PLAINS
CHIROPRACTIC & ACUPUNCTURE

Name: _____Date: _____

Address: _____City, State, Zip: _____

E-mail: _____Phone: _____

Age: _____ Birth Date: _____ Social Security #: _____ Gender: _____

Marital Status: S M D W Spouse/Guardian: _____ # of Children: _____

Occupation: _____Employer: _____

Whom may we thank for your referral? _____Primary Care Provider: _____

Emergency Contact: _____ Phone: _____Relation: _____

Purpose of this appointment: _____

Date symptoms appeared or accident occurred: _____

Have you seen other health care providers for these symptoms? _____

What surgeries have you had? _____

Any other health conditions treated in the last year? Yes____ No____ If yes, please describe: _____

What medications, supplements, or drugs are you taking? _____

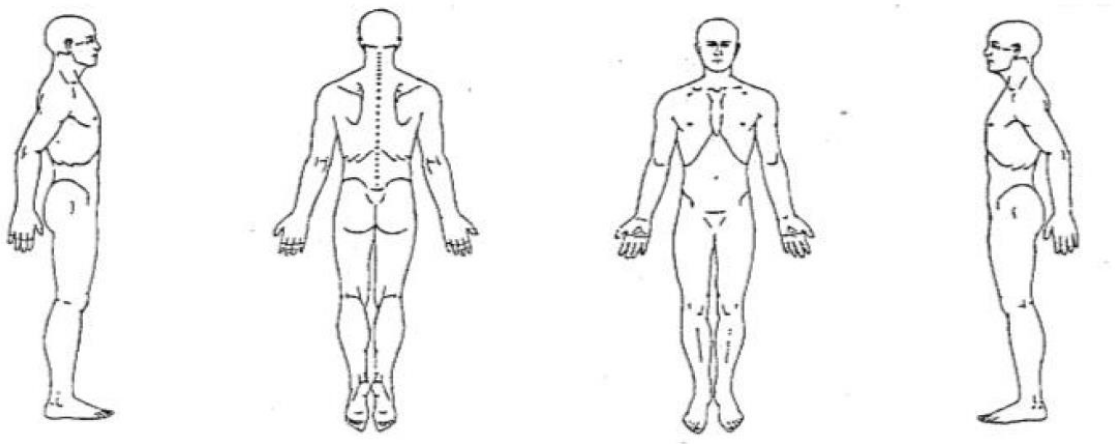
Have you had chiropractic care previously? Yes____ No____ Clinic/Doctor's name: _____

The following questions are necessary to properly file your insurance for you. Please answer as fully as possible.

1. Is the condition we are treating related to current or previous employment? Yes____ No____
2. Is the condition we are treating related to an auto accident? Yes____ No____
3. Is the condition we are treating related to another type of accident? Yes____ No____
4. Is there another health benefit plan? Yes____ No____ If yes, please list: _____
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes____ No____
6. Are you entitled to Medicare because of End Stage Renal Disease? Yes____ No____
7. Are you entitled to any benefits under the Federal Black Lung Program? Yes____ No____
8. Do you have a Medicare Medigap Policy? Yes____ No____ Name of Company _____
9. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from): Yes____ No____ Please List: _____

Using the symbols indicated below; please mark the areas on the illustrations where you are experiencing pain.

A: Dull, Nagging Ache **N**: Numbness, tingling **B**: Burning **S**: Sharp, Stabbing



1. What are your major symptoms?_____
2. Have you ever had the same or a similar condition? Yes ____ No____ If Yes, when _____
   How did it originally occur?_____
3. Has it become worse recently? Yes____ No____ Same____ Better____ Gradually Worse____
   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only_____
5. How long do the symptoms last? All Day_____ Hours_____ Minutes_____
6. Is there anything you can do to relieve the problem? Yes____ No____ If yes, please describe _____
   If no, what have you tried that has not helped? _____
7. What makes the problem worse? Standing____ Sitting____ Lying____ Bending____ Lifting ____ Twisting ____ Other____
8. Are there any other conditions or symptoms that may be related to your major symptom? Yes____ No____
   If yes, please describe_____
9. Have you had any broken bones? Yes____ No____ Please list _____
10. List any major accidents you have had other than those that might be mentioned above:_____
    _____
11. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes____ No____ If yes, please explain _____
12. Women Only: Are you pregnant or is there any possibility you may be pregnant? Yes____ No____

Please place an "X" on the Numeric Pain Rating Scale to indicate the severity of your problem

0_____5_____10

No Symptoms **Extreme Symptoms**

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

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www.chiroevidence.com

Please Check All That Apply:

Family Medical History
- ❑ Allergies
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Illness
- ❑ Multiple Sclerosis
- ❑ Seizures
- ❑ Stroke

Parents Health:
❑Good ❑Fair ❑Poor

Your Past/Present Medical Conditions
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Blood Sugar Disorders
- ❑ Cancer
- ❑ Chronic Fatigue/ CFS
- ❑ Crohn's/IBS
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Seizures
- ❑ Stroke
- ❑ STD's
- ❑ Thyroid Disorders
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Whooping Cough
- ❑ Major Trauma_____

_____
Other_____
_____

Do you have any infectious diseases? Yes / No If yes, please describe:

_____
_____

Past Surgeries/ Hospitalizations/Major Illnesses:

_____
_____
_____

Your Diet
Glasses of water consumed per day: _____
Coffee: Yes / No
# of cups per day? _____
Soft Drinks: Yes / No
# of 12oz drinks per day? __

Your Sleep
Average # of hours per night?___
Quality of Sleep:
□Excellent □Good □Fair □Poor
Sleep Position:
□Side □Back □Stomach

Your lifestyle
Alcohol: Yes / No
Of drinks per week_____
Tobacco: Yes / No
Vapor: Yes / No
How often? _____
What form(s) of tobacco?
_____
Recreational drug use: Yes / No
Stress Level:
❑Low ❑Moderate ❑High
Do you enjoy your work? Yes / No

Emotions commonly felt:
- ❑ Anger
- ❑ Irritability
- ❑ Happiness
- ❑ Sadness
- ❑ Anxiety
- ❑ Fear
- ❑ Depression
- ❑ Worry
- ❑ Mood Swings
- ❑ Nervousness
- ❑ Mental Tension

Interests and Hobbies:

_____
_____
_____
_____

Physical Exercise:
Type_____
Frequency_____
Type_____
Frequency_____

General Symptoms
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Frequent colds/flu
- ❑ Slow wound healing
- ❑ Chronic infections
- ❑ Lymph node swelling
- ❑ Feeling hot
- ❑ Feeling cold
- ❑ Chills and Fever
- ❑ Cold hands/feet
- ❑ Recent weight loss
- ❑ Recent weight gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Waking up tired/sluggish
- ❑ Night Sweats

Head, Eyes, Ear, Nose, Throat
- ❑ Heaviness in the head
- ❑ Confusion
- ❑ Difficulty concentrating
- ❑ Headache
- ❑ Blurred vision
- ❑ Spots in eyes
- ❑ Dry eyes
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Ringing in the ears
- ❑ Ear aches
- ❑ Ear infections
- ❑ Sinus problems
- ❑ Nose bleeds
- ❑ Dry mouth/throat
- ❑ Scratchy/Itchy throat
- ❑ Recurrent Sore throat
- ❑ Difficulty swallowing
- ❑ TMJ problems
- ❑ Grinding teeth

Skin, Hair, Nails
- ❑ Dry skin
- ❑ Itchy skin
- ❑ Eczema
- ❑ Psoriasis
- ❑ Rashes
- ❑ Hives
- ❑ Hair loss
- ❑ Dry, brittle nails
- ❑ Soft nails

Musculoskeletal
- ❑ Neck/Shoulder tightness
- ❑ Neck pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Rib pain
- ❑ Muscle pain
- ❑ Painful joints
- ❑ Radiating pain
- ❑ Limited use
- ❑ Other

Neurological
- ❑ Numbness
- ❑ Tingling
- ❑ Fainting
- ❑ Seizures
- ❑ Paralysis
- ❑ Muscle weakness
- ❑ Loss of coordination
- ❑ Loss of balance
- ❑ Dizziness/Lightheadedness
- ❑ Involuntary movements
- ❑ Poor concentration
- ❑ Memory problems
- ❑ Concussion/head injury
  When?_____

Respiratory
- ❑ Chest congestion
- ❑ Chest tightness
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Persistent cough
- ❑ Coughing up blood
- ❑ Phlegm/mucus
  Color_____

Cardiovascular
- ❑ Heart failure
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Irregular heart rate
- ❑ Murmurs
- ❑ Hypertension
- ❑ Hypotension
- ❑ Swelling of the ankles
- ❑ Varicose veins
- ❑ Blood clots
- ❑ Rheumatic fever

Gastrointestinal
- ❑ Nausea/Vomiting
- ❑ Belching
- ❑ Gas
- ❑ Indigestion/Bloating
- ❑ Heartburn
- ❑ Ulcers
- ❑ Abdominal pain;
  Acute, severe pain: Y / N
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloody stool
- ❑ Black stool

Genito-Urinary Tract
- ❑ Painful urination
- ❑ Impaired urination
- ❑ Frequent urination
- ❑ Unable to hold urine
- ❑ Blood in urine
- ❑ Frequent UTI's
- ❑ Kidney stones
- ❑ Infertility

Male Reproductive
- ❑ Testicular pain
- ❑ Prostate problems

Gynecological
Age at first menses _____
Date last period began
_____
Of pregnancies _____
Of live births _____
- ❑ Menopause

If yes, what age _____

Other Concerns: _____
_____
_____
_____
_____

Authorization and Consent to the Use and Disclosure of Health Information for Treatment, Payment, and Healthcare Operations

I authorize payment of insurance benefits directly to the Plains Chiropractic & Acupuncture. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. This authorization is to apply to all occasions of service until it is revoked in writing.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as: a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. Our organization utilizes the North Dakota Health Information Network (NDHIN) to coordinate care and access medical records. Coverage or care will NOT be withheld if you have chosen to opt out of participation of the NDHIN. We comply with the privacy and data practices and policies set forth by the NDHIN and HIPAA. Plains Chiropractic & Acupuncture complies with applicable Federal Civil Rights Laws and does not discriminate based on race, color, national origin, age, disability, or sex. Plains Chiropractic & Acupuncture does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

Signature of Patient or Authorized Representative_____ Date: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s), acupuncture, and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the providers of the clinic listed below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the clinic. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or for any errors or omissions that I may have made in the completion of this form.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: soreness, soft tissue injury, fractures, disc injuries, dislocations, muscle strain, physical therapy burns, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The most recent studies estimate that the incidence of stroke is 1 in every 5 million upper cervical adjustments. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the provider of care and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Name and Address of Clinic
Plains Chiropractic & Acupuncture P.C.
3750 32nd Ave S Suite #103
Grand Forks, ND 58201

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

Signature of Patient's Representative: _____ Date: _____