Personal Information

Date: ___/___/_____ First Name: _____ Last Name: _____ Initial: _____

How would you like us to address you? _____ (nickname, title, etc.)

How were you referred to our office? _____

Address: _____City:_____State:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Cell: ( )_____

Email: _____ (we will not send you jokes or junk)

Date of Birth:___/___/____ SS# _____ Spouse's Name _____

Employer: _____ Occupation _____

Address_____City_____St_____Zip_____

Drivers Lic # _____ state_____

Primary Insurance

Insurance Company: _____ Phone #_____

Insured's Name _____ Insured's DOB_____

Insured's SS#_____ Relationship _____

Policy/ID#_____ Group #_____

Insured's Employer _____ Occupation _____

Employer's Address _____

Secondary Insurance

Insurance Company: _____ Phone #_____

Insured's Name _____ Insured's DOB_____

Insured's SS#_____ Relationship _____

Policy/ID#_____ Group #_____

Insured's Employer _____ Occupation _____

Employer's Address _____

First Name: _____ **Last Name:** _____ **Date of Birth:** ___/___/_____

Primary Care Physician: Name: _____ Phone: _____

Address: _____

Please fill out the following section if accident related:

Auto Information: Company: _____ Phone: _____ Date of Accident: ___/___/___

Adjuster's Name: _____ Policy: _____ Claim#:_____

Attorney Information (If Personal Injury Case):

Atty Name _____ Phone Number: _____

Address _____

Worker's Comp Information

Date of Accident _____ Supervisor's Name _____

Date the accident was reported _____

To whom was the accident reported _____

Worker's Comp Insurance Carrier _____

Phone # ( ) _____ Adjuster's Name _____ Claim #: _____

CONSENT TO TREAT: I hereby authorize Balanced Health Chiropractic/ Dr. David Gobbie and their assistants to perform examinations, physical therapy, and / or noninvasive diagnostic testing (including X-rays), and any other treatment that is medically necessary to me today and throughout the course of my treatment plan.

Signature: _____ Date: _____

CONSENT TO TREAT A MINOR CHILD: I, _____, hereby give my permission for Balanced Health Chiropractic to treat my minor child with examinations, physical therapy and any other noninvasive procedures that are medically necessary.
Parent /Guardian: _____ Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: By signing on the line below, I am indicating that I have been given a copy of the Health Insurance Accountability and Portability Act to read. I was also informed by Balanced Health Chiropractic that a copy of these privacy practices can be made available to me anytime.

Patient Signature: _____ Date: ___/___/_____ Witness: _____

Scheduling Appointments: Balanced Health Chiropractic understands that sometimes circumstances prevent our patient's from keeping their scheduled appointments. If you cannot keep your regularly scheduled appointment please notify our office 24 hours in advance so that others in need can take your appointment slot. Also, if you are running more than 15 minutes late for your scheduled appointment, please notify our office. Thank you.

First Name: _____ **Last Name:** _____ **DOB:** ____/____/_____

Confidential Case History

O - Occasional
F - Frequent
C - Constant

Please use the frequency above and check off any of the following symptoms that you have experienced in the past year. If the symptom does not pertain to you, leave it blank.

	O	F	C
Allergy	_	_	_
Chills	_	_	_
Convulsions	_	_	_
Dizziness	_	_	_
Fainting	_	_	_
Fatigue	_	_	_
Fever	_	_	_
Headache	_	_	_
Loss of Sleep	_	_	_
Weight Loss	_	_	_
Nervous	_	_	_
Depressed	_	_	_
Neuralgia	_	_	_
Numbness	_	_	_
Sweats	_	_	_
Tremors	_	_	_

	O	F	C
Arthritis	_	_	_
Bursitis	_	_	_
Foot trouble	_	_	_
Hernia	_	_	_
Pain:			
Low Back	_	_	_
Neck	_	_	_
Shoulders	_	_	_
Arms	_	_	_
Elbows	_	_	_
Hands	_	_	_
Hips	_	_	_
Legs	_	_	_
Knees	_	_	_
Feet	_	_	_
Tailbone	_	_	_
Poor Posture	_	_	_
Sciatica	_	_	_
Spinal Curve	_	_	_
Swollen Joints	_	_	_

	O	F	C
Belching/Gas	_	_	_
Colitis	_	_	_
Colon Trouble	_	_	_
Constipation	_	_	_
Diarrhea	_	_	_
Digestion	_	_	_
Abdomen	_	_	_
Hunger	_	_	_
Gall Bladder	_	_	_
Hemorrhoids	_	_	_
Intestine worm	_	_	_
Jaundice	_	_	_
Liver trouble	_	_	_
Nausea	_	_	_
Stomach pain	_	_	_
poor appetite	_	_	_
Vomitting	_	_	_
Vomit blood	_	_	_

	O	F	C
Asthma	_	_	_
Colds	_	_	_
crossed eyes	_	_	_
Deafness	_	_	_
Dental Decay	_	_	_
Earache	_	_	_
Ear Discharge	_	_	_
Ear Noises	_	_	_
Glands	_	_	_
Thyroid	_	_	_
Eye Pain	_	_	_
Failing Vision	_	_	_
Far sighted	_	_	_
Gum trouble	_	_	_
Hay fever	_	_	_
Hoarseness	_	_	_
nasal block	_	_	_
Near sighted	yes		no
Nose bleeds	_	_	_
Sinus infection	_	_	_
Sore throat	_	_	_
Tonsillitis	_	_	_

	O	F	C
Hard arteries	_	_	_
high bld pres	_	_	_
low bld pres	_	_	_
heart pain	_	_	_
bad circulation	_	_	_
fast heartbeat	_	_	_
slow heartbeat	_	_	_
swollen ankles	_	_	_

	O	F	C
Chest Pain	_	_	_
chronic cough	_	_	_
diff. breathing	_	_	_
spit up blood	_	_	_
spit up phlegm	_	_	_
wheezing	_	_	_

	O	F	C
boils	_	_	_
bruise easily	_	_	_
dryness	_	_	_
hives/allergy	_	_	_
itching	_	_	_
skin rash	_	_	_
varicose veins	_	_	_

	O	F	C
bed wetting	_	_	_
blood in urine	_	_	_
freq. urination	_	_	_
kidney infect.	_	_	_
kidney stones	_	_	_
urination pain	_	_	_
prostate prob.	_	_	_

For women:	O	F	C
Breast pain	_	_	_
cramps	_	_	_
heavy flow	_	_	_
hot flashes	_	_	_
irregular cycle	_	_	_
menopausal	_	_	_
discharge	_	_	_

Pregnant yes___ No___

First Name: _____ **Last Name:** _____ **DOB:** ___/___/_____

Please circle the follow conditions you have or have had:

Cancer	Cold sores	Goiter	Measles	Rheumatic fever	Epilepsy
Anemia	Diabetes	Gout	Miscarriage	Scarlet fever	Venereal disease
Appendicitis	pneumonia	heart disease	mult.sclerosis	stroke	Whooping cough
exzema	HIV/AIDS	mumps	tuberculosis	arthritis	Polio
emphysema	influenza	pleurisy	ulcers	fever blisters	arteriosclerosis

Tell us about why you are here today:

What is your **major** complaint? _____

When did it start?_____ How did it start? gradually___ suddenly___

Explain: _____

Have you ever had this same or a similar condition in the past? yes____ no____

What aggravates your condition? (ex: bending, lifting, etc.)_____

What brings relief? (ex: rest, ice, etc.)_____

How does it feel? (cicle) sharp achy dull deep stabbing stinging burning numb tingling crawling

Does it radiate to any other part of your body? yes___ no___ If yes, where? _____

With 0 representing no pain at all and 10 representing severe pain, please rate your pain: _____

When is the pain at its worse? (upon waking, with movement, etc.)_____

What past injuries may have caused this condition? (ex: accident, falls, sports injuries, etc.)

_____

What (if any) other doctors have you seen for this condition? _____

Briefly describe your occupational duties: _____

Have you ever fractured a bone? yes___ no___ If yes, which one and when? _____

List any past surgeries: _____

Family Health History (parents, siblings) if relevant: _____

Please list any medications you are presently taking (be sure to include over the counter medications and vitamins). _____

_____

for additional symptoms/complaints please use a separate page (Please ask for separate page)

SUBJECTIVE ANALYSIS

Patient Name:_____ Date:_____
(Initial: Re-exam)

VISUAL ANALOG SCALE

(please indicate the pain level you are currently experiencing by writing each involved body area on the scale)

0----------10

(no pain) 1 2 3 4 5 6 7 8 9 (unbearable pain)

ACTIVITIES OF DAILY LIVING

People with spinal pain may find that certain activities are restricted or difficult to do.
Ciricle all activities that you find difficult to do now:

- Sleep through the night
- Get out of bed
- Bathe yourself
- Wash, comb or dry hair
- Bend over sink for 10 minutes
- Go to the bathroom
- Put on socks, shoes or clothing
- Walk up one flight of stairs
- Walk down one flight stairs
- Crawl on all fours
- Turn a door knob
- Open a heavy door
- Sit in a chair for 30 minutes
- Sit and work at a desk for one hour
- Get up from a low seat
- Cross legs
- Walk one mile
- Stand for 30 minutes
- Travel on journeys that take over one hour
- Push or pull vacuum cleaner or lawn mower
- Carry laundry basket, groceries or a small child
- Wash windows or walls
- Bend over to clean bathtub
- Shovel snow or dirt
- Use, pencil, scissors, screwdriver or pliers
- Lift a heavy suitcase (about 40 pounds)
- Reach in front or overhead to high shelves
- Enjoy hobbies or social activities
- Enjoy sexual activities

Total #ADL items circled:_____

Circle any of the following conditions you are currently experiencing:

Subjective total:_____

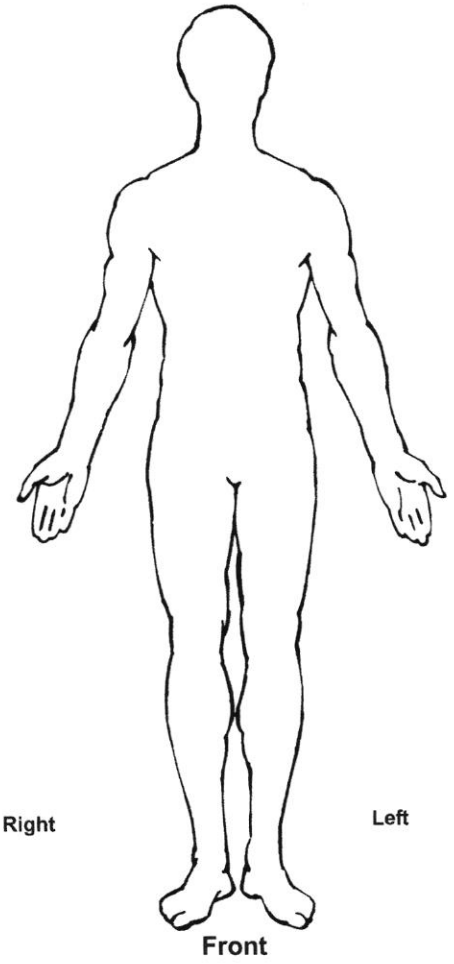
- Neck or back weakness
- Restricted movement of neck or back
- Persistent tender areas in muscles around neck or back
- "Catch" or "kink" in neck

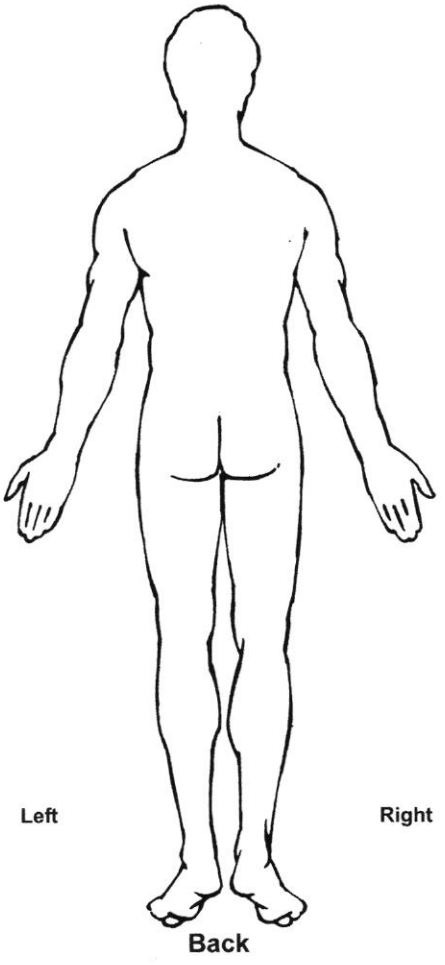
PATIENT PAIN DRAWING

Name:_____ Date_____

Where is your pain now?
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching	Numbness	Pins and Needles	Burning	Stabbing
▲▲▲	= = =	O O O	x x x	/ / /





Back Index

Form BI100

DOB:

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

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 is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

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 sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

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 1 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 pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

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 Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

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 worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect 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.

Changing degree of pain

⓪ My pain is 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 or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

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

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 5 – HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50] BENCHMARK -5 = _____