Voithofer Chiropractic
& Accident Rehabilitation

Welcome!

DATE _____

PATIENT

TITLE: ☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR. ☐ OTHER _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER _____

FIRST NAME M.I. LAST NAME

DATE OF BIRTH GENDER: ☐ MALE ☐ FEMALE SOCIAL SEC. #:

STREET ADDRESS CITY ST ZIP

PHONE NUMBERS

HOME WORK CELL

EMAIL ADDRESS

SPOUSE / EMERGENCY CONTACT

FIRST NAME M.I. LAST NAME

PHONE NUMBERS

HOME WORK CELL

☐ **WORKPLACE INJURY**

HAVE YOU FILED AN INJURY REPORT WITH YOUR EMPLOYER? ☐ YES ☐ NO DATE:

☐ **AUTO INJURY**

HAVE YOU SUPPLIED US WITH THE AUTO ACCIDENT REPORT (FR-10) AND LEGAL REPRESENTATION INFORMATION? ☐ YES ☐ NO

HIPAA PRIVACY PRACTICES

I acknowledge that I have received and/or have been given the opportunity to review Voithofer Chiropractic & Accident Rehabilitation's Notice of HIPAA Privacy Practices for protected health information.

PATIENT'S NAME (PLEASE PRINT) DATE

PATIENT'S SIGNATURE

CONSENT TO TREAT A MINOR

NAME OF MINOR PATIENT DATE

SIGNATURE OF PARENT / GUARDIAN AUTHORIZING CARE

PATIENT HISTORY

PATIENT NAME_____ DATE _____

How did you hear about us? _____

Have you ever been treated by another chiropractor? ☐ YES ☐ NO
If so, was it a positive experience? ☐ YES ☐ NO

IF "NO" PLEASE EXPLAIN: _____

_____

CHIROPRACTIC HISTORY: Please mark any symptoms you have experienced in the last six months.

☐ Headaches (Frequency: _____)

☐ Neck pain	☐ Sleeping problems	☐ Numbness in feet	☐ Numbness in hands	☐ Dizziness	☐ Weakness in arms or legs
☐ Stiff neck	☐ Loss of balance	☐ Back pain	☐ Tension	☐ Fainting	☐ Shoulder / neck / arm pain
☐ Cold hands	☐ Cold feet	☐ Arthritis	☐ Muscle spasms	☐ Joint pain / swelling	

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ YES ☐ NO If so, may we contact him / her? ☐ YES ☐ NO

Medical Group: _____ Doctor's name: _____

☐ YES ☐ NO Are you pregnant?
☐ Yes ☐ No Have you ever been hospitalized or had major surgery? _____
☐ YES ☐ NO Have you ever had a serious head, back, or neck surgery? _____
☐ YES ☐ NO Do you have any allergies? _____
☐ YES ☐ NO Are you currently taking any medications? (Please list) _____

_____

_____

MEDICAL CONDITIONS: Please mark all that apply to you.

☐ AIDS / HIV	☐ Asthma	☐ Blood disorders	☐ Bronchitis	☐ Cancer	☐ Chronic fatigue
☐ Depression	☐ Diabetes	☐ Emphysema	☐ Fractures	☐ G.I. issues	☐ Glaucoma
☐ Gout	☐ Heart attack	☐ Heart disease	☐ Hepatitis	☐ Hernia	☐ Herniated disc
☐ Herpes	☐ High cholesterol	☐ High blood pressure	☐ Kidney disease	☐ Liver disease	☐ Migraines
☐ Miscarriage	☐ Mono	☐ M.S.	☐ Osteoporosis	☐ Parkinson's	☐ Polio
☐ Pacemaker	☐ Pneumonia	☐ Prostate	☐ Seizures	☐ Stroke	☐ Thyroid problems
☐ Fibromyalgia	☐ Other _____				

SOCIAL HISTORY: Please mark all that apply to you.

CAFFEINE USE:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
ALCOHOL USE:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
EXERCISE:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
NICOTINE USE:	☐ Never	☐ Occasionally	☐ Regularly (amount / frequency: _____)
WEAR SEAT BELT:	☐ Never	☐ Occasionally	☐ Always

OTHER: _____

FAMILY HISTORY: Please mark all that apply to members of your immediate family.

RHEUMATOID ARTHRITIS:	☐ Parent	☐ Sibling	☐ Grandparent
CANCER:	☐ Parent	☐ Sibling	☐ Grandparent
DIABETES:	☐ Parent	☐ Sibling	☐ Grandparent
HEART DISEASE:	☐ Parent	☐ Sibling	☐ Grandparent
HIGH BLOOD PRESS:	☐ Parent	☐ Sibling	☐ Grandparent
STROKE:	☐ Parent	☐ Sibling	☐ Grandparent
THYROID DISEASE:	☐ Parent	☐ Sibling	☐ Grandparent
OTHER: _____	☐ Parent	☐ Sibling	☐ Grandparent

PATIENT SELF-ASSESSMENT - 1

PATIENT NAME_____ DATE _____

HEIGHT	WEIGHT	BLOOD PRESSURE	HEART RATE

SYMPTOM MAP

Mark the areas where you are experiencing symptoms.

Use the key letters to indicate type of discomfort.

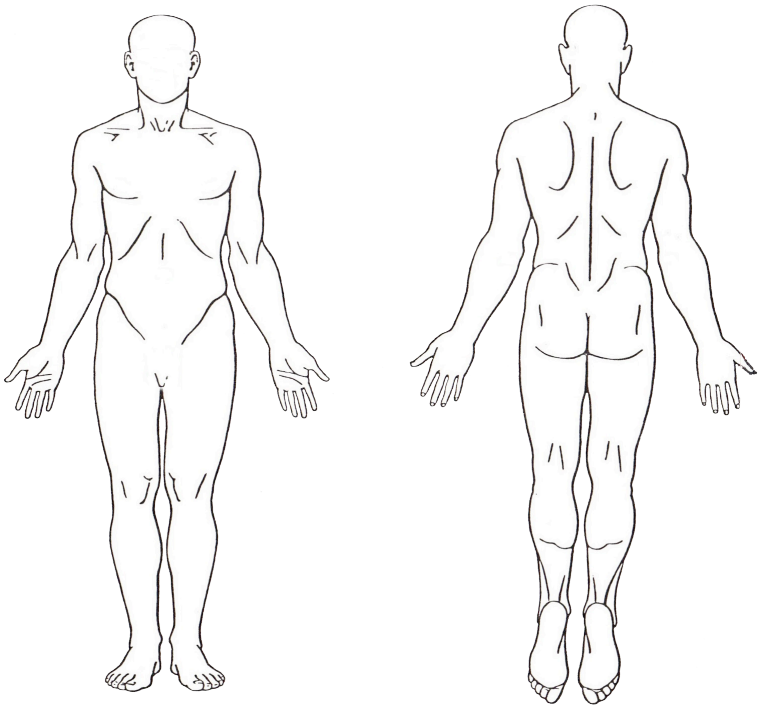
N - NUMBNESS

B - BURNING

S - STABBING

T - TINGLING

A - ACHE



When did symptoms begin? _____

Briefly describe your symptoms: _____

_____

How did your symptoms begin? _____

_____

Rate the average severity / intensity of your pain:

Last 24 hours:	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	WORST PAIN
Past week:	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	WORST PAIN

How much of the time do you experience your symptoms?

☐ 75 - 100 % ☐ 50 - 75% ☐ 25 - 50% ☐ 0 - 25%

How much do your symptoms interfere with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How would you describe the state of your symptoms over time?

☐ Much worse ☐ Slightly worse ☐ No change ☐ Slightly improved ☐ Much improved

How would you describe general state of your health right now?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

PATIENT SELF-ASSESSMENT - 2

PATIENT NAME_____ DATE _____

EMPLOYMENT

Mark the categories that best describe your job.

- ☐ Business owner
- ☐ Administrator
- ☐ Administrative assistant
- ☐ Executive / Legal
- ☐ Data processing
- ☐ Heavy equipment operator
- ☐ Childcare
- ☐ Construction
- ☐ Health care
- ☐ Food service
- ☐ Heavy manual labor
- ☐ Medium manual labor
- ☐ Light manual labor
- ☐ Manufacturing
- ☐ Home services
- ☐ OTHER: _____

How much does your condition interfere with your job performance?

- ☐ Has no effect
- ☐ Allows normal activity
- ☐ Slightly limits activity
- ☐ Moderately hinders duties
- ☐ Significantly hinders duties
- ☐ Prevents duties

ACTIVITIES OF DAILY LIFE (ADL)

Rate how your symptoms affect your daily activities.

BEND:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
CARRY GROCERIES:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
SIT - TO - STAND:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
CLIMB STAIRS:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
KNEEL:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
LIFT AND CARRY:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
DRIVE VEHICLE:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
USE COMPUTER:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
EAT MEALS:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
PERFORM HOUSEWORK:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
CARE FOR CHILDREN & PETS:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
READ / STUDY (FOCUS):	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
BATHE SELF:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
DRESS SELF:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
SHAVE SELF:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
SEXUAL INTERCOURSE:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
SLEEP:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
SIT 30 MINUTES OR MORE:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
STAND 30 MINUTES OR MORE:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
WALK:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
WORK IN YARD:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action

RECREATION

Rate how your symptoms affect your recreational activities.

PLAY WITH CHILDREN OR PETS:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
FAMILY OUTINGS:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
TRAVEL:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
LEISURE TIME AT HOME:	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
SPORT:_____	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
SPORT:_____	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
HOBBY: _____	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
HOBBY: _____	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
OTHER: _____	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action
OTHER: _____	☐ No effect	☐ Mild: discomfort does not limit	☐ Moderate: pain limits action	☐ Severe: pain prevents action

DOCTOR'S SIGNATURE: _____

BACK INDEX

PATIENT NAME_____ DATE _____

*This questionnaire will give your provider information about how your **back condition** affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

PAIN INTENSITY

- [0] The pain comes and goes, and is very mild.
- [1] The pain is mild and does not vary much.
- [2] The pain comes and goes and is moderate.
- [3] The pain is moderate and does not vary much.
- [4] The pain comes and goes, and is very severe.
- [5] The pain is very severe and does not vary much.

CHANGING DEGREE OF PAIN

- [0] My pain is rapidly getting better.
- [1] My pain fluctuates, but over all is definitely getting better.
- [2] My pain seems to be getting better, but improvement is slow.
- [3] My pain is neither getting better nor worse.
- [4] My pain is gradually worsening.
- [5] My pain is rapidly worsening.

SLEEPING

- [0] I get no pain in bed.
- [1] I get pain in bed, but it does not prevent me from sleeping well.
- [2] Because of pain my normal sleep is reduced by up to 25%.
- [3] Because of pain my normal sleep is reduced by up to 50%.
- [4] Because of pain my normal sleep is reduced by up to 75%.
- [5] The pain prevents me from sleeping at all.

SITTING

- [0] I can sit in any chair as long as I please.
- [1] I can only sit in my favorite chair as long as I please.
- [2] Pain prevents me from sitting more than one hour.
- [3] Pain prevents me from sitting more than 30 minutes.
- [4] Pain prevents me from sitting more than ten minutes.
- [5] I avoid sitting because it increases pain immediately.

STANDING

- [0] I can stand as long as I want without pain.
- [1] I have some pain while standing, but it does not increase with time.
- [2] I cannot stand for longer than one hour without increasing pain.
- [3] I cannot stand for longer than 30 minutes without increasing pain.
- [4] I cannot stand for longer than ten minutes without increasing pain.
- [5] I avoid standing because it increases pain immediately.

WALKING

- [0] I have no pain while walking.
- [1] I have some pain while walking, but it does not increase with distance.
- [2] I cannot walk more than one mile without increasing pain.
- [3] I cannot walk more than a half-mile without increasing pain.
- [4] I cannot walk more than a quarter mile without increasing pain.
- [5] I cannot walk at all without increasing pain.

PERSONAL CARE

- [0] I do not have to change my ways of washing and dressing to avoid pain.
- [1] I do not normally alter my ways of washing or dressing even though it causes some pain.
- [2] Washing and dressing increases the pain, but I manage not to change my ways of doing it.
- [3] Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
- [4] Because of the pain, I am unable to do some washing and dressing without help.
- [5] Because of the pain, I am unable to do any washing and dressing without help.

LIFTING

- [0] I can lift heavy weights without extra pain.
- [1] I can lift heavy weights, but it causes extra pain.
- [2] Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned (e.g., on a table).
- [3] Pain prevents me from lifting heavy weights off the floor, but I can manage light-to-medium weights if they are conveniently positioned.
- [4] I can only lift very light weights.
- [5] I cannot lift or carry anything at all.

TRAVELING

- [0] I get no pain while traveling.
- [1] I get some pain while traveling, but none of my usual forms of travel make it worse.
- [2] I get extra pain while traveling, but it does not cause me to seek alternate forms of travel.
- [3] I get extra pain while traveling which causes me to seek alternate forms of travel.
- [4] Pain restricts all forms of travel except that done while lying down.
- [5] Pain restricts all forms of travel.

SOCIAL LIFE

- [0] My social life is normal and gives me no extra pain.
- [1] My social life is normal, but increases the degree of pain.
- [2] Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., dancing, etc.).
- [3] Pain has restricted my social life and I do not go out very often.
- [4] Pain has restricted my social life to my home.
- [5] I have hardly any social life because of the pain.

BACK INDEX SCORE:

$$\text{Index Score} = \left(\frac{\text{sum of all statements selected}}{\text{\# of sections with a statement selection x 5}} \right) \times 100$$

NECK INDEX

PATIENT NAME_____ DATE _____

*This questionnaire will give your provider information about how your **neck condition** affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

PAIN INTENSITY

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain comes and goes and is moderate.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imagineable at the moment.

SLEEPING

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

READING

- 0 I can read as much as I want with no neck pain.
- 1 I can read as much as I want with slight neck pain.
- 2 I can read as much as I want with moderate pain.
- 3 I cannot read as much as I want because of moderate neck pain.
- 4 I can hardly read at all because of severe neck pain.
- 5 I cannot read at all because of neck pain.

CONCENTRATION

- 0 I can concentrate fully when I want, with no difficulty.
- 1 I can concentrate fully when I want, with slight difficulty.
- 2 I have a fair degree of difficulty concentrating when I want.
- 3 I have a lot of difficulty concentrating when I want.
- 4 I have a great deal of difficulty concentrating when I want.
- 5 I cannot concentrate at all.

WORK

- 0 I can do as much work as I want.
- 1 I can only do my usual work but no more.
- 2 I can only do most of my usual work, but no more.
- 3 I cannot do my usual work.
- 4 I can hardly do any work at all.
- 5 I cannot do any work at all.

PERSONAL CARE

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

LIFTING

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned (e.g., on a table).
- 3 Pain prevents me from lifting heavy weights off the floor, but I can manage light-to-medium weights if they are conveniently positioned.
- 4 I can only lift very light weights.
- 5 I cannot lift or carry anything at all.

DRIVING

- 0 I can drive my vehicle without any neck pain.
- 1 I can drive my vehicle as long as I want with slight neck pain.
- 2 I can drive my vehicle as long as I want with moderate neck pain.
- 3 I cannot drive my vehicle as long as I want because of moderate neck pain.
- 4 I can hardly drive at all because of severe neck pain.
- 5 I cannot drive my vehicle at all because of neck pain.

RECREATION

- 0 I am able to engage in all my recreational activities without neck pain.
- 1 I am able to engage in all my usual recreational activities with some neck pain.
- 2 I am able to engage in most but not all my usual recreational activities because of neck pain.
- 3 I am only able to engage in a few of my usual recreational activities because of neck pain.
- 4 I can hardly do any recreational activities because of neck pain.
- 5 I cannot do any recreational activities at all.

HEADACHES

- 0 I have no headaches at all.
- 1 I have slight headaches which come infrequently.
- 2 I have moderate headaches which come infrequently.
- 3 I have moderate headaches which come frequently.
- 4 I have severe headaches which come frequently.
- 5 I have headaches almost all the time.

NECK INDEX SCORE:

$$\text{Index Score} = \left(\frac{\text{sum of all statements selected}}{\text{\# of sections with a statement selection x 5}} \right) \times 100$$

Informed Consent for Chiropractic Care

I hereby request and authorize the performance of chiropractic and other chiropractic procedures, including various modes of manual therapy, physical therapy, massage therapy, traction, rehabilitation exercised and diagnostic x-ray procedures, by the Chiropractic Physician/s, or any other licensed staff associated with Voithofer Chiropractic & Accident Rehabilitation.

It is understood that the doctor does not offer to diagnose or treat any disease or condition other than vertebral subluxation, neuromuscular, or other musculoskeletal conditions. In the event of any non-chiropractic or unusual medical findings, the doctor will recommend that the patient seek services of a healthcare provider who specializes in that area if the patient desires advice, diagnosis or treatment of such findings.

I understand that results from treatment are not guaranteed. I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some very remote risks to treatment. I wish to rely on the doctor and staff to exercise their best judgment during my course of treatment.

I have read the above consent I have also had the opportunity to ask questions about any concerns I may have. I request the above treatments be performed for current and/or any future treatments I will be receiving.

_____ _____

Patient or Authorized Person's Signature Date Completed
If under 18 years of age, must be signed by a Parent or Guardian.

_____

Patient's Name (please print)

Voithofer Chiropractic
& Accident Rehabilitation

HIPPA

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties with respect to your health information. Other than the uses and disclosures described below, we will not sell or provide any of your health information to any outside marketing organization.

USES AND DISCLOSURES

Here are examples of how we might have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider, or a hospital, etc. if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.

- We may have to disclose your examination, treatment records and billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of the services you have or will received.

- We may need to use any information in your file for quality control purposes or any other administrative purposes within our practice.

YOUR RIGHT TO LIMIT OR DISCLOSE

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding to us.

PREMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- We are providing health care services to you based on orders (referral) of another health care provider.
- We provide health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, bit in our professional judgment we believe that you intend for is to provide care.

RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I understand and have been provided with a "Notice of Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____ _____

Patient or Authorized Person's Signature Date Completed

If under 18 years of age, must be signed by a Parent or Guardian.

_____

Patient's Name (please print)