

New Patient Initial Paper Work Instructions

The next 5 pages contain all of our new patient paper work that is necessary to help us offer you the best treatment possible. To help speed your first visit up we have our paperwork online. You can print these pages out and fill them out and you won't have to sit in our office and fill out these forms.

Form 1 – Patient Confidential – This is required on all patients. If you are unsure about something just leave it blank.

Form 2 – Past Health History – This is also required on all patients.

Form 3 – Symptom Intensity and Frequency Form – This is also required on all patients. Instructions are on the first paragraph of the form.

Form 4 – Neck Disability Index – This is only required if you are experiencing Neck and / or Upper Back Pain. Please choose only one answer for each of the 10 sections. Sometimes the answers don't match your situation perfectly, but just choose the one answer in each section that is closest to how you feel in your Neck and Upper Back.

Form 5 – Low Back Disability Index - Disability Index – This is only required if you are experiencing Lower Back Pain. Please choose only one answer for each of the 10 sections. Sometimes the answers don't match your situation perfectly, but just choose the one answer in each section that is closest to how you feel in your Lower Back.

*** If you are experiencing both neck and low back pain, please do both the Neck Disability Index and the Low Back Disability Index.**

Form 6 – Auto Injury History – Only do this if you are entering for treatment for an Auto Injury.

Thank You so much! We Look Forward to Seeing You Soon!

CHIPLEY CHIROPRACTIC PLLC
CONFIDENTIAL PATIENT INFORMATION

Name _____ Date _____
(First) (Middle) (Last)

Address _____

City _____ State _____ Zip _____ Home Phone _____

In case of emergency, please notify: _____ Relationship _____
Address _____ Phone _____

Who referred you to our office? _____

Birthdate _____ Age: _____ SSN: _____ Sex _____ Marital Status: M S D W
(Circle One)

Employer _____ Occupation _____

Address _____

City _____ State _____ Zip _____ Work Phone _____

Method of Payment:

_____ Cash _____ Health Ins. Name of Company _____
_____ Car (MedPay) Name of Company _____ Claim No. _____
_____ Car (Other Person) Name of Company _____ Claim No. _____
_____ Workers Compensation Claim No. _____ DOI: _____

Who is your family physician? _____ May we send a treatment plan? __ Yes __ No

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION

I assign to Chipley Chiropractic PLLC my insurance benefits, settlement or judgement proceeds, which are or shall become payable to me as a result of my injuries, in an amount equal to their fee for treating me and grant them an irrevocable lien on those benefits or proceeds for their fee.

I am aware that I am responsible for paying Chipley Chiropractic's fee for treating me and at any time they can demand that I pay all or part of the balance of their fee.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I authorize Chipley Chiropractic PLLC to examine all hospital/medical/healthcare records pertaining to this injury and or any condition for which I have previously received medical attention.

Patient's Signature _____ Date _____

Guardian's
Signature Authorizing Care _____ Date _____

Past History

Patients Name: _____

Today's Date: _____

Date of Injury: _____

Marital Status: Married Single Widow
 Divorced

Habits:

Smoke: None Pk/day _____ Years _____

Alcohol: Never Social Moderate Heavy

Employed:

At the time of Accident/Injury? No Yes:

Where? _____

Currently: Yes: Where? Same or _____

Unemployed: Is this due to injury? Yes No

Type of Work: Office/Clerical Light Labor

Moderate Labor Heavy Labor

Have you missed work due to this injury? Yes No

If yes, How many days have you missed? _____

Past Medical History:

Surgeries (dates and any chronic problems)

None _____

Fractures (dates and chronic problems)

None _____

Past Serious Illnesses (dates and chronic problems)

None _____

If Female, Are you pregnant? No Yes

Work Injuries (dates and chronic problems) None

Past Personal Injuries (dates and chronic problems)

None _____

Sports or other injuries to head, neck, or back:

None _____

Any past history of current complaints: Yes

No

1. _____

2. _____

3. _____

Have you had chiropractic treatment? Yes

No

If Yes: For what? _____

Do you have any current health problems besides what you are here for today? Yes

No

If Yes: For What? _____

Current Medications:

SYMPTOM INTENSITY AND FREQUENCY FORM

PATIENT: _____ DATE: _____

For **SECTION 1**, describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels present currently. A zero (0) indicates that no symptoms exists. **1-3 pain** level is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slight level or where pain doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity ability to a significant degree. A **8-10 pain** level is severe and indicates that your pain intensity is to point where you have complete inability to perform some tasks. For **SECTION 2**, describe how frequent you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion.

SECTION 1. CURRENT PAIN INTENSITY LEVELS

Circle the box following the area of pain that best indicates your overall average-usual pain severity today.

Pain Intensity	None	MINIMAL Discomfort/Ache/Stiff			SLIGHT-TO-MODERATE Hurts/Sore/Bearable Sensation				SEVERE Sharp/Intense Pain		
Headache	0	1	2	3	4	5	6	7	8	9	10
Neck Pain/Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm/Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Low back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg/Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10

SECTION 2a. CURRENT PAIN FREQUENCY LEVELS

Circle the box following the area of pain that best indicates the average percentage of time you have pain today.

Pain Frequency	None	Occasional			Intermittent			Frequent		Constant	
Neck pain/soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm/Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid-back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Low Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg/Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

SECTION 2b. CURRENT HEADACHE FREQUENCY & DURATION

During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.

A. How frequently do you have headaches/migraines currently?

<input type="checkbox"/> No headaches	<input type="checkbox"/> once a week	<input type="checkbox"/> 4 times a week
<input type="checkbox"/> once a month	<input type="checkbox"/> twice a week	<input type="checkbox"/> 5 times a week
<input type="checkbox"/> twice a month	<input type="checkbox"/> 3 times a week	<input type="checkbox"/> Almost daily

B. How many hours does your typical headache/migraine last? _____ Hours?

Name: _____ Date: _____

Neck Pain – Choose ONLY 1 Answer for each section

SECTION 1--Pain Intensity

- I have no pain at the moment
- The pain is mild at the moment.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is severe but comes and goes.
- The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

- I can look after myself 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 extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, 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 lift very light weights.
- I cannot lift or carry anything at all.

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 with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I cannot read as much as I want because of moderate pain in my neck.
- I cannot read as much as I want because of severe pain in my neck.
- I cannot read at all.

SECTION 5--Headache

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come in-frequently.
- 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 cannot do any work at all.

SECTION 8--Driving

- I can drive my car without 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 cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9--Sleeping

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

SECTION 10--Recreation

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

Name: _____ Date: _____

Low Back Pain – Choose Only 1 Answer in each section

SECTION 1--Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is severe but comes and goes.
- The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

- I can look after myself without causing extra pain.
- I can look after myself normally but it causes some extra pain.
- It is painful to look after myself but I manage not to change my way of doing it.
- Washing and dressing do increase the pain enough that I have to change my way of doing it.
- Because of the pain, I am unable to do **some** washing or dressing without help.
- Because of the pain, I am unable to do **any** washing or dressing without help.

SECTION 3--Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights off the floor.
- 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 at the most.

SECTION 4 --Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk for more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5--Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain right away.

SECTION 6 – Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for more than 1 hour without increasing the pain.
- I cannot stand for more than ½ hour without increasing the pain.
- I cannot stand for longer than 10 minutes without increasing the pain.
- I avoid standing because it increases the pain right away.

SECTION 7--Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal nights sleep is reduced by less than ¼.
- Because of pain my normal nights sleep is reduced by less than ½.
- Because of pain my normal nights sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8—Social Life

- My social life is normal and gives me no 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., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9--Traveling

- I get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10—Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but is definitely getting better.
- My pain seems to be getting better, but is definitely slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Name: _____

Today's Date: _____

Date of Injury: _____

Was the accident on-the-job? Y N

You were: Driver Front Seat Passenger
Rear Seat Passenger

Vehicle Driven By? _____

Your Vehicle (Year/Make/Model) _____

Other Vehicle _____

Your estimated speed at the time of the accident?

Time of day: Daylight Dawn Dusk Dark

Road Conditions: Dry Damp Wet Snow Ice
Other _____

Head Restraints: None Integral to seat Adjustable
 type: Up Down Unsure

Was the head rest position altered by the crash? Yes
No

Was the seat broken? Yes No

Wearing Lap Belt? Yes No

Wearing Shoulder Belt? Yes No None

Did air bag deploy? Yes No

If air bag deployed, were you struck? Yes No

Was your body position? Good Forward Lean
Other: _____

Was your head facing? Forward Left Right Up
Down _____

Hands: One on Wheel Two on wheel N/A

Brakes Applied? Yes No

Were you wearing hat or glasses? Y N

If yes, still on after crash? Y N

Accident description: _____

Accident Diagram:

Were you aware of impending crash? Yes No

During the crash:
 Did you strike any part of the vehicle? Y N
 If yes, describe: _____

Did vehicle strike any objects after the crash? Y N
 If yes, describe: _____

Did you lose consciousness? Y N
 If yes, how long? _____

Estimated damage to your vehicle? \$ _____

Estimated damage to other vehicle? None Minimal
Moderate Severe Single car collision

Did the police come to the scene? Y N

After the crash:

Symptoms: Headaches Dizziness Nausea
Confused/stunned Neck pain Back pain
Numbness- where? _____
Arm pain- where? _____
Leg pain- where? _____

When did symptoms first appear: Immediate That evening 1-2 days 1 week or more

What symptom appeared first? _____

Where did you go after the accident? Home Work
Hospital Other _____

Mode of transportation: _____

Have you been evaluated for the injuries sustained in
 this accident prior to coming here? Y N