

WELLNESS PROFILE

Doctors of Chiropractic work with the nervous system which in turn controls all bodily functions and systems. People see Chiropractors for a variety of reasons. Some go for merely relief of pain and some to correct the cause of pain. Our goal is to provide you with a holistic evaluation of your health, considering mind, body and spirit. There may be seemingly insignificant events or aspects of your daily life that are contributing to today's picture of you. Please answer to the best of your ability.

On a scale of 0-10 with 10 being the best, please rate your overall health today: _____

On that same scale, please rate your current diet: _____

And rate your current stress level: Life is Good Mild Moderate High Pass me the Bottle

Do you follow a special diet? _____

List any supplements you currently take

_____	_____
_____	_____

Do you have any allergies (seasonal, foods, meds, etc?) _____

What is your normal sleeping position? Side Back Stomach

How many hours of sleep do you get per day? _____ What is the age of your mattress? _____

Indicate the type and number of pillows you use:

Thick _____ Thin _____ Medium _____ Memory Foam _____ Contoured _____

Do you wear: heel lifts _____ arch supports _____ orthotics _____

Patient name: _____ Signature: _____ Date: _____

This questionnaire has been designed to give the doctor 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 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.**

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 to 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 – 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 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 hr. 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 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. 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 recreation activities at all.

INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, we need a copy of the card
It is your responsibility as the patient to know and understand your medical benefits. Please note: The agreement of insurance is a contract between you and your insurance company. You are responsible for payment in full if for any reason payment is not made on a claim within 30 days of submission. For Your Convenience we accept Cash, Checks and all major Credit Cards.	Carrier Name:
	Address:
	Telephone:
	ID Number:
	Group Number:
Are you the insured person or dependent (Spouse/Child)?	<input type="checkbox"/> Insured, <input type="checkbox"/> Dependent
If you are the insured persons dependent (spouse/child), we need the insured persons name, date of birth, social security number, and the name of the insured employers business in order to do billing.	Name of Insured Person:
	Social Security Number:
	Insured Date of Birth:
	Name of Insured Employer:

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier within 30 days of claim submission. All requests for copies of Medical Records or a Report will require a minimum \$35.00 payment from the patient to cover clerical and copy fees. You are also responsible for any treatment your Insurance company may deem not medically necessary.* _____ **initial**

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT.
 24-hour notice is required for cancellation or you will be charged a cancellation fee of \$35.00

Your signature on this document indicates that you understand and agree with our Office Policies.

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Signature of responsible party (Patient or Parent): _____ Date: _____

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:
 DHHS, Office of Civil Rights
 20 Independence Avenue, S.W.
 Room 509F HHH Building
 Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.
 By way of signature, I provide Tice Valley chiropractic Center with my authorization and consent to use and disclose my protected health care information for purposes of treatment, payment and health care operations as described in the Privacy Notice.

 Patient's Name (Print)

 Date

 Patient's Signature

 Date

Medical History Information

Last Name:		Spouse Name:		Marital status (circle one)	
First Name:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Widow	
Email:			Birth date:		Age:
Would you like our Newsletter? Y N					Sex:
Address:			City:		State/Zip Code
Social Security No.:		Home Phone:		Cell Phone:	
Occupation:		Employer:			Work Phone:
Medical Care Information					
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:					
Address:		City:		State:	ZIP Code:
Date of last Visit: / /			Date of last exam: / /		
Do You Have a Family Chiropractor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor:					
Address:		City:		State:	ZIP Code:
Date of last Visit: / /			Date of last exam: / /		
Have you had surgeries in the last 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Last Surgery Date:					
Reason for Surgery:					
Present illness /Conditions:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio	<input type="checkbox"/>
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S	<input type="checkbox"/>
Other:					
Family History of illness:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis
Other:					
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other:					
Social History:					
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?	Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?	Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?	Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Hours per week? (circle one) Light / Moderate / Strenuous		
Misc.:					

Patient name: _____ Signature: _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only 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.**

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 severe.
- The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)

- 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 gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor but I can 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 with walking but it does not increase with distance.
- I cannot walk more than One Mile without increasing pain.
- I cannot walk more than 1/2 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 30 minutes.
- 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 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases 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 nights sleep is reduced by less than 1/4.
- Because of pain my normal nights sleep is reduced by less than 1/2.
- Because of pain my normal nights 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 my 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 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 sorts 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 overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at the present.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.