

# **Minges Creek Chiropractic**

## **New Patient Forms**

**Please complete these forms and bring them to your initial visit.**

**If you are unable to print these forms, we are happy to provide them to you when you arrive at the office.**

**See you soon!**

# Minges Creek Chiropractic

Dr. Douglas 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 \_\_\_\_\_ Name of Spouse \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

What is the purpose of today's appointment? \_\_\_\_\_

What other doctors have you have seen for this condition? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

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

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Back Pain                |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Ear Infections           |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Immunity Problems        |
| <input type="checkbox"/> Insomnia/Sleep Issues | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Sciatica           | <input type="checkbox"/> Sinus Infections         |
| <input type="checkbox"/> Spinal Curvatures     | <input type="checkbox"/> Thyroid Conditions  | <input type="checkbox"/> Vertigo/Dizziness  | <input type="checkbox"/> Other (please describe): |

Are you currently under care for 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:

- |                                      |                                    |                                    |  |
|--------------------------------------|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Work/Career | <input type="checkbox"/> Childcare | <input type="checkbox"/> Household | <input type="checkbox"/> Exercise/Sports |
| <input type="checkbox"/> Travel      | <input type="checkbox"/> Sleep     | <input type="checkbox"/> School    | <input type="checkbox"/> 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 REGARD TO A RECENT AUTOMOBILE OR WORK-RELATED INJURY.**

# Minges Creek Chiropractic

Dr. Douglas Gordon, DC

---

## **Informed Consent for Treatment:**

I consent to examination, treatment, and chiropractic care as deemed necessary by the healthcare providers at this practice.

## **Release of Information:**

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and/or other appropriate parties involved with my care.

## **Consent to Evaluate and Treat a Minor:**

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_ consent for this child to receive chiropractic care.

## **Third Party Release of Information:**

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

Spouse/Parent/Other: \_\_\_\_\_

Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_

## **Notice of HIPAA Policy:**

I acknowledge that I am aware of the privacy policies 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.

## **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. Finally, I 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:** \_\_\_\_\_

---

**Print Name**

**Signature**

**Date**

***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 / MIGRAINES**

- 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 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 family & friends have no idea what I am going through with 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. |