MASTERS BACK & NECK PAIN RELIEF CENTER

1010 South King Street, Suite 213
Honolulu, HI 96814
Phone: (808) 591-0099
Fax: (808) 593-0994

PATIENT: ____________________

DATE: ____________________

EMAIL: ____________________

Emergency Contact: ____________________

Phone Number: ____________________

A. PATIENT INFORMATION

Patient's Home Address

Phone FAX

Employer Business Address

Phone

Occupation

Social Security #

Referred By

Date Of Birth Age

Sex: ◯ Male ◯ Female

Marital Status:
◯ Single
◯ Married
◯ Widowed
◯ Divorced
◯ Other

Patient Resides With:
◯ Lives Alone ◯ Spouse ◯ Parents
◯ Children ◯ Other

Children:
◯ Yes ◯ No How Many? 1 2 3 4 5+

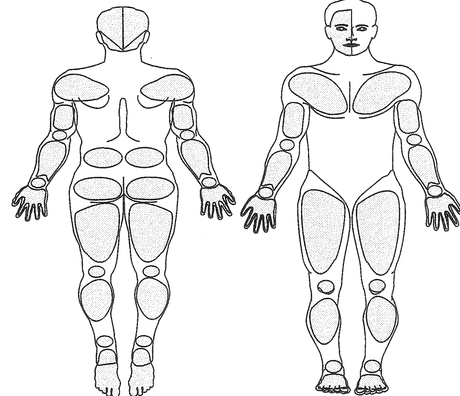
B. COMPLAINTS

1. What Are Your Primary Complaints? ◯ *None*

LEFT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling		RIGHT SIDE: Pain	Numbness	Tingling	Stiffness	Soreness	Weakness	Swelling
P	N	T	S	S	W	S	Head	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Neck	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Upper Back	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Mid Back	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Lower Back	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Shoulder	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Arm	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Forearm	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Wrist	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Hand	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Ribs	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Buttock	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Hip	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Thigh	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Leg	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Knee	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Ankle	P	N	T	S	S	W	S
P	N	T	S	S	W	S	Foot	P	N	T	S	S	W	S

If Your Symptoms Change, When Are They Worse
◯ Morning ◯ Evening ◯ Afternoon
◯ Night ◯ Other ________

PAIN DIAGRAMS Please Mark The Location Of Your Pain On These Figures



3. Additional Complaints? ◯ Yes ◯ No Please List:

4. When Did Your Symptoms Begin?
◯ Date

5. How Often Do Your Symptoms Occur?
◯ Occasional ◯ Intermittent ◯ Frequent
◯ Constant ◯ Other

6. How Would You Rate Your Pain Today With 0 Being No Pain and 10 Being The Worst Pain?
0 1 2 3 4 5 6 7 8 9 10
No Pain — Worst Pain Possible

SCANTRON EW-270770-1:654

B. COMPLAINTS (CONTINUED)

7. Are You Getting? ⬭ Better ⬭ Worse ⬭ Same

8. If Your Complaints Include Pain, Is It Aggravated By?
   - ⬭ Coughing
   - ⬭ Sneezing
   - ⬭ Straining At Stool
   - ⬭ Neck Movement
   - ⬭ Reaching
   - ⬭ Lifting
   - ⬭ Bending
   - ⬭ Sitting
   - ⬭ Standing
   - ⬭ Walking
   - ⬭ Other

9. If Your Complaints Include Pain, Is It Relieved By?
   - ⬭ Nothing
   - ⬭ Rest
   - ⬭ Ice
   - ⬭ Heat
   - ⬭ Stretching
   - ⬭ Exercise
   - ⬭ Sitting
   - ⬭ Standing
   - ⬭ Other

10. Have You Had Recent Treatment For This Condition?
    ⬭ Yes ⬭ No If Yes, List Dates, Treatments, And Doctors:

11. Has This Condition Existed In The Past? ⬭ Yes ⬭ No

12. Since Your Symptoms Began, Have You Noticed A Change In? If Yes, Indicate

	Onset Date	Duration
⬭ Bowel Function		
⬭ Bladder Function		
⬭ Sexual Function		

C. REVIEW OF SYSTEMS

1. Are You Currently Suffering From Any Of The Symptoms Listed Below?

a. General
- ⬭ **Normal**
- ⬭ Fatigue
- ⬭ Weakness
- ⬭ Fever
- ⬭ Loss Of Sleep
- ⬭ Chills
- ⬭ Weight Change
- ⬭ Night Sweats
- ⬭ Other

b. Skin
- ⬭ **Normal**
- ⬭ Rash
- ⬭ Redness
- ⬭ Itching
- ⬭ Dryness
- ⬭ Eczema
- ⬭ Hair Changes
- ⬭ Nail Changes
- ⬭ Bruise Easily
- ⬭ Other

c. Neurologic
- ⬭ **Normal**
- ⬭ Headache
- ⬭ Dizziness
- ⬭ Fainting
- ⬭ Convulsions
- ⬭ Nervousness
- ⬭ Other

d. Eyes
⬭ **Normal**

	Right	Left
Vision Trouble	⬭	⬭
Pain	⬭	⬭
Discharge	⬭	⬭
Other	⬭	⬭

Right

Left

e. Ears
⬭ **Normal**

	Right	Left
Hearing Trouble	⬭	⬭
Ringing	⬭	⬭
Pain	⬭	⬭
Discharge	⬭	⬭
Other	⬭	⬭

Right

Left

f. Nose
- ⬭ **Normal**
- ⬭ Pain
- ⬭ Bleeding
- ⬭ Sinus Problems
- ⬭ Infections
- ⬭ Absence Of Smell
- ⬭ Other

g. Mouth/Throat
- ⬭ **Normal**
- ⬭ Sores
- ⬭ Bleeding
- ⬭ Enlarged Glands
- ⬭ Absence Of Taste
- ⬭ Abnormal Taste
- ⬭ Tonsilitis
- ⬭ Other

h. Cardio-Vascular-Pulmonary (Heart/Lungs)
- ⬭ **Normal**
- ⬭ Cough
- ⬭ Wheezing
- ⬭ Difficulty Breathing
- ⬭ Swollen Extremities
- ⬭ Blue Extremities
- ⬭ Varicosities
- ⬭ Murmur
- ⬭ Chest Pain
- ⬭ Palpitations
- ⬭ Other

i. Breasts
- ⬭ **Normal**
- ⬭ Lumps In Breast(s)
- ⬭ Redness/Itching
- ⬭ Pain
- ⬭ Dimpling
- ⬭ Discharge
- ⬭ Other

j. Gastrointestinal (Stomach/Digestion)
- ⬭ **Normal**
- ⬭ Decreased Appetite
- ⬭ Increased Appetite
- ⬭ Abdominal Pain
- ⬭ Hemorrhoids
- ⬭ Excess Gas
- ⬭ Vomiting
- ⬭ Diarrhea
- ⬭ Constipation
- ⬭ Other

k. Genitourinary
- ⬭ **Normal**
- ⬭ Inability To Hold Urine
- ⬭ Painful Urination
- ⬭ Frequent Urination
- ⬭ Bedwetting
- ⬭ Irregular Menstruation
- ⬭ Painful Menstruation
- ⬭ Abnormal Vaginal Bleeding
- ⬭ Impotence
- ⬭ Sterility
- ⬭ Prostate Problems
- ⬭ Other

l. Endocrine (Metabolism)
- ⬭ **Normal**
- ⬭ Heat/Cold Intolerance
- ⬭ Sugar In Urine
- ⬭ Goiter
- ⬭ Tremor
- ⬭ Other

m. Psychologic
- ⬭ **Normal**
- ⬭ Anxiety
- ⬭ Depression
- ⬭ Memory Loss Or Impairment
- ⬭ Phobias
- ⬭ Mood Swings
- ⬭ Other

C. REVIEW OF SYSTEMS (CONTINUED)

2. What Hobbies Do You Participate In?

List Hobbies:	Occasionally	Frequently	Constantly
1. ______	O	F	C
2. ______	O	F	C
3. ______	O	F	C

3. What Are Your Habits?

			Packs/Day			
Smoking	Never	<1	1-2	2-3	3-4	5+
			Drinks/Day			
Alcohol	Never	<1	1-2	2-3	3-4	5+
			Cups-Glasses/Day			
Caffeinated Drinks	Never	<1	1-2	2-3	3-4	5+
			Days/Week			
Exercise	Never	<1	1-2	3-4	5-6	7
Drug/Substance Abuse	Never	Yes	If Yes, Discuss With Doctor			

D. MEDICAL HISTORY

1. Health Care

a. **Have You Been To A Chiropractor . . . .** Yes ○ No ○

b. **Do You Have A Family Physician . . . .** Yes ○ No ○

Date Of Last Physical Exam ______

Physician's Name & Address ______

______

c. **Have You Been Hospitalized In The Past Five Years . . . .** Yes ○ No ○

Date & Reason For Hospitalization ______

______

d. **Have You Had Surgery In The Past Five Years . . . .** Yes ○ No ○

Date & Reason For Surgery ______

______

e. **Have You Had A Serious Accident In The Past Five Years . . . .** Yes ○ No ○

○ Auto ○ Work ○ Home ○ Other ______

List Date & Describe Injury ______

______

f. **Do You Have Any Drug Allergies . . . .** Yes ○ No ○

List Drugs ______

______

g. **Are You Currently Taking Any Medication .** Yes ○ No ○

○ Anti-inflammatory (Aspirin, Motrin, etc.)
○ Muscle Relaxants ○ Pain Medication/Analgesic
○ Tranquilizers ○ Antibiotics
○ Blood Pressure Pills ○ Other
○ Birth Control Pills ______

For What Condition/s Are You Taking Medication?

______

______

h. **WOMEN ONLY:**

To Your Knowledge Are You Pregnant . . . . Yes ○ No ○

Have Your Past Pregnancies Been Normal . Yes ○ No ○

Are You Seeing An OB-GYN Regularly . . . . Yes ○ No ○

Date Of Last Exam ______

Physician's Name & Address ______

______

______

2. If you now have or you have had one of the following illnesses, please fill in EITHER bubble NH or bubble HH.

○ *No Previous Conditions/Illnesses*

Now Have	Have Had		Now Have	Have Had	
NH	HH	Arthritis	NH	HH	Sexually Transmitted Disease
NH	HH	Asthma	NH	HH	Ulcer
NH	HH	Sinus Trouble	NH	HH	Cancer
NH	HH	Hay Fever	NH	HH	Polio
NH	HH	Allergies	NH	HH	Rheumatic Fever
NH	HH	Tuberculosis	NH	HH	Serious Injury
NH	HH	Diabetes	NH	HH	Bone Fracture
NH	HH	Epilepsy	NH	HH	Dislocated Joints
NH	HH	Thyroid Trouble	NH	HH	Spinal Disc Disease
NH	HH	High Blood Pressure	NH	HH	Multiple Sclerosis
NH	HH	Low Blood Pressure	NH	HH	Scoliosis
NH	HH	Heart Trouble	NH	HH	Mental/Emotional Difficulty
NH	HH	Pacemaker	NH	HH	Prostate Trouble
NH	HH	HIV/ARC	NH	HH	Kidney Trouble
NH	HH	AIDS	NH		Other ______
				HH	Other ______

3. Family History

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Joint Problems	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis	Bad Posture	Present Age or Age at Death	Deceased
Father	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Mother	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Bro 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Sis 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 1	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 2	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D
Child 3	C	D	H	H	S	M	H	N	B	D	J	A	P	O	S	B		D

E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Job Type

○ Full Time ○ Temporary
○ Part Time ○ Other ______

2. Work Week

Hours Per Day	1	2	3	4	5	6	7	8	9	10	11	12
Days Per Week	1	2	3	4	5	6	7					

○ Other ______

3. Do Your Present Complaints Affect The Number Of Hours You Work Per Day ○ Yes ○ No

4. Length Of Time At Present Occupation

Years	10		20		30		40		50		
	1	2	3	4	5	6	7	8	9		
Months	1	2	3	4	5	6	7	8	9	10	11

...URANCE INFORMATION

.. Is Your Condition Due To:

	Yes	No
An Automobile Accident	O	O
A Personal Injury	O	O
A Job Injury	O	O

2. Have you contacted an insurance adjuster or representative regarding this claim? O O

Company:____________________

Adjuster: ____________________

Claim #: ____________________

	Yes	No
3. Do You Have Health Insurance	O	O

Company____________________

Policy #____________________

	Yes	No
4. Is Your Spouse Employed	O	O

Business____________________

Address____________________

____

	Yes	No
5. Is Your Spouse The Primary Insured	O	O

Company____________________

Policy #____________________

	Yes	No
6. Are You Covered By Medicare	O	O

Medicare #____________________

IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.

AUTHORIZATION TO RELEASE RECORDS TO MY INSURANCE CARRIER

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.

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 me will be immediately due and payable.

This is my authorization to Masters Back & Neck Pain Relief Center to release my records to my insurance carrier.

____

Patient or Guardian Signature

ACKNOWLEDG...MENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Masters Back and Neck Pain Relief Center's "NOTICE OF PRIVACY PRACTICES"**, revision date 03-06-2003.

As required by the Privacy Regulations, Dawn Davidson of Masters Back and Neck Pain Relief Center has explained and provided me with a copy of the **"NOTICE OF PRIVACY PRACTICES"**.

As required by the Privacy Regulations, I am aware the Masters Back and Neck Pain Relief Center has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

I understand that this office is not required to honor any changes to the **"Notice of Privacy Practices"**.

____

Patient or Guardian Signature

PLEASE LIST THE NAME OF YOUR FAMILY DOCTOR:

______________________________,MD/DO

It is our policy to communicate with your family doctor to coordinate the care being provided in this office. This is an effort to maintain the highest quality of care for you and your family. Should you **NOT** want us to communicate with them please indicate by checking the appropriate box below.

[ ] You are welcome to communicate with my family doctor (PCP).

[ ] I would prefer you not communicate with my family doctor unless medically necessary.

Initial________________

FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your symptoms/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	Worse 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 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 ½ Mile	Increased Pain After ¼ Mile	Increased Pain After 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 ½ Hour	Increased Pain With Any Standing

Name ______________________________
PRINTED

____
SIGNATURE

____
DATE

Total Score ____________________

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www.chiroevidence.com

Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: ____________________ Date: ____________

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other____________

Race?

- ☐ I do not wish to provide this information.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other ____________

Ethnicity?

- ☐ I do not wish to provide this information.
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other ____________

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes. What? ____________________

Are you currently taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes…

What? ____________________ ________ mg

What? ____________________ ________ mg

What? ____________________ ________ mg

Please read this entire document before you sign it. This information is very important and you need to understand this information.

The Chiropractic office visit:

Spinal manipulative therapy is the primary treatment of a chiropractor. You will receive spinal manipulation/adjusting as we treat you.

This adjusting/manipulation will be done with an instrument and/or by our hands. The purpose is to move the locked joints that we have identified by examination. You may or may not hear a "pop" or "click" and/or feel a sense of movement.

Examination - Treatments:

As part of the examination and treatment, you are consenting to the following when necessary:

- Spinal adjusting/manipulation — Vital signs — Orthopedic and neurological testing
- Muscle testing — Palpation — X-ray
- Electrical stimulation — Spinal traction — Low Level Laser therapy

Spinal Manipulation risks:

Certain complications may arise with any healthcare procedure. Spinal manipulation risks include: Stroke, fractures, disc injuries, muscle strain, rib strains and burns.

Some patients may feel some stiffness and soreness following the first few adjustments.

Every reasonable effort is made during the examination to screen for contraindications to the adjustment. **If you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.**

The probability of the above risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone. This is assessed during our consultation and x-ray exam. **Strokes are estimated to occur one in five million neck adjustments. Research concludes stroke occurs at the same frequency whether you are treated by your family doctor or by your chiropractor.**

Other Treatment Option for your condition:

Over the counter drugs and/or rest.

Prescription drug, pain-killers, muscle relaxants, and anti-inflammatories.

Hospitalization or surgery.

You should be aware that these "other options" have their own risks and benefits.

Risk of no treatment for you condition:

Allows for further adhesions and fixations that lead to a cascade of degeneration setting up more pain and immobility.

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

I have read or had read to me the above explanation of chiropractic treatments. I have discussed it with my chiropractor and any questions have been answered satisfactorily. Having been informed of the risks, I give my consent to chiropractic examination and treatment.

Patient Name ______________________________ Date__________