PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. PLEASE PRINT. *All information will be confidential.*

Account # _____

Patient's Name: _____ Date: _____

Phone: _____ SS#: _____ Male: _____ Female: _____

Birth Date: _____ Age: _____

Alternate Phone#: _____ Email: _____

Address: _____

City, State, Zip: _____

Check Appropriate Box: ( ) Married ( ) Single ( ) Minor ( ) Widow ( ) Other

Patient or Guardian's Employer: _____

Work Phone: _____ Address: _____

Spouse or Parent / Guardian Name: _____

Person to Contact In Case of Emergency: _____

Whom may we thank for referring you? _____

Were you recently in an automobile accident? **( ) Yes ( ) No If yes, complete the following:**

Date of accident: _____

Are you still under litigation for the auto accident? **( ) Yes ( ) No**

Responsible Party:

Name of person responsible for this account: _____

Relation to patient: ( ) Self ( ) Spouse ( ) Other: _____

Insurance Information:

Name of Insured: _____ Relation to Patient: _____

Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Do you have any additional insurance? ( ) Yes ( ) No If yes, complete the following:

Name of Insured: _____ Relation to Patient: _____

Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

I authorize Pham Chiropractic Services to release any information regarding my examination or treatment for the purposes of obtaining insurance compensation, pre-certification, or medical records. I authorize payment of the chiropractic benefits to Pham Chiropractic Services when claim forms are filed upon my behalf for treatment of extensive office procedures. I also give my permission for treatment to patient, if minor. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or updating of this form.

Signed: _____ **Dated:** _____

Confidential Health Record

Name _____ **Date** _____

Current Health Condition

Major Complaint: _____

_____

Where specifically does this cause you pain or discomfort? _____

When did it begin? _____

Was there a specific mechanism or injury that brought on the pain/condition? _____

Was the onset of pain: (circle all that apply) Sudden Gradual

Has this pain occurred before? Yes No If yes when? _____

How long have you had this current episode of pain? _____

How present are the complaints/pain? ___ Constant 75-100% ___ Frequent 50-75%
___ Occasional 25-49% ___ Intermittent 25% or less

Have you had prior or current treatment for this condition? _____

What helped and what did not help with your pain? _____

Rate your pain on a scale of 1 to 10 with 10 being the max: 1 2 3 4 5 6 7 8 9 10

Is the condition/pain getting worse? _____

Is the condition interfering with your: (circle all that apply) Work Sleep Daily routine

What activities are you unable to do now that you previously were able to do? _____

_____

Does this condition wake you at night? Yes No Sometimes

Is the pain localized or does it radiate to other areas? _____

What aggravates your condition? _____

What relieves your condition? _____

Are you wearing any orthotics or heel lifts? Yes No If yes, how long? _____

Other doctors seen for this condition: _____

Type of treatment received: _____

List all medications (prescriptions or over the counter) you are taking: _____

_____

Health History

Have you previously had Chiropractic care? Yes No
If yes, Chiropractor's name: _____
Date of last visit? _____

List any other medical doctors you are seeing: _____

_____

Personal History

Have you ever been in an automobile accident? Yes No
If yes, list dates of injuries: _____

Have you ever broken any bones? Yes No
If yes, list which ones, where and when? _____

_____

Have you had any falls, sprains, strains or stitches in the past? Yes No
Details: _____

Have you had x-rays or your neck or spine? Yes No
If yes, when? _____
Can you get a copy of your x-rays for our office? Yes No

Did you use ice or heat on the painful areas? Yes No If yes, which one? _____

Family History

Check any of the following conditions found in your family and the family member beside it. (Example: Mother, Brother, Aunt)

_____ Cancer _____
_____ Diabetes _____
_____ Hypertension _____
_____ Heart Attack _____
_____ Heart Disease _____
_____ Kidney Disease _____
_____ Stroke _____
_____ Thyroid Disease _____
_____ Tuberculosis _____
_____ Other _____

PLEASE CHECK THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Malaria
- ☐ Appendicitis
- ☐ Goiter
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema
- ☐ Alcoholism
- ☐ Venereal Disease
- ☐ N/A

CIRCLE CURRENT CONDITIONS – CHECK FORMER CONDITIONS

GENERAL SYMPTOMS

- ☐ Tremors
- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nerviousness
- ☐ Depression
- ☐ Loss of weight
- ☐ Numbness or pain in arms hands, elbows, shoulders, hips, legs, knees or feet
- ☐ Paralysis
- ☐ Forgetfulness
- ☐ Confusion

EYES, EARS, NOSE & THROAT

- ☐ Failing vision
- ☐ Near sightedness
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Eye inflamiation
- ☐ Deafness
- ☐ Earache
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Horseness
- ☐ Difficult speech
- ☐ Hay fever
- ☐ Allergies
- ☐ Dental decay
- ☐ Gum troubles
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands
- ☐ Tonsillitis

SKIN

- ☐ Skin eruptions itching
- ☐ Itching
- ☐ Bruises easly
- ☐ Dryness
- ☐ Boils
- ☐ Rashes
- ☐ Sensitive skin
- ☐ Hives or allergy
- ☐ Eczema

RESPIRATORY

- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Whooping cough
- ☐ Influenza
- ☐ Pleurisy
- ☐ Asthma

CARDIO-VASCULAR

- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over the heart
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart attack
- ☐ Varicose veins

MUSCLE AND JOINT

- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Painful tail bone
- ☐ Foot trouble
- ☐ Pain between shoulders
- ☐ Hernia
- ☐ Spinal curvature (Scoliosis)
- ☐ Faulty posture

MUSCLE AND JOINT CONT..

- ☐ Arthritis
- ☐ Stiff joints
- ☐ painful joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

GENITOURINARY

- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostate trouble
- ☐ Bladder trouble
- ☐ Discolored urine

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over the stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool
- ☐ Colon trouble
- ☐ Hemorrhoids (piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight trouble
- ☐ Antibiotic therapy
- ☐ Appendicitis
- ☐ Ulcers
- ☐ Bloody stool

GASTROINTESTINAL CONT..

- ☐ Goiter
- ☐ Gout

OTHER

- ☐ Foot orthotic/ supports
- ☐ Prosthesis
- ☐ Breast implants

FEMALE

- ☐ Painful menstrual
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or back ache
- ☐ Miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps in the breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding

When was your last period?

_____

Are you pregnant?

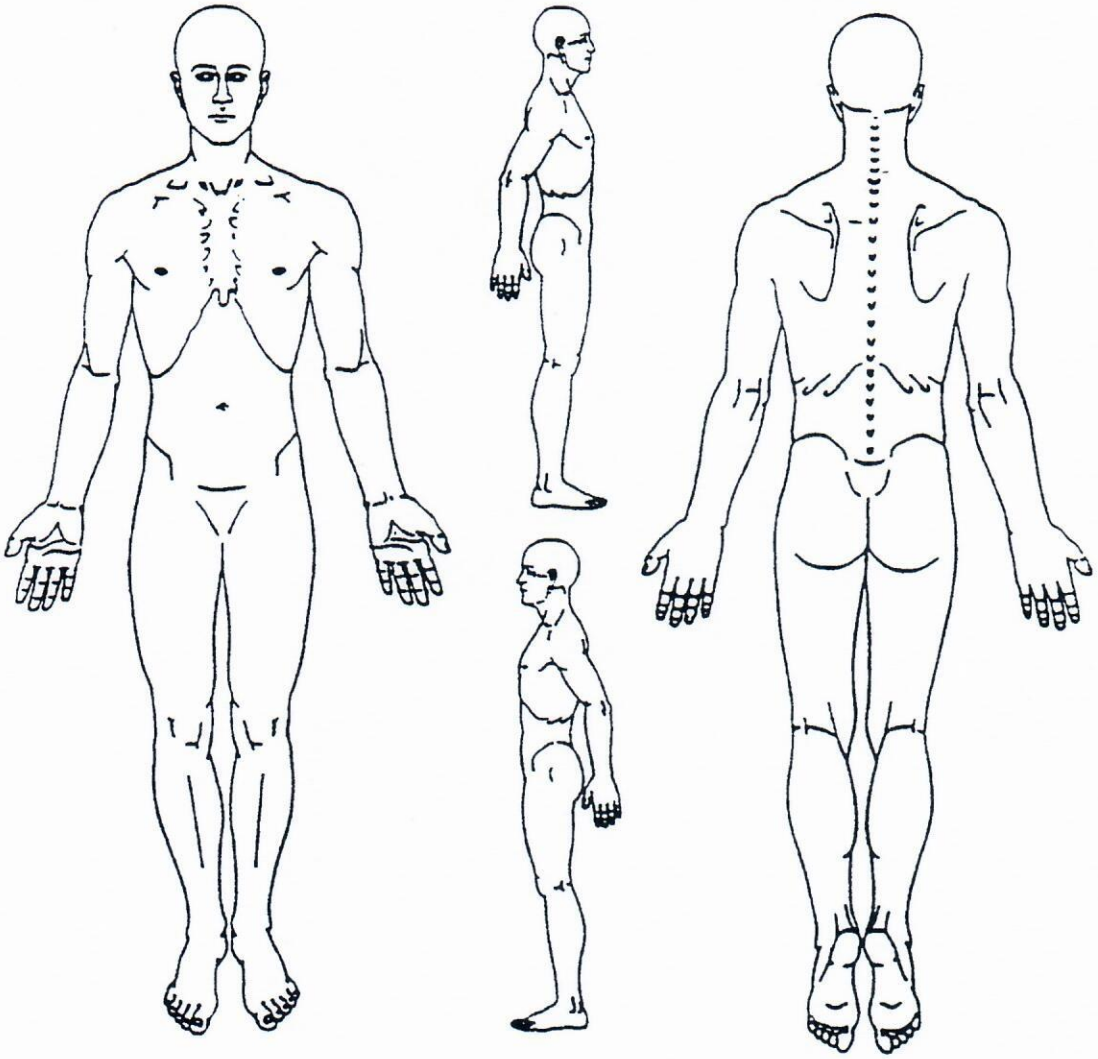
- ☐ Yes
- ☐ No
- ☐ Not sure

Patient Name:_____ Phone: _____ Date: _____

PAIN DRAWING ASSESSMENT

Draw the location of your pain on the body outlines using the appropriate symbol. Include all affected areas. Mark the severity of your pain at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
ZZZ	BBB	XXX	= = =	////



CIRCLE YOUR PAIN ESTIMATE

NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE PAIN

I understand and agree that health and accident Insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and that any amount authorized to be paid to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Informed consent to Chiropractic Treatment

The nature of Chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop, such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligament us sprain dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patient's may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Possibility of risks occurring: The risk of complications due to chiropractic treatments have been described as "rare" about as often as complications are seen from the taking of a single aspirin tablet. The risks of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

Other treatment options which could be considered may include the following:

- Over-the-counter analgesics. The risk of these medications include: irritation to stomach, liver and kidneys and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds the risks of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well an extended convalescent period in a significant number of cases.

Risk of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Printed Name	Signature	Date
Witness Printed Name	Signature	Date

MOTOR VEHICLE ACCIDENT HISTORY

*NAME_____ *BIRTHDATE _____

*DATE OF ACCIDENT_____ TIME _____AM/PM

LOCATION_____ CITY_____

*AUTO INSURANCE CO._____ *POLICY #_____

*DO YOU HAVE MEDPAY? _____ *AMOUNT OF MEDPAY _____ *CLAIM # _____

*INSURANCE CLAIM ADJUSTER _____PHONE #_____ FAX# _____

ADDRESS (Insurance Co.) _____ City _____ Zip Code _____

Were you employed at the time of your accident? ☐ Yes ☐ No

** required field*

Do you currently have legal representation? ☐ Yes ☐ No

If yes, who is representing you? _____

Attorney Phone Number: _____

Tell Us About The Accident:

What type of accident was it? ☐ Head on ☐ Rear end ☐ Side impact ☐ Other_____

Road Conditions: ☐ Wet ☐ Dry ☐ Snow/Ice ☐ Other_____

Where were you seated in the vehicle? ☐ Driver's seat ☐ Passenger's seat ☐ Back (driver side) ☐ Back (passenger side)

Were you wearing a **seatbelt**? **Yes / No** ☐ Lap belt ☐ Shoulder strap

What speed were you traveling? _____ mph **What speed** was the other car traveling? _____ mph

Was **your vehicle** ☐ speeding up ☐ slowing down at the time of the accident?

Was the **other vehicle** ☐ speeding up ☐ slowing down at the time of the accident?

Describe, to the best of your ability, **what happened during the accident:**

_____

_____

Were you prepared for the impact at the time of the collision? ☐**Yes** ☐ **No**

Was your head turned at the time of the accident? ☐**Yes** ☐ **No** If yes, ☐ **Left** ☐ **Right**

Did you hit your head or other body part during the accident? ☐**Yes** ☐ **No** if yes**, where?** _____

Did you lose consciousness? ☐**Yes** ☐ **No** If yes, **how long?** _____

Do you have any visible bruising? ☐**Yes** ☐ **No** if yes, please take pictures

When did you **first notice pain?** ☐ immediately ☐ gradually _____ **hours/days** after the accident?

Were you taken to the **hospital** following the accident? ☐ **Yes** ☐ **No**

Did you have **X-rays taken**? ☐ **Yes** ☐ **No** If yes, what body parts _____

Have you had **any treatment** since the accident? ☐**Yes** ☐ **No** Describe: _____

_____

Have you **lost any time from work** as a result of the accident? ☐**Yes** ☐ **No** **How much** time? _____ days.

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | ***Unbearable pain***

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – 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 severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would 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 increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase 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.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only 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 ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on 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 ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – 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 nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it 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.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but 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.

TOTAL _____

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **ONE BOX** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **MOST CLOSELY** describes your present -day situation.

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

- ❑ 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 causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

Section 7 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

Section 8 – Driving

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

Section 9 – Reading

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

Section 10 – Recreation

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

Patient Name _____ **Date** _____

Score _____ **[50]** **Benchmark -5 =** _____

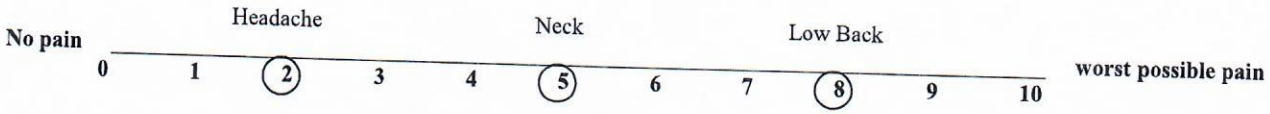
QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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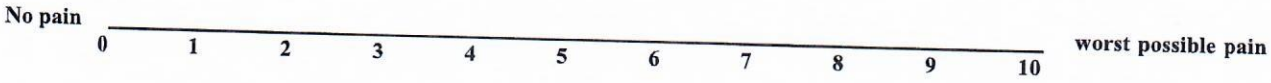
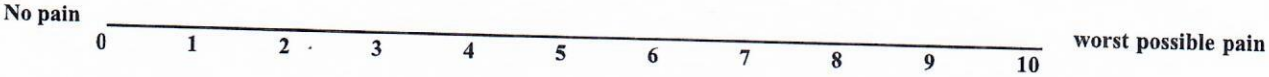
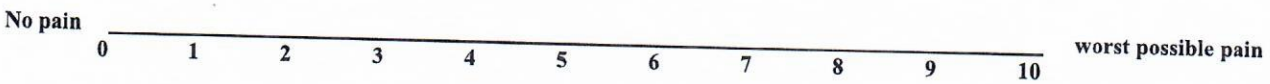
1 – What is your pain RIGHT NOW?



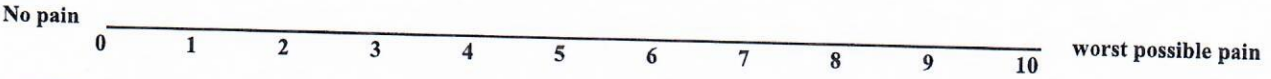
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature