BRADFORD FAMILY CHIROPRACTIC

CHIROPRACTIC MASSAGE SPORTS REHAB
PHYSICAL THERAPY

Healthcare Authorization

☐ I give permission to Bradford Family Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, gift certificates, holiday related cards and information about treatment alternatives or other health related information.

☐ If Bradford Family Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

Right to Revoke Authorization

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. Please address all revocations to the Privacy official at Bradford Family Chiropractic.

You have a right to refuse to sign this authorization. If you refuse to sign this Authorization, Bradford Family Chiropractic will not refuse to provide treatment.

_____ Date _____

Signature

Informed Consent

I have been informed of the nature and risks associated with Chiropractic treatment. I have had an 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

_____ _____

Witness printed name Signature

_____

Date

Patient's Written Acknowledgement of Doctor's Notice of Privacy Practices:

I_____, acknowledge that I have read and was given a copy of Bradford Family Chiropractic's Notice of
Print Patient's Name
Privacy Practices and fully understood them and have had all my questions answered to my satisfaction.

_____ _____

Patient's Signature Date

_____ _____

Signature of Privacy Office Date

BRADFORD FAMILY CHIROPRACTIC

CHIROPRACTIC MASSAGE SPORTS REHAB

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Business Phone: _____

Birth Date: _____ Age: ____ Sex: M F Height: _____ Weight: _____

SSN: _____ Email: _____

Married___ Single____ Widowed ____ Divorced___ Referred to this office by: _____

HEALTH HISTORY

1. What is your Primary Complaint? _____
2. What is your Secondary Complaint? _____
3. What other doctors have you seen for this condition and when? _____
4. When did this condition begin? _____
5. How often do these symptoms occur? Occasionally Constant Intermittent Frequent
6. How would you rate the pain today with 0 being no pain and 10 being the worst pain?

0	1	2	3	4	5	6	7	8	9	10

7. Are you getting ____ better ____ worse ____ same
8. What aggravates the pain _____
9. What relieves the pain _____
10. Has this condition existed previously? _____

MEDICAL HISTORY

Have you been to a Chiropractor? Yes No If Yes Doctors Name_____
For what reason_____.
Are you currently under the care of another doctor? Yes No If Yes Doctors Name_____
For What reason_____
Have you been hospitalized or had surgery in the past five years? Yes No
Date & reason for hospitalization _____
Have you recently had an Xray MRI or CT scan? Yes No
List date and reason _____ _____.
Have you had a serious accident in the past five years? Yes No
List date and describe injury _____.
Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

List any known Allergies you have had to any Medications.: If NONE check here: ❑

1) _____ 3) _____

2) _____ 4) _____

Does anyone in your immediate family suffer from any of the following? (Circle all that apply)

Cancer	Diabetes	Heart trouble	High blood pressure	Stroke
Multiple Sclerosis	Headaches	Neck problems	Arthritis	Back problems
Disc Problems	Pinched nerve	Scoliosis	Osteoporosis	

WOMEN ONLY: To your knowledge are you pregnant? Yes No

SOCIAL HISTORY

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ Asian ❑ Asian Indian
❑ I choose not to specify ❑Other_____

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Other ❑ I choose not to specify

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____
Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
No interest *Very Interested*

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

BRADFORD FAMILY CHIROPRACTIC

CHIROPRACTIC MASSAGE SPORTS REHAB PHYSICAL THERAPY

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW***.

Section 1 – Pain Intensity

0. I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment
4. The pain is very severe at the moment
5. The pain is the worst imaginable at the moment

Section 2 – Personal Care (Washing, Dressing, etc.)

0. I can look after myself normally without causing extra pain
1. I can look after myself normally, but it causes extra pain
2. It is painful to look after myself and I am slow and careful
3. I need some help, but manage most of my personal care
4. I need help every day in most aspects of self care
5. I do not get dressed, I wash with difficulty, and stay in bed

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 from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4. I can lift very light weights
5. I cannot lift or carry anything at all

Section 4 – Reading

0. I can read as much as I want to with no pain in my neck
1. I can read as much as I want to with slight pain in my neck
2. I can read as much as I want to with moderate pain in my neck
3. I cannot read as much as I want because of moderate pain in my neck
4. I cannot read as much as I want because of severe pain in my neck
5. I cannot read at all

Section 5 – Headaches

0. I have no headaches at all
1. I have slight headaches which come infrequently
2. I have moderate headaches which come infrequently
3. I have moderate headaches which come frequently
4. I have severe headaches which come frequently
5. I have headaches almost all the time

Section 6 – Concentration

0. I can concentrate fully when I want to with no difficulty
1. I can concentrate fully when I want to with slight difficulty
2. I have a fair degree of difficulty in concentrating when I want to
3. I have a lot of difficulty in concentrating when I want to
4. I have a great deal of difficulty in concentrating when I want to
5. I cannot concentrate at all

Section 7 – Work

0. I can do as much work as I want to
1. I can only do my usual work, but no more
2. I can do most of my usual work, but no more
3. I cannot do my usual work
4. I can hardly do any work at all
5. I cannot do any work at all

Section 8 – Driving

0. I can drive my car without any neck pain
1. I can drive my car as long as I want with slight pain in my neck
2. I can drive my car as long as I want with moderate pain in my neck
3. I cannot drive my car as long as I want because of moderate pain in my neck
4. I can hardly drive at all because of severe pain in my neck
5. I cannot drive my car at all

Section 9 – Sleeping

0. I have no trouble sleeping
1. My sleep is slightly disturbed (less than 1 hour sleepless)
2. My sleep is mildly disturbed (1-2 hours sleepless)
3. My sleep is moderately disturbed (2-3 hours sleepless)
4. My sleep is greatly disturbed (3-5 hours sleepless)
5. My sleep is completely disturbed (5-7 hours sleepless)

Section 10 – Recreation

0. I am able to engage in all of my recreational activities with no neck pain at all
1. I am able to engage in all of my recreational activities with some pain in my neck
2. I am able to engage in most, but not all of my recreational activities because of pain in my neck
3. I am able to engage in a few of my recreational activities because of pain in my neck
4. I can hardly do any recreational activities because of pain in my neck
5. I cannot do any recreational activities at all

NAME: _____ **DATE:** _____

OFFICE USE ONLY :

SCORE _____

BRADFORD FAMILY CHIROPRACTIC

CHIROPRACTIC MASSAGE SPORTS REHAB PHYSICAL THERAPY

LOW BACK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW***.

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 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 do 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 increases the pain, but I manage not to change my way of doing it
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it
4. I am unable to do some washing and dressing without help
5. I am unable to do any washing or 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 from lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned (e.g. on a table)
4. Pain prevents me from 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 the most

Section 4 – Walking

0. Pain does not prevent me from walking any distance
1. Pain prevents me from walking more than one mile
2. Pain prevents me from walking more than 1/2 mile
3. Pain prevents me from walking more than 1/4 mile
4. I can only walk while using a cane or on crutches
5. I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting

0. I can sit in any chair as long as I like without pain
1. I can only sit in my favorite chair as long as I like
2. Pain prevents me from sitting more than one hour
3. Pain prevents me from sitting more than 1/2 hour
4. Pain prevents me from sitting more than 10 minutes
5. Pain prevents me from sitting at all

Section 6 – Standing

0. I can stand as long as I want without pain
1. I have some pain while standing, but it does not increase with time
2. I cannot stand for longer than one hour without increasing pain
3. I cannot stand for longer than 1/2 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 straight away

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 night's sleep is reduced by less than one quarter
3. Because of pain, my normal night's sleep is reduced by less than one half
4. Because of pain, my normal night's 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 increases the degree of my 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 while traveling
1. I get some pain while 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 alternative forms of travel
3. I get extra pain while traveling which compels me to seek alternative forms of travel
4. Pain restricts all forms of travel
5. Pain prevents all forms of travel except that done lying down

Section 10 – Changing Degree of Pain

0. My pain in rapidly getting better
1. My pain fluctuates, but overall is definitely getting better
2. My pain seems to be getting better, but improvement is slow
3. My pain is neither getting better nor worse
4. My pain is gradually worsening
5. My pain is rapidly worsening

NAME: _____ **DATE:** _____

OFFICE USE ONLY:
SCORE:_____