Minges Creek Chiropractic

Douglas J Gordon, DC

Thank you for visiting us today. Let's get started...

Confidential Patient Information

Date _____

Name _____Date of Birth_____
Address _____City_____ Zip_____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____
Marital Status M S D W Number of Children _____SS # _____
Occupation _____ Employer _____
Work Address _____
Name of Spouse _____
What is the purpose of today's appointment?_____
What other doctors have you have seen for this condition?_____
Who should we thank for referring you to our office?_____

THE FOLLOWING INFORMATION IS REQUIRED:
Current Medications: _____
_____
Medication Allergies:_____
Weight:_____Height:_____ Do you smoke? Y N Do you use other kinds of tobacco? Y N
Have you ever smoked / used tobacco? Y N Are you interested in a smoking cessation program? Y N

Have you suffered from or been diagnosed with any of the following:

☐ Allergies	☐ Arthritis	☐ Anxiety/Depression	☐ Back Pain
☐ Cancer	☐ Diabetes	☐ Digestion Problems	☐ Ear Infections
☐ Fatigue	☐ Headaches/Migraines	☐ Hypertension	☐ Immunity Problems
☐ Insomnia/Sleep Issues	☐ Neck Pain	☐ Sciatica	☐ Sinus Infections
☐ Spinal Curvatures	☐ Thyroid Conditions	☐ Vertigo/Dizziness	☐ Other (please describe):

_____

Are you currently under care for any of these conditions? Y N Are you pregnant? Y N
Please describe any hospitalizations, surgeries, and/or significant injuries:_____
_____
_____
_____

We need to know how your current concerns interfere with your life. Are you limited in any of the following:

☐ Work/Career	☐ Childcare	☐ Household	☐ Exercise/Sports
☐ Travel	☐ Sleep	☐ School	☐ Other: _____

Are your concerns: ☐ Staying the Same ☐ Getting Worse ☐ Getting Better

_____ _____
Signature of Patient or Guardian Date

PLEASE INFORM OUR OFFICE STAFF
IF THIS VISIT IS IN REGARDS TO A RECENT AUTOMOBILE OR WORK-RELATED INJURY.

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INFORMED CONSENT FOR TREATMENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

CONSENT TO EVAULATE AND ADJUST A MINOR CHILD:

I, _____, being the parent or legal guardian of

_____ have read and fully understand the above informed consent and

hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation, if clinically necessary. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date

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Patient Name: _____ DOB:_____

Release of Information:

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor and/or attorney involved in this case; and hereby release this clinic of any consequence thereof.

I also authorize Minges Creek Chiropractic to release any pertinent medical and/or financial information to:

Spouse/Parent/Other:_____ DOB:_____

Physician:_____ Practice Name:_____

Notice of HIPPA Policy:

I acknowledge that I am aware of the Notice of Privacy Practices for Minges Creek Chiropractic.

Assignment:

I hereby instruct and direct my insurance company to reimburse this clinic for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

Financial Responsibility:

I agree to be financially responsible for all charges incurred at this clinic including any insurance deductible, co-payment and/or any services not covered by my insurance company. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Minges Creek 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 Minges Creek Chiropractic will be credited to my account on 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.

Name of the person responsible for payment _____

Do you have health insurance? Y N Company _____

_____ _____

Patient Signature Date

YOUR PAYMENT AT THE DATE OF SERVICE IS APPRECIATED. THANK YOU.

NAME: _____ Date:_____

NECK / SHOULDER / UPPER SPINE DISABILITY INDEX

PLEASE READ: This questionnaire is designed to give the doctor information regarding how your condition affects your daily life. Please answer these questions as they relate to any **NECK, SHOULDER, and/or UPPER SPINE pain, stiffness or dysfunction** that you may experience. If more than one statement relates to you, please mark the box with the statement that most closely describes your condition. Thank you.

PAIN INTENSITY
- □ A. I have no pain.
- □ B. My pain is mild.
- □ C. My pain is moderate.
- □ D. My pain is fairly severe.
- □ E. My pain is very severe .
- □ F. This is the worst pain imaginable.

PERSONAL CARE
- □ A. Caring for myself is pain-free.
- □ B. My personal care is normal, but it causes pain.
- □ C. My personal care is painful and slower due to pain.
- □ D. I need help from others for some of my care.
- □ E. I need help from others for most of my care.
- □ F. I am completely dependent on others for care.

LIFTING
- □ A. I can lift a heavy weight with no pain.
- □ B. Lifting heavy weights causes some pain.
- □ C. I can only lift a heavy weight from a table.
- □ D. I can only lift a light weight from a table.
- □ E. I can only lift a very light weight.
- □ F. I cannot lift any weight.

READING
- □ A. I do not have pain while reading.
- □ B. I have slight pain while reading.
- □ C. I have moderate pain while reading.
- □ D. I have severe pain while reading.
- □ E. I have severe pain and only read when necessary.
- □ F. I cannot read due to the pain.

HEADACHES / MIRGRAINES
- □ A. I do not have headaches.
- □ B. I have slight, infrequent headaches.
- □ C. I have moderate, infrequent headaches.
- □ D. I have moderate, frequent headaches.
- □ E. I have severe, frequent headaches.
- □ F. I have constant headaches.

CONCENTRATION
- □ A. I can concentrate without any difficulty.
- □ B. I can concentrate with slight difficulty.
- □ C. I can concentrate, but it is fairly difficult.
- □ D. I can concentrate, but it is moderately difficult.
- □ E. I can concentrate, but it is extremely difficult.
- □ F. I cannot concentrate.

WORK
- □ A. My work is not restricted.
- □ B. I can do my usual work, but no more.
- □ C. I am unable to do some of my work.
- □ D. I am unable to do most of my work.
- □ E. I can hardly do any work at all.
- □ F. I cannot do any work.

DRIVING
- □ A. I can drive without pain.
- □ B. Driving causes me some pain.
- □ C. Driving causes me moderate pain.
- □ D. I cannot drive for a long time due to the pain.
- □ E. I can hardly drive at all due to the pain.
- □ F. I cannot drive due to the pain.

SLEEPING
- □ A. I have no pain while I sleep.
- □ B. I have pain but I sleep well.
- □ C. My quality of sleep is reduced by 25%.
- □ D. My quality of sleep is reduced by 50%.
- □ E. My quality of sleep is reduced by 75%.
- □ F. I cannot sleep because of this pain.

RECREATION
- □ A. My recreation is not affected.
- □ B. I have pain but it does not affect my recreation.
- □ C. Some of my activity is affected by the pain.
- □ D. Most of my activity is affected by the pain.
- □ E. My activity is severely restricted by the pain.
- □ F. I cannot do any activity.

THANK YOU!

NAME: _____ Date:_____

LOW BACK / SACROILIAC / HIP / LEG DISABILITY INDEX

PLEASE READ: This questionnaire is designed to give the doctor information regarding how your condition affects your daily life. Please answer these questions as they relate to any **LOWER BACK, SACROILIAC, HIP, and/or LEG pain, stiffness or dysfunction** that you may experience. If more than one statement relates to you, please mark the box with the statement that most closely describes your condition. Thank you.

PAIN INTENSITY
- □ A. The pain comes and goes and is mild.
- □ B. The pain is mild and constant.
- □ C. The pain comes and goes and is moderate.
- □ D. The pain does not vary and is moderate.
- □ E. The pain comes and goes and is severe.
- □ F. The pain is constant and severe.

PERSONAL CARE
- □ A. Caring for myself is pain-free.
- □ B. My personal care is normal, but it causes pain.
- □ C. My personal care is painful and slower due to pain.
- □ D. I need help from others for some of my care.
- □ E. I need help from others for most of my care.
- □ F. I am completely dependent on others for my care.

LIFTING
- □ A. I can lift a heavy weight with no pain.
- □ B. Lifting heavy weights causes some pain.
- □ C. I can only lift a heavy weight from a table.
- □ D. I can only lift a light weight from a table.
- □ E. I can only lift a very light weight.
- □ F. I cannot lift any weight.

WALKING
- □ A. I do not have pain while walking.
- □ B. I have slight pain while walking.
- □ C. I have moderate pain while walking.
- □ D. I have severe pain while walking.
- □ E. I can only walk with assistance.
- □ F. I cannot walk due to the pain.

SITTING
- □ A. I can sit in any chair as long as I desire.
- □ B. I can sit in a specific chair as long as I desire.
- □ C. I cannot sit for longer than one hour.
- □ D. I cannot sit for longer than 30 minutes.
- □ E. I cannot sit for longer than 10 minutes.
- □ F. I cannot sit at all due to this pain.

STANDING
- □ A. I can stand for an unlimited time without pain.
- □ B. I have some pain with standing.
- □ C. I cannot stand for more than 1 hour.
- □ D. I cannot stand for more than 30 minutes.
- □ E. I cannot stand for more than 10 minutes.
- □ F. This pain prevents me from standing.

SLEEPING
- □ A. I have no pain while I sleep.
- □ B. I have pain but I sleep well.
- □ C. My quality of sleep is reduced by 25%.
- □ D. My quality of sleep is reduced by 50%.
- □ E. My quality of sleep is reduced by 75%.
- □ F. I cannot sleep because of this pain.

TRAVELING
- □ A. I can travel without pain.
- □ B. Traveling causes me some pain.
- □ C. Traveling causes me moderate pain.
- □ D. I cannot travel for a long time due to the pain.
- □ E. I can hardly travel at all due to the pain.
- □ F. I cannot travel due to the pain.

SOCIAL
- □ A. My social life is not affected by the pain.
- □ B. My social life is slightly affected by the pain.
- □ C. My pain limits my interests in social activities.
- □ D. My social life is limited to only major events.
- □ E. My social life is restricted to staying at home.
- □ F. I have no social life due to this pain.

CHANGES IN PAIN
- □ A. This condition is rapidly improving.
- □ B. This condition fluctuates, but is improving.
- □ C. This condition is improving slowly.
- □ D. This condition is unchanged.
- □ E This is condition is gradually getting worse.
- □ F. This condition is rapidly getting worse.

THANK YOU!

HEADACHE DISABILITY INDEX

INSTRUCTIONS: Please CIRCLE the correct response: 1. I have headache: (1) 1 per month (2) more than 1 but, less than 4 per month (3) more than one per week 2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO	
_____	_____	_____	E1. Because of my headaches I feel handicapped.
_____	_____	_____	F2. Because of my headaches I feel restricted in performing my routine daily activities.
_____	_____	_____	E3. No one understands the effect my headaches have on my life.
_____	_____	_____	F4. I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
_____	_____	_____	E5. My headaches make me angry.
_____	_____	_____	E6. Sometimes I feel that I am going to lose control because of my headaches.
_____	_____	_____	F7. Because of my headaches I am less likely to socialize.
_____	_____	_____	E8. My significant other, or family & friends have no idea what I am going through because of my headaches.
_____	_____	_____	E9. My headaches are so bad that I feel that I am going to go insane.
_____	_____	_____	E10. My outlook on the world is affected by my headaches.
_____	_____	_____	E11. I am afraid to go outside when I feel that a headaches is starting.
_____	_____	_____	E12. I feel desperate because of my headaches.
_____	_____	_____	F13. I am concerned that I am paying penalties at work or at home because of my headaches.
_____	_____	_____	E14. My headaches place stress on my relationships with family or friends.
_____	_____	_____	F15. I avoid being around people when I have a headache.
_____	_____	_____	F16. I believe my headaches are making it difficult for me to achieve my goals in life.
_____	_____	_____	F17. I am unable to think clearly because of my headaches.
_____	_____	_____	F18. I get tense (eg, muscle tension) because of my headaches.
_____	_____	_____	F19. I do not enjoy social gatherings because of my headaches.
_____	_____	_____	E20. I feel irritable because of my headaches.
_____	_____	_____	F21. I avoid traveling because of my headaches.
_____	_____	_____	E22. My headaches make me feel confused.
_____	_____	_____	E23. My headaches make me feel frustrated.
_____	_____	_____	F24. I find it difficult to read because of my headaches.
_____	_____	_____	F25. I find it difficult to focus my attention away from my headaches and on other things.