# Patient History (Please Print)

Date: _____

Name: _____ Email: _____ Phone: _____
Address: _____City: _____ Zip: _____
Birth Date: ☐ Male ☐ Female Spouse's Name (Parent): _____
_____
#Children _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Occupation: _____ Social Security #: _____

How were you referred to our office? _____

Have you ever had chiropractic care before? _____ If yes, when? _____

**List your chief complaints in order of severity; Check all those that describe your condition:**

**Complaint 1:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Complaint 2:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

**Complaint 3:** _____ For how long? _____

What originally caused this problem? _____

☐ Sharp ☐ Throbbing ☐ Shooting ☐ Cramps ☐ Stiffness
☐ Dull Ache ☐ Numb/Tingling ☐ Burning ☐ Other: _____

☐ Constant (100%) ☐ Frequent (50%-75%) ☐ Intermittent (25% – 50%) ☐ Occasional (1%-25%)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

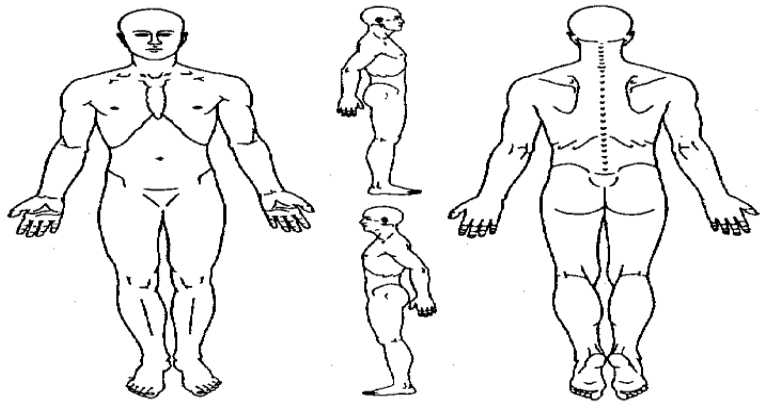
**Does your condition interfere with your:**

| | | | | |
|---|---|---|---|---|
| Work | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE |
| Sleep | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE |
| Daily Routine | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE |
| Recreation | ☐ NO | ☐ MILD | ☐ MODERATE | ☐ SEVERE |

**List other doctors consulted for condition:**

1. _____ Address: _____
2. _____ Address: _____

**Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected areas**



**Health History (Check if you have ever had any of the following:)**

| | | |
|---|---|---|
| ☐ Abdominal Aortic Aneurysm | ☐ Fractures | ☐ Osteoporosis |
| ☐ AIDS/HIV | ☐ Glaucoma | ☐ Pacemaker |
| ☐ Alcoholism | ☐ Goiter | ☐ Parkinson's |
| ☐ Allergy Shots | ☐ Gonorrhea | ☐ Pinched Nerve |
| ☐ Anemia | ☐ Gout | ☐ Pneumonia |
| ☐ Anorexia | ☐ Heart Disease | ☐ Prostate Problems |
| ☐ Appendicitis | ☐ Hepatitis | ☐ Psychiatric Care |
| ☐ Arthritis | ☐ Hernia | ☐ Rheumatoid Arthritis |
| ☐ Asthma | ☐ Herniated Disc | ☐ Stroke |
| ☐ Bleeding Disorders | ☐ Herpes | ☐ Suicide Attempt |
| ☐ Bulimia | ☐ High Cholesterol | ☐ Tuberculosis |
| ☐ Cancer | ☐ Kidney Disease | ☐ Tumors/Growths |
| ☐ Cataracts | ☐ Kidney Stones | ☐ Typhoid Fever |
| ☐ Chemical Dependency | ☐ Liver Disease | ☐ Ulcers |
| ☐ Chicken Pox | ☐ Measles | ☐ UTI |
| ☐ Diabetes | ☐ Miscarriage | ☐ Vaginal Infections |
| ☐ Eczema | ☐ Mononucleosis | ☐ Venereal Disease |
| ☐ Emphysema | ☐ Multiple Sclerosis | ☐ Whooping Cough |
| ☐ Epilepsy | ☐ Mumps | ☐ Other: _____ |

Are you pregnant? ☐ Yes ☐ No Due Date: _____

**Family History (please list all known conditions/illnesses that may apply):**

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Other known familial conditions: _____

**Is there anything else you think we should know about or that you would like to discuss? (Explain):** _____

_____

_____

**Patient's Signature:** _____ **Date:** _____

**Notice:** Not all patients require x-rays to determine or verify a diagnosis, type and length of care. If your examination warrants x-ray analysis, the following office policy prevails:

1. All first visit charges are to be paid when services are rendered.

The fee paid for x-rays is for analysis only. The film itself is the property of this office and cannot be released.

*** If you have insurance please give the front desk your card***

# Personal Medical Information Consent Form

**The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.**

**This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.**

**HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.**

**You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.**

**Patient Signature: _____ Date: _____**

**Restrictions:**
**Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on office visit. The revised policies and practices will be applied to all protected health information we maintain.**

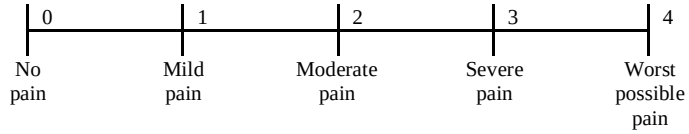
**Doctor/Staff Signature: _____ Date: _____**

# Functional Rating Index

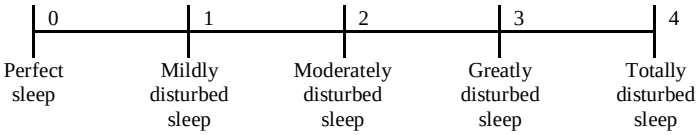
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

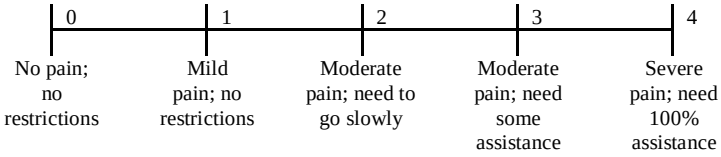
### 1. Pain Intensity



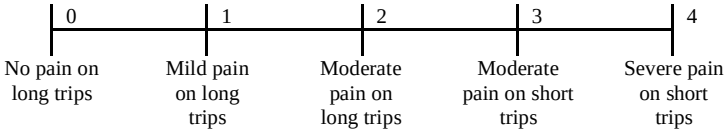

### 2. Sleeping



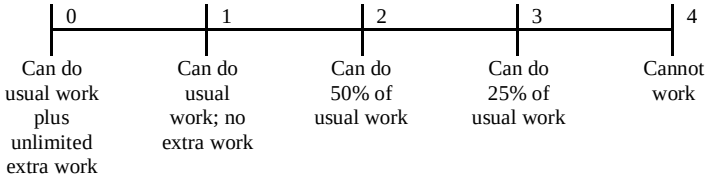

### 3. Personal Care (washing, dressing, etc.)



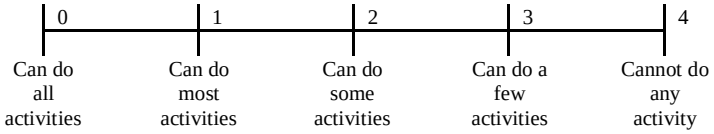

### 4. Travelling (driving, etc.)



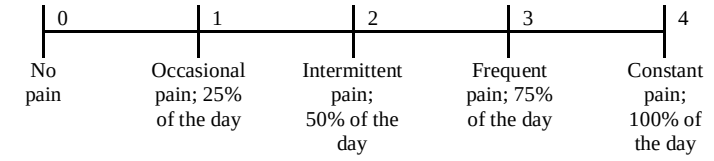

### 5. Work



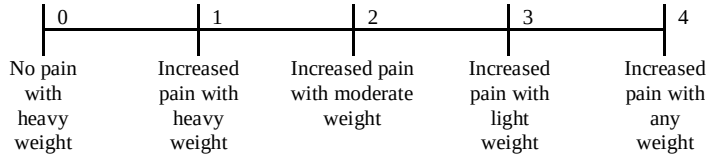

### 6. Recreation



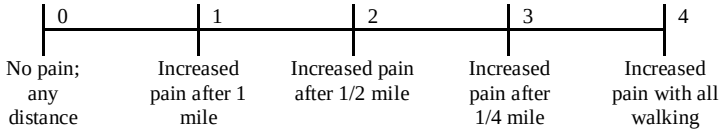

### 7. Frequency of Pain



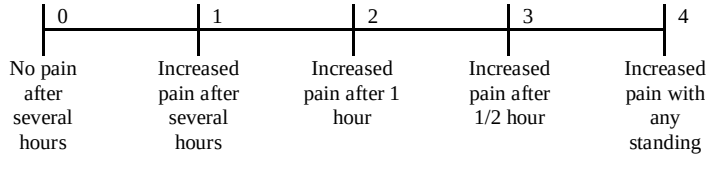

### 8. Lifting




### 9. Walking




### 10. Standing




_____ _____

**Patient's Signature** **Date**

**For Office Use Only:**

Practitioner ID#: _____

**Total Score _____/ 40**

Clinical Diagnosis Codes:

Patient ID#:_____

# OSWESTRY DISABILITY INDEX 2.0

**NAME**_____ **DATE**_____ **SCORE**_____

***PLEASE READ:*** Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer ***every section***. Mark ***one box only*** in each section that most closely describes you ***today.***

*SECTION 1 - Pain Intensity*
- A ☐ I have no pain at the moment.
- B ☐ The pain is very mild at the moment.
- C ☐ The pain is moderate at the moment.
- D ☐ The pain is fairly severe at the moment.
- E ☐ The pain is very severe at the moment.
- F ☐ The pain is the worst imaginable at the moment.

*SECTION 2 - Personal Care (washing, dressing, etc.)*
- A ☐ I can look after myself normally without causing extra pain.
- B ☐ I can look after myself normally but it is very painful.
- C ☐ It is painful to look after myself and I am slow and careful.
- D ☐ I need some help but manage most of my personal care.
- E ☐ I need help every day in most aspects of self care.
- F ☐ I do not get dressed, wash with difficulty and stay in bed.

*SECTION 3 - Lifting*
- A ☐ I can lift heavy weights without extra pain.
- B ☐ I can lift heavy weights, but it causes extra pain.
- C ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E ☐ I can only lift very light weights, at the most.
- F ☐ I cannot lift or carry anything at all.

*SECTION 4 - Walking*
- A ☐ Pain does not prevent me from walking any distance.
- B ☐ Pain prevents me from walking more than one mile.
- C ☐ Pain prevents me from walking more than 1/4 mile.
- D ☐ Pain prevents me from walking more than 100 yards.
- E ☐ I can only walk while using a stick or crutches.
- F ☐ I am in bed most of the time and have to crawl to the toilet.

*SECTION 5 - Sitting*
- A ☐ I can sit in any chair as long as I like.
- B ☐ I can only sit in my favorite chair as long as I like.
- C ☐ Pain prevents me from sitting more than 1 hour.
- D ☐ Pain prevents me from sitting more than 1/2 hour.
- E ☐ Pain prevents me from sitting more than ten minutes.
- F ☐ Pain prevents me from sitting at all.

*SECTION 6 - Standing*
- A ☐ I can stand as long as I want without extra pain.
- B ☐ I can stand as long as I want but it gives me extra pain.
- C ☐ Pain prevents me from standing for more than 1 hour.
- D ☐ Pain prevents me from standing for more than 1/2 hour.
- E ☐ Pain prevents me from standing for more than 10 minutes.
- F ☐ Pain prevents me from standing at all.

*SECTION 7 - Sleeping*
- A ☐ My sleep is never disturbed by pain.
- B ☐ My sleep is occasionally disturbed by pain.
- C ☐ Because of pain I have less than 6 hours' sleep.
- D ☐ Because of pain I have less than 4 hours' sleep.
- E ☐ Because of pain I have less than 2 hours' sleep.
- F ☐ Pain prevents me from sleeping at all.

*SECTION 8 - Sex Life (if applicable)*
- A ☐ My sex life is normal and causes me no extra pain.
- B ☐ My sex life is normal, but causes some extra pain.
- C ☐ My sex life is nearly normal but is very painful.
- D ☐ My sex life is severely restricted by pain.
- E ☐ My sex life is nearly absent because of pain.
- F ☐ Pain prevents any sex life at all.

*SECTION 9 - Social Life*
- A ☐ My social life is normal and causes me no extra pain.
- B ☐ My social life is normal, but increases the degree of pain.
- C ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- D ☐ Pain has restricted my social life and I do not go out as often.
- E ☐ Pain has restricted my social life to my home.
- F ☐ I have no social life because of the pain.

*SECTION 10 - Traveling*
- A ☐ I can travel anywhere without pain.
- B ☐ I can travel anywhere but I gives extra pain.
- C ☐ Pain is bad but I manage journeys over 2 hours.
- D ☐ Pain restricts me to journeys of less than 1 hour.
- E ☐ Pain restricts me to short necessary journeys under 30 minutes.
- F ☐ Pain prevents me from traveling except to receive treatment.

**COMMENTS:** _____

*Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine **25**(24): 3115-24.*

# NECK DISABILITY INDEX QUESTIONNAIRE

**NAME**_____ **AGE**_____ **DATE**_____ **SCORE**_____

***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 THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

| | |
|---|---|
| *SECTION 1 - Pain Intensity*<br>A. I have no pain at the moment.<br>B. The pain is very mild at the moment.<br>C. The pain is moderate at the moment.<br>D. The pain is fairly severe at the moment.<br>E. The pain is very severe at the moment.<br>F. The pain is the worst imaginable at the moment. | *SECTION 6 - Concentration/*<br>A. I can concentrate fully when I want to with no difficulty.<br>B. I can concentrate fully when I want to with slight difficulty.<br>C. I have a fair degree of difficulty in concentrating when I want to.<br>D. I have a lot of difficulty in concentrating when I want to.<br>E. I have a great deal of difficulty in concentrating when I want to.<br>F. I cannot concentrate at all. |
| *SECTION 2 -Personal Care (Washing, Dressing, etc.)*<br>A. I can look after myself normally without causing extra pain.<br>B. I can look after myself normally, but it causes extra pain.<br>C. It is painful to look after myself and I am slow and careful.<br>D. I need some help, but manage most of my personal care.<br>E. I need help every day in most aspects of self care.<br>F. I do not get dressed, I wash with difficulty and stay in bed. | *SECTION 7 - Work*<br>A. I can do as much work as I want to.<br>B. I can only do my usual work, but no more.<br>C. I can do most of my usual work, but no more.<br>D. I cannot do my usual work.<br>E. I can hardly do any work at all.<br>F. I cannot do any work at all. |
| *SECTION 3 - Lifting*<br>A. I can lift heavy weights without extra pain.<br>B. I can lift heavy weights, but it gives extra pain.<br>C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.<br>D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.<br>E. I can lift very light weights.<br>F. I cannot lift or carry anything at all. | *SECTION 8 – Driving*<br>A. I can drive my car without any neck pain.<br>B. I can drive my car as long as I want with slight pain in my neck.<br>C. I can drive my car as long as I want with moderate pain in my neck.<br>D. I cannot drive my car as long as I want because of moderate pain in my neck.<br>E. I can hardly drive at all because of severe pain in my neck.<br>F. I cannot drive my car at all. |
| *SECTION 4 - Reading*<br>A. I can read as much as I want to with no pain in my neck.<br>B. I can read as much as I want to with slight pain in my neck.<br>C. I can read as much as I want to with moderate pain in my neck.<br>D. I cannot read as much as I want because of moderate pain in my neck.<br>E. I cannot read as much as I want because of severe pain in my neck.<br>F. I cannot read at all. | *SECTION 9 – Sleeping*<br>A. I have no trouble sleeping.<br>B. My sleep is slightly disturbed (less than 1 hour sleepless).<br>C .My sleep is mildly disturbed (1-2 hours sleepless).<br>D. My sleep is moderately disturbed (2-3 hours sleepless).<br>E. My sleep is greatly disturbed (3-5 hours sleepless).<br>F. My sleep is completely disturbed (5-7 hours) |
| *SECTION 5 – Headaches*<br>A. I have no headaches at all.<br>B. I have slight headaches which come infrequently.<br>C. I have moderate headaches which come infrequently.<br>D. I have moderate headaches which come frequently.<br>E. I have severe headaches which come frequently.<br>F. I have headaches almost all the time. | *SECTION 10 – Recreation*<br>A. I am able to engage in all of my recreational activities with no neck pain at all.<br>B. I am able to engage in all of my recreational activities with some pain in my neck.<br>C. I am able to engage in most, but not all of my recreational activities because of pain in my neck.<br>D. I am able to engage in a few of my recreational activities because of pain in my neck.<br>E. I can hardly do any recreational activities because of pain in my neck.<br>F. I cannot do any recreational activities at all. |

**COMMENTS**: _____

_____

_____

*Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.*

## Concerns:

We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Add any others that are relevant and **circle your top 3.**

| | |
|---|---|
| Is it going to hurt? | I don't want to be cracked |
| Do I have to come forever? | Is it addictive? |
| Are the X-rays dangerous? | Is it safe for children? |
| Is it expensive? | What if insurance does not cover chiropractic? |
| What do I do if chiropractic does not work? | Can this be fixed? |
| | |
| | |

## Strengths:

Strong habits are key to health. It helps us take care of you if we have an idea of how you take care of your body. Add any others that are relevant and **circle your top 3.**

| | |
|---|---|
| Stretch 3-5 times a week | Exercise 3-5 times a week |
| Drink ½ my body weight of ounces of water | Take supplements for health |
| Have a positive attitude | Sleep 6-8 hours a night |
| Drink or eat something green everyday | Get maintenance chiropractic 2-4 times a year |
| Do activities to minimize stress regularly | Non-smoker |
| | |
| | |

## Goals:

We want to make sure you get lasting relief and enjoy maximum functional improvement. Add any others that are relevant and **circle your top 3.**

| | |
|---|---|
| Sleep through the night | Exercise again |
| Continue working/get back to work | Avoid future flare ups |
| Play with kids/grandkids normally | Get off pain medications |
| Be ready for an upcoming event | Have a better attitude |
| Have some moments of relief | Sit/stand comfortably for an extended period |
| | |
| | |

# EXPLANATION OF PROFESSIONAL FEES

## *MENU OF SERVICES*

**CONSULTATION:** No Charge
The consultation takes place subsequent to the New Patient History Examination. The Doctor will discuss with the patient any current complaints. The Doctor will also give the patient a brief explanation of Chiropractic and the care they will be receiving.

**CHIROPRACTIC EXAMINATIONS:**

**New Patient History Examination:**
The Doctor or a Chiropractic Assistant will take a case history on the new patient, which involves questions regarding their past and present health complaints. The Doctor or Chiropractic Assistant will also perform various ranges of motion tests, and occasionally a hand dynamometer test.

**Brief Examination:**
The Doctor questions the patient as to their current subjective status. The Doctor also performs several examinations: prone and supine leg length differential test, Derifield leg check, Ely's test, Thompson test, Sacral leg check, spinal motion palpitation and cervical syndrome tests, to determine the patient's objective status. Based upon the Outcome Assessment, the doctor will determine whether the patient requires a corrective adjustment on that visit.

**Established Patient History Examination:**
Subsequent to each 15th visit a Chiropractic Assistant will perform various ranges of motion tests, and occasionally hand dynamometer tests. The Doctor will then perform several Chiropractic Tests so that he may evaluate the patient's progress.

**CHIROPRACTIC X-RAY STUDIES:**
Subsequent to the Consultation and after careful review of the patient's complaints, the Doctor will determine if x-rays are necessary for the proper care of the patient.

**DOCTOR /PATIENT CONFERENCE:**
The Doctor/Patient Conference is a specific office visit at which time the Doctor relays to the patient their examination findings; i.e. physical examination, x-ray examination study. Therefore, educating the patient's understanding and encouraging participation in their health findings and care.

**CHIROPRACTIC ADJUSTMENT:**
The Chiropractic Adjustment is the correction (reduction) of a subluxated vertebra or pelvic segment by means of making specific, predetermined adjustments. The Chiropractic Adjustment is made only after careful analysis, delivered in a specific manner, to achieve a predetermined goal.

**DIAGNOSTIC TESTING:**

**Range of Motion Examination:**
The Doctor or Chiropractic Assistant will perform a digital range of motion exam to assess patient impairment or progress in function. A computer-generated report will be discussed with the patient.

**Muscle Testing:**
The Doctor or Chiropractic Assistant will perform specific digital muscle testing to determine neurological balance and function.

**MODALITIES:**

**Mechanical Traction:**
A modality used to assist the body in repositioning misaligned joints by use of pelvic blocks, cervical rolls, pads, or intersegmental rollers.

**Manual Therapy:**
Performed by hand to release myofacial trigger points and relax hypertonic musculature.

**Electrical Muscle Stimulation:**
A modality used to help the body repair and heal damaged tissues, increase circulation to the affected area and promote pain relief.

**Neuromuscular Re-Education:**
Specific movements and exercises, performed with Doctor or Chiropractic Assistant supervision, to enhance muscular and neurologic coordination.

**Kinetic Activity:**
Dynamic joint movement applied to the patient's joints encouraging and restoring motion.

**Daily Living Activity Training:**
Education and supervision of daily activities to maximize and maintain the healing process and limiting excessive stress.

**Gait Training:**
One on one training to facilitate coordination and balance of complex kinematic movement.

**Therapeutic Exercises:**
Specific exercises performed with the Doctors supervision to promote, muscle strength and balance. To the spine and extremities.

**SIGNATURE:** _____ **DATE:** _____

BARRETT WHOLE BODY CHIROPRACTIC

571 Clairton Blvd.
Pleasant Hills, PA 15236
412-653-HEAL (4325)
412-653-4324
wrbarrettdc@gmail.com

# Credit Card Authorization Form

[ ] VISA [ ] MASTERCARD [ ] AMERICAN EXPRESS [ ] DISCOVER [ ] OTHER _____

CARD NUMBER: _____ EXPIRATION DATE: _____

CVV (LOCATED ON BACK OF CARD): _____

NAME AS LISTED ON CARD: _____

BILLING ADDRESS OF CARDHOLDER: _____

_____

**PLEASE CHOOSE FROM THE FOLLOWING OPTIONS**:

[ ] I hereby authorize Barrett Whole Body Chiropractic to utilize the card provided above to pay patient balance when it exceeds $20.

[ ] I prefer prior verbal authorization for each transaction. (Please note if patient balance exceeds 30 days past due, payment will be drafted from the card provided)

You agree to reimburse Barrett Whole Body Chiropractic the fees of any collection agency, which will be added to the account at the time it is placed with the agency for collection and may be based on a percentage at a maximum of 30% of the debt, and all reasonable costs and expenses, included reasonable attorneys' fees, incurred in such collection efforts.

PLEASE NOTE NO REFUNDS WILL BE ISSUED AFTER 30 DAYS.

SIGNATURE OF CARDHOLDER: _____