CONFIDENTIAL PATIENT CASE HISTORY

Name: _____ Sex:_____ Marital Status: ____ Birthdate: ____/____/_____

Home Phone: (____)_____ Cell Phone: (____)_____ Social Sec. #_____-_____-_____

Address:_____ Apt #_____ City_____ State_____ Zip_____

E-mail address_____

Employer:_____ Work Phone: (____)_____ Spouse's name_____

Emergency Contact name and phone number:_____

Who or what made you decide to visit our office (e.g., Yellow pages, referral from friend, etc.)_____

Is you visit due to an accident?_____

Describe your present complaint:_____

Who is your primary care doctor?_____

Have you seen any other doctor(s) for this condition?_____

Medical History- Please label any of these that you or any of your family members have had or are now suffering from as:

M=myself, F=family member, B= both myself and a family member

__AIDS	__Alcoholism	__Diverticulitis	__Emphysema	__Muscular Dystrophy
__Anemia	__Back Problems	__Diabetes	__Epilepsy	__Multiple Sclerosis
__Arteriosclerosis	__Cancer	__Dizziness	__Heart Problems	__Nervousness
__Arthritis	__Concussion	__Drug Abuse	__High Blood Pressure	__Numbness
__Asthma	__Convulsions	__Digestive Problems	__Hepatitis	__Polio
__Rheumatic Fever	__Stroke	__Scarlet Fever	__Sinus Trouble	__Seizures
__Sexually Transmitted Disease		__Thyroid Trouble	__Tuberculosis	__Typhoid Fever

Any other medical problesm?_____

Any significant trauma, (e.g., falls, car accident, broken bones):_____

Do you smoke or chew tobacco?_____

List any hospitalizations or operations and their dates:_____

_____

Have you been treated or examined by a physician in the past two years?____ Describe:_____

_____

Date of last physical exam:_____

List the medications and vitamins or supplements you are taking:_____

_____

Do you have a pacemaker?_____ Are you pregnant?_____ Do you have any implants of any kind_____

Have you had chiropractic care before?_____ When was that?_____ Was it helpful?_____

Signed:_____ Date:_____

First Visit Agreement

Assignment of Benefits/Release of Records/Limited Power of Attorney/Garnishment Authorization: I hereby assign all medical benefits – to include but not limited to, Medicare, private insurance health plans, automobile insurance, or any other payers – to Jon L. Mills, DC (hereafter referred to as Dr. Mills). I direct that all payments made to him, regardless of any other agreement or contract I may enter into with any attorney, individual, or group either before or after this date. I further authorize him to release any information, including medical information, necessary to secure payment. I also authorize any medical provider to supply copies of my medical records to Dr. Mills, or his agent, to endorse my checks, drafts, money orders, or any other financial instrument made payable to myself from any third party as payment for his services. Should I become delinquent on the payment of my bill to Dr. Mills, I authorize my employer to withhold this amount from my wages and to pay Dr. Mills directly from my earnings.

_____
initials

Consent to Treatment: I hereby request and consent to the performance of chiropractic adjustments, examinations, tests and other treatments by Dr. Mills or any other licensed practitioner who may be in practice at his office. I also authorize Dr. Mills or any other licensed practitioner who may be in practice at his office to exchange information about me with any other physician I have seen or will see in the future.

I have had the opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science, and that my care may involve making judgments based on the facts known to the doctor at the time: that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment, that no guarantee has been made to me as to results, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he feels at the time, based upon the facts then known, is in my best interests.

I also realize that, although the incidence of complications associated with chiropractic services is very low, possible hazards and complications do exist. These include, but are not limited to: fractures, intervertebral disc injuries, vertebral artery dissection, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor.

No Warranty or Guarantee: I understand that no warranty or guarantee has been made to me as to the curing of may condition.

Payment Method: I have selected the following method of paying my bill. *I realize however, that I am personally liable and responsible for payment for my services, in the event that my insurance carrier does not pay the full amount of my bill. I also agree to pay a 1.5% per month service charge on all amounts past due owed to Dr. Mills for the services he provided to me.* I request that my bill be settled by the following method (please circle your choice):

1. My condition is the result of an auto accident. I request my auto insurer be billed.
2. This is a workers' compensation claim. Please bill the insurer that provides this coverage to my employer.
3. Bill my health insurer for my care.
4. I will be paying for each visit at the time of my treatment.
5. My condition is the result of an auto accident, but I do not have insurance to cover my care. I will pay my bill according to a payment schedule that I will set up with Dr. Mills.

Signature:_____ Date:_____

Printed Name:_____ Witness:_____

Acknowledgement of Privacy Practices

I, _____, have been advised that
(printed name of patient)
Mills Chiropractic PC has a Notice of Privacy Practices.

I am aware that I have full access to it today in Mills's office, that it is also available on www.MillsChiro.com, and that I can have a printed copy of it provided to me today should I request one.

_____ _____
(signature) (date)

NECK DISABILITY INDEX

Name_____ Date____/____/____ File #_____
(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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 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 from lifting heavy weights off the floor, but I can manage 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 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 cannot 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.

From Vernon H, Mior S. JMPT 1991; 14(7): 409-415

0	1	2	3	4	5	6	7	8	9	10

No pain Excruciating pain

Figure1

Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name:_____ **File #** _____ **Date:** _____

This questionnaire has been designed to give the doctor 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. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem right now.

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 comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and 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.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. 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 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 more than ½ mile without increasing pain.
- ☐ I cannot walk more than 1/4 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 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 half hour
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight 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 longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight 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 night's sleep is reduced by less than 1/4.
- ☐ Because of pain my normal night's sleep is reduced by less than ½.
- ☐ Because of pain my normal night's sleep is reduced by less than 3/4.
- ☐ 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 - TRAVELLING
- ☐ I get no pain whilst travelling.
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative form of travel.
- ☐ I get extra pain whilst travelling 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 overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Pain Severity Scale:

Rate your usual level of pain today by checking one box on the following scale

0	1	2	3	4	5	6	7	8	9	10

No pain **Excruciating pain**

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: _____ Scores Total: _____:E_____: F_____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than 1 but less than 4 per month [3] more than one per week
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: (Please read carefully): The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	☐	☐	☐
F2. Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
E3. No one understands the effect my headaches have on my life.	☐	☐	☐
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches).	☐	☐	☐
E5. My headaches make me angry.	☐	☐	☐
E6. Sometimes I feel that I am going to lose control because of my headaches	☐	☐	☐
F7. Because of my headaches I am less likely to socialize.	☐	☐	☐
E8. My spouse (significant other), or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel that I am going to go insane.	☐	☐	☐
E10. My outlook on the world is affected by my headaches.	☐	☐	☐
E11. I am afraid to go outside when I feel that a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
E13. I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14. My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15. I avoid being around people when I have a headache.	☐	☐	☐
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
F17. I am unable to think clearly because of my headaches.	☐	☐	☐
F18. I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
F19. I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20. I feel irritable because of my headaches.	☐	☐	☐
F21. I avoid traveling because of my headaches.	☐	☐	☐
E22. My headaches make me feel confused.	☐	☐	☐
E23. My headaches make me feel frustrated.	☐	☐	☐
F24. I find it difficult to read because of my headaches.	☐	☐	☐
F25. I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐