CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION Date_____

Name_____ Male ☐ Female ☐ Social Security #_____

Birthdate_____ Age_____ Single☐ Married☐ Widowed☐ Separated☐ Divorced☐ Children?_____
Address_____City/State/Zip_____
Home phone_____ Work phone_____
Patient's occupation_____Employer_____
Employer address/city/state/zip_____
EMAIL ADDRESS_____

SPOUSE ☐ PARENT ☐ LEGAL GUARDIAN ☐ (check one)

Name_____ Male ☐ Female ☐ Social Security #_____

Birthdate_____ Age_____ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Children?_____
Address_____City/State/Zip_____
Home phone_____ Work phone_____
Patient's occupation_____Employer_____
Employer address/city/state/zip_____

How were you referred to our office?_____

INSURANCE
Who is responsible for this account?_____Relation to Patient_____
Patient's Insurance_____ Spouse's Insurance_____
Name of Ins._____ Name of Ins._____
Address_____Address_____
Policy #_____Policy #_____
Group # _____Group #_____
Phone #_____Phone #_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Sullivan Family Chiropractic 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 Sullivan Family Chiropractic will be credited to my account upon receipt. I also give Sullivan Family Chiropractic power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature_____Date_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release Dr. Sullivan and whomever he/she may designate as his assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any other services that he deems necessary in my case. I further authorize Dr. Sullivan to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to Sullivan Family Chiropractic or to the patient or to a family member or employer of the patient for all or part of the services rendered to me, including and not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds or employers.

Patient's Signature_____Date_____

IF A MINOR-Signature of Parent/Guardian_____Date_____

HEALTH QUESTIONAIRE

Patient's Name_____ DATE_____

CURRENT CONDITION

Describe your symptoms/location of problems?_____
Your goals for treatment/what do you want to be able to do that you currently cannot:_____
Date symptoms first appeared?_____Is this related to an automobile or work-related accident?_____
What caused your pain to begin?_____
What treatment, tests, xrays, and/or medications have you already received for your condition?
_____
Other doctors seen for this condition:_____
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
Type of pain (mark all that apply): □ sharp □ dull □ throbbing □ numbness □ aching □ burning □ shooting □ tingling □ cramps □ stiffness □ swelling □ other
How often are your symptoms present: □ constant □ frequent □ occasional □ intermittent (comes and goes)
Since it began, is your problem: □ improving □ no change □ getting worse
What makes the problem better ?_____
What makes the problem worse ?_____
Can you perform your daily home activities? □ yes □ yes, limited by myself □ yes, only with help □ not at all
Can you perform your daily work activities? □ yes □ yes, limited by myself □ yes, only with help □ not at all
Describe your daily job requirements:_____
Your stress level: □ none □ mild □ moderate □ severe

PAST HEALTH HISTORY

Have you been treated by a doctor or health care professional in the last year?____ If yes, for what conditions:
_____
Have you ever been under chiropractic care before?_____ Where:_____
Same condition? _____ Other _____

If you have *ever* had a listed symptom in the *past*, please check the symptom in the *past column*. If you are presently experiencing a particular symptom, check that symptom in the *present column*. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT OR THERAPY YOU ARE TO RECEIVE.

Past	Present	Condition
□	□	Neck pain
□	□	Shoulder pain R□ L□
□	□	Pain in upper arm or elbow R□ L□
□	□	Hand pain R□ L□
□	□	Wrist pain R□ L□
□	□	Upper back pain
□	□	Low back pain
□	□	Pain in upper leg or hip R□ L□
□	□	Pain in lower leg or knee R□ L□
□	□	Pain in ankle or foot R□ L□
□	□	Jaw pain
□	□	Swelling, stiffness of joint(s)
□	□	Pain that wakes you at night
□	□	Fainting
□	□	Visual Disturbance
□	□	Convulsions
□	□	Dizziness
□	□	Headache
□	□	Muscular Incoordination
□	□	Tinnitus (ringing or noises in ear)
□	□	Rapid Heart Beat
□	□	Chest pain
□	□	Loss of Appetite
□	□	Anorexia
□	□	Abnormal weight loss
□	□	Abnormal weight gain
□	□	Chronic cough

Past	Present	Condition
□	□	Heartburn/Indigestion
□	□	Dermatitis/Eczema/Rash
□	□	Numbness
□	□	Nosebleeds
□	□	Depression
□	□	Aortic Aneurysm
□	□	Heart Attack (date)_____
□	□	Stroke (date)_____
□	□	Cancer, explain below
□	□	Tumor, explain below
□	□	Asthma
□	□	Prostate problems
□	□	Blood disorder
□	□	Emphysema (chromic lung disorders)
□	□	Arthritis
□	□	Rheumatoid Arthritis
□	□	Diabetes
□	□	Epilepsy
□	□	Ulcer
□	□	Liver/gallbladder problem
□	□	Kidney stones
□	□	Hepatitis
□	□	Bladder Infection
□	□	Kidney Disorders
□	□	Colitis/Irritable Colon
□	□	Excessive thirst
□	□	Chronic sinusitis (sinus infections)

Past	Present	Condition
□	□	General fatigue
□	□	Irregular menstrual cycle
□	□	Abdominal pain
□	□	Breast soreness □ lumps □
□	□	Endometriosis
□	□	PMS
□	□	Loss of bladder control
□	□	Painful urination
□	□	Frequent urination
□	□	Excessive bowel action
□	□	Constipation
Avg.# of bowel movements per day____		
□	□	HIV/AIDS
□	□	Difficulty breathing
□	□	Other_____

If a family member has had any of the following, please mark the appropriate box:
□ Cancer □ Epilepsy □ Rheumatoid
□ Diabetes □ Heart problems □ Lung problems
□ Stroke □ Mental problems □ Back problems
□ Other_____
Relationship to patient
_____

Please check all that apply to you:
□ currently pregnant □ # of births_____ □ Tobacco □ Alcohol □ Drug or alcohol dependence

CURRENTMEDICATIONS/HOSPITALIZATIONS/SURGERIES:_____

PRIMARY CARE PHYSICIAN:
NAME/LOCATION_____
I AUTHORIZE DR. SULLIVAN TO SEND A MEDICAL UPDATE OF MY CURRENT CONDITION TO MY PRIMARY CARE PHYSICIAN Signature_____

HEALTH CARE AUTHORIZATION FORM

This form authorizes us to file your insurance, have your signature on file for insurance purposes, comply with Health Insurance Portability and Accountability Act (HIPAA) regulations, and provide you with better overall service. THE PATIENT IDENTIFIED BELOW AUTHORIZES SULLIVAN FAMILY CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- ✓ I give Sullivan Family Chiropractic permission to treat me in an area where other patients are also being treated. I give permission to use my name aloud in the office during my visit (Including but not limited to, general conversation with me, calling me from the waiting area, taking me to treatment room). I am aware that other persons may overhear some of my protected health information during the course of care. Please hold any private information or questions until you are in a private room with the staff or doctor. (It is our office policy to not discuss health information and private issues in from of other patients, all precautions will be made to adhere to this policy)

- ✓ I authorize the use of my name in print for general purpose; such as posting my name on an internal Referral Board if and when I refer people to their office for evaluation and treatment, patient of the month listing, etc. I further authorize the use of my signature to be on a universal (consecutively viewed by each patient signing in) sign in sheet for each visit.

- ✓ I authorize Sullivan Family Chiropractic to use my address, phone numbers and clinical records to contact me with appointment reminders, to leave a message, to reschedule an appointment, missed appointment notification, birthday cards, newsletters, holiday cards, or other health related information. If I am contacted by phone, I give permission to leave a message with a member of my household, on my answering machine or voice mail.

- ✓ I authorize use of this form on all of my insurance submissions [SIGNATURE ON FILE] I authorize release of information to all my insurance companies. I authorize Sullivan Family Chiropractic to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to Sullivan Family Chiropractic from my insurance companies.

- ✓ I understand that I am ultimately responsible for my bill and payment is due when services are rendered, unless other arrangements have been made.

- ✓ I permit a copy of this authorization to be used in place of the original.

- ✓ I understand that this office is complying with federal HIPAA guidelines by advising me that they are doing everything in their power to protect my private health information. At any time, I am able to ask this office of the safety and protected nature of my health information, or any other related issues or concerns.

- ✓ By signing this form I am giving Sullivan Family Chiropractic permission to use and disclose my protected health information in accordance with the directives listed above.

Name (Please print)_____ Date of Birth _____

Signature_____ Date_____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/guardian Signature_____ Date _____

Witness Signature _____ Date_____

GENERAL PAIN DISABILITY INDEX

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words we would like to know how much your pain is preventing you from doing what you would normally do. Respond to each category indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories or daily living listed, **PLEASE NUMBER EACH ITEM WITH A SCORE OF 0-10 WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES**. A score of 0 means no functioning at all and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

0	1	2	3	4	5	6	7	8	9	10

NO LIMITATION
COMPLETELY ABLE TO FUNCTION

TOTAL LIMITATION
UNABLE TO FUNCTION

_____**1. Family/Home Responsibilities-**Chores and duties performed around the house (ex. Yard work, carpool, etc.)

_____**2. Recreation-**Hobbies, sports, and other similar leisure time activities.

_____**3. Social Activity**-Participation with friends and family. Parties, theater, concerts, dining out and other social functions.

_____**4. Occupation**-Directly related to your job. Full, part, or non-paid positions; including homemaker.

_____**5. Self Care**-Personal maintenance and independent daily living (ex. Taking a shower, driving, getting dressed, etc.)

_____**6. Life-Support Activity**-Eating, sleeping, and breathing.

_____ Total

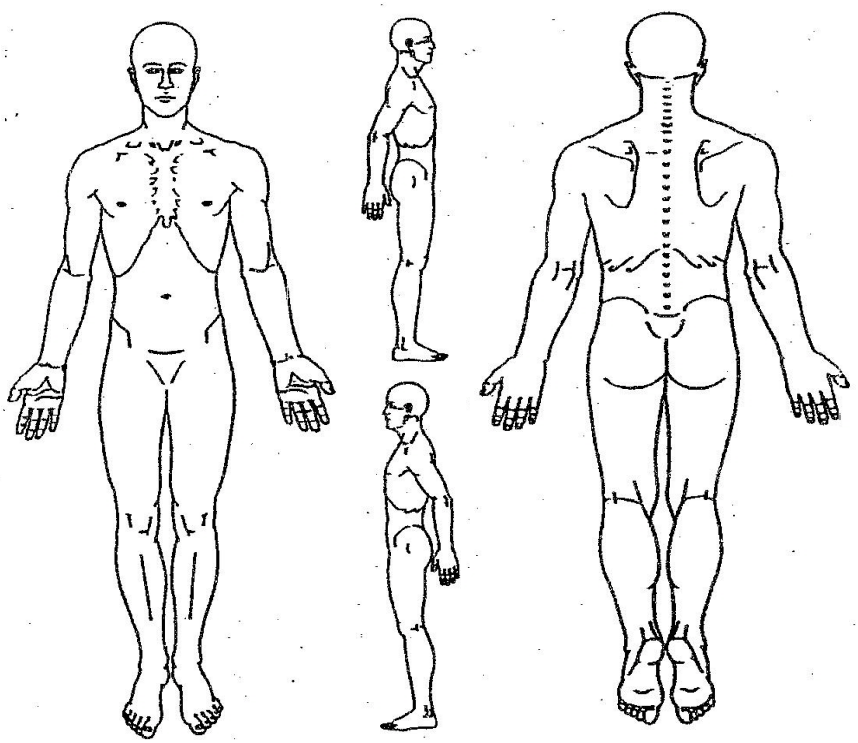
_____ Signature

_____ Date

VISUAL ANALOG PAIN SEVERITY SCALE (VAS SCALE)

INSTRUCTIONS: Please mark on the line below how you currently feel.

NO PAIN----------WORST PAIN EVER



PLEASE MARK ON THE BODIES TO THE LEFT, THE LOCATION AND TYPE OF PAIN YOU ARE EXPERIENCING

NUMBNESS	====
BURNING	XXXXX
SHARP/STABBING	///////
PINS AND NEEDLES	ooooo
ACHING	aaaaa

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Back Index

Form BI100

rev 3/27/2003

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.

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 less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 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 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 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 doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way 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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

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 affect 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.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score ☐

Neck Index

Form N1-100

rev 3/27/2003

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 imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 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 neck 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 they 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 car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car 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 car at all because of neck pain.

Recreation

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score