purposes. Marketing We may contact you for marketing purposes or fundraising purposes, as described below: (example) "As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment. "It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may need to send you a letter, post card or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of TRILOGY Chiropractic sponsored fund- raising events." Change of Ownership In the event that TRILOGY Chiropractic is sold or merged with another organization, your health information will become the property of the new owner. Your Health Information Rights · You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that TRILOGY Chiropractic is not required to agree to the restriction you requested. · You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. · You have the right to inspect and receive a copy of your health information. · You have the right to request that TRILOGY Chiropractic amend your protected health information. Please be advised, however, that TRILOGY Chiropractic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. · You have the right to receive an accounting of disclosures of your protected health information made by TRILOGY Chiropractic · You have the right to a paper copy of this Notice of Privacy Practices at any time upon request. Changes to this Notice of Privacy Practices TRILOGY Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, TRILOGY Chiropractic is required by law to comply with this Notice.

_____ _____

Patient Name (Please Print) Signature Date

Subjective Analysis

Patient Name: _____ Date: _____

People with spinal pain may find that certain activities are restricted or difficult to do. Circle all activities that you find difficult to do now:

- Sleep through the night
- Get out of bed
- Make your bed
- Bathe yourself
- Wash, comb, or dry your hair
- Bend over a sink for 10 minutes
- Go to the bathroom
- Put on socks, shoes, or clothing
- Walk up one flight of stairs
- Crawl on all fours
- Turn a door knob
- Open a heavy door
- Sit in a chair for 30 minutes
- Sit and work at a desk for 1 hour
- Get up from a low seat
- Cross legs
- Walk 1 mile
- Stand for 30 minutes
- Travel on journeys over 1 hour
- Push/Pull vacuum cleaner or lawn mower
- Carry laundry basket, groceries, or small child
- Wash windows or walls
- Bend over to clean bathtub
- Shovel snow or dirt
- Use pencils, scissors or pliers
- Lift a heavy suitcase (over 40 lbs)
- Reach in front of overhead
- Enjoy hobbies or social activities
- Enjoy sexual activities

Circle any of the following conditions you experienced before the injury or condition:

- Neck or back weakness Persistent tenderness of neck or back
- Restricted movement of neck or back "Catch" or "kink in neck or back

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is be specific adjustments of the spine. Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity. Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

Patient Name (Please Print) Signature Date

LOW BACK PAIN OSWESTRY QUESTIONNAIRE

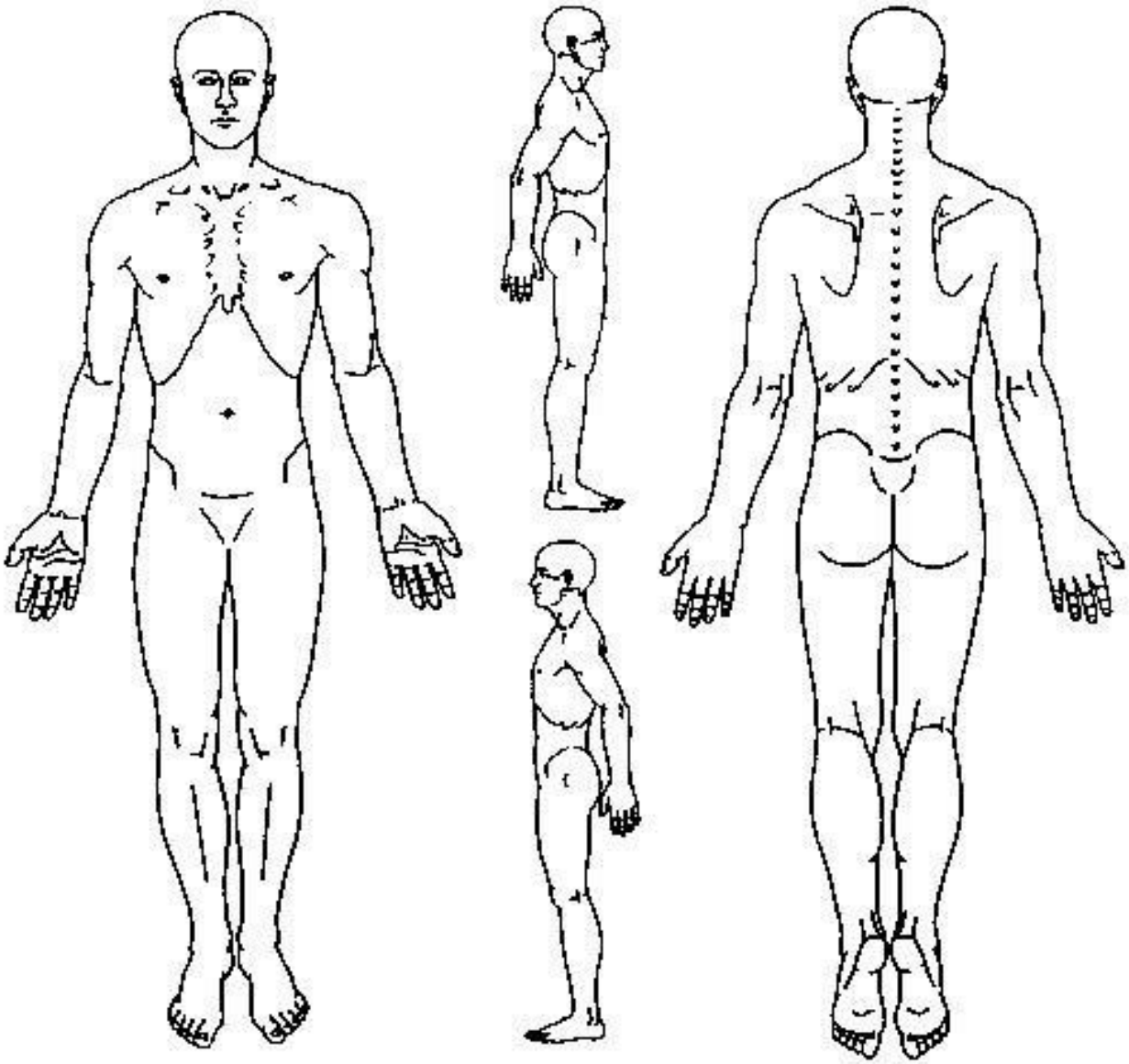
BCC 014

NAME _____ DATE

How long have you had low back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.

A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER



Please Read: This questionnaire is designed to enable us to understand how much your **Low Back Pain** has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

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 is severe but comes and goes.
F. The pain is severe and does not vary much.

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 increase the pain and it is necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I stay in bed, do not get dressed, and am washed with help.

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, e.g. on the 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 4 --Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than two miles.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than _ 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 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 _ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

Signature: _____ Date: _____

DISABILITY INDEX SCORE: _____ %

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 can't stand for longer than one hour without increasing my pain.
D. I can't stand for longer than _ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain, my normal night's sleep is reduced by less 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 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 mor energetic interests, e.g. dancing.
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. Pain prevents me from having any social interaction at all.

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 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 INDEX

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

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

- □ **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 do not get dressed. I wash with difficulty and stay in bed.**

SECTION 3 – LIFTING

- □ **I can lift heavy weights without causing extra pain.**
- □ **I can lift heavy weights, but it gives me extra pain.**
- □ **Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.**
- □ **Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.**
- □ **I can lift only very light weights.**
- □ **I cannot lift or carry anything at all.**

SECTION 4 – WORK

- □ **I can do as much work as I want.**
- □ **I can only do my usual work, but no more.**
- □ **I can do most of my usual work, but no more.**
- □ **I can't do my usual work.**
- □ **I can hardly do any work at all.**
- □ **I can't do any work at all.**

SECTION 5 – HEADACHES

- □ **I have no headaches at all.**
- □ **I have slight headaches that come infrequently.**
- □ **I have moderate headaches that come infrequently.**
- □ **I have moderate headaches that come frequently.**
- □ **I have severe headaches that come frequently.**
- □ **I have headaches almost all the time.**

SECTION 6 – CONCENTRATION

- □ **I can concentrate fully without difficulty.**
- □ **I can concentrate fully with slight difficulty.**
- □ **I have a fair degree of difficulty concentrating.**
- □ **I have a lot of difficulty concentrating.**
- □ **I have a great deal of difficulty concentrating.**
- □ **I can't concentrate at all.**

SECTION 7 – SLEEPING

- □ **I have no trouble sleeping.**
- □ **My sleep is slightly disturbed for less than 1 hour.**
- □ **My sleep is mildly disturbed for up to 1-2 hours.**
- □ **My sleep is moderately disturbed for up to 2-3 hours.**
- □ **My sleep is greatly disturbed for up to 3-5 hours.**
- □ **My sleep is completely disturbed for up to 5-7 hours.**

SECTION 8 – DRIVING

- □ **I can drive my car without neck pain.**
- □ **I can drive as long as I want with slight neck pain.**
- □ **I can drive as long as I want with moderate neck pain.**
- □ **I can't drive as long as I want because of moderate**
- □ **neck pain.**
- □ **I can hardly drive at all because of severe neck pain.**
- □ **I can't drive my care at all because of neck pain.**

SECTION 9 – READING

- □ **I can read as much as I want with no neck pain.**
- □ **I can read as much as I want with slight neck pain.**
- □ **I can read as much as I want with moderate neck pain.**
- □ **I can't read as much as I want because of moderate neck pain.**
- □ **I can't read as much as I want because of severe neck pain.**
- □ **I can't read at all.**

SECTION 10 – RECREATION

- □ **I have no neck pain during all recreational activities.**
- □ **I have some neck pain with all recreational activities.**
- □ **I have some neck pain with a few recreational activities.**
- □ **I have neck pain with most recreational activities.**
- □ **I can hardly do recreational activities due to neck pain.**
- □ **I can't do any recreational activities due to neck pain.**

PATIENT NAME _____ **DATE** _____/_____/_____

SCORE _____ **[50] BENCHMARK -5 =** _____