

**Mulholland Chiropractic Center, LLC**

**Confidential Patient Information**

Page 1

Please **print** the following information:

*Personal Information*

Patients Name (First, Middle, Last): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address, if different: \_\_\_\_\_

Patients Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Patients E-mail address: \_\_\_\_\_

Patients Date of Birth: \_\_\_\_\_ Patients SSN: \_\_\_\_\_

Patients Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Wk No: \_\_\_\_\_

If a Minor, Guardian Name: \_\_\_\_\_

Emergency Contact Person (name and phone number):

What is your Primary Complaint today? \_\_\_\_\_

**Who may we thank for referring you to our office?**

**Mulholland Chiropractic Center, LLC**

**Confidential Patient Information**

Page 2

Please **print** the following information:

*Billing Information*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Ins Co: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Secondary Ins Co: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Third Ins Co: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Patients Date of Birth: \_\_\_\_\_ Patients SSN: \_\_\_\_\_

Is this a Work Injury? Y / N    Automobile Accident? Y / N    Other? Y / N    Is a Claim Pending? Y / N

If Other, Describe: \_\_\_\_\_

Do you have an Attorney? (Name and address)

**If you have Insurance, we will need a copy of your Insurance Card, Claim Number, or completed Accident Report Form.**

The attorney(s) and/or insurance carrier(s) are hereby authorized and directed to pay directly to Mulholland Chiropractic Center, LLC any and all money due on my account(s), and that money is to be paid directly to Mulholland Chiropractic Center, LLC from any proceeds or settlement(s) made on my behalf. I authorize Mulholland Chiropractic Center, LLC to release any information necessary and appropriate to recover those benefits.

**I also agree that I'm responsible for the full amount of charges from Mulholland Chiropractic Center, LLC regardless of whether my condition is covered or not, or if for any reason the insurance carrier(s) or responsible party(s) refuse to pay my claim. I understand that Mulholland Chiropractic Center, LLC has the right to file a lien according to law, and I authorize Mulholland Chiropractic Center, LLC to do so to insure that payment is directed as outlined above. A copy of this agreement is as valid as the original.**

**By signing this I also acknowledge that a copy of our Notice of Privacy Practices has been given to me and I understand my privacy rights.**

Patients Name (First, Middle, Last): \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PAIN DISABILITY QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?  
Work normally Unable to work at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?  
Take care of myself completely Need help with all my personal care  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
3. Does your pain interfere with your traveling?  
Travel anywhere I like Only travel to see doctors  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
4. Does your pain affect your ability to sit or stand?  
No problems Can not sit/stand at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?  
No problems Can not do at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?  
No problems Can not do at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
7. Does your pain affect your ability to walk or run?  
No problems Can not walk/run at all  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
8. Has your income declined since your pain began?  
No decline Lost all income  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
9. Do you have to take pain medication every day to control your pain?  
No medication needed On pain medication throughout the day  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
10. Does your pain force you to see doctors much more often than before your pain began?  
Never see doctors See doctors weekly  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?  
No problem Never see them  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
12. Does your pain interfere with recreational activities and hobbies that are important to you?  
No interference Total interference  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?  
Never need help Need help all the time  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
14. Do you now feel more depressed, tense, or anxious than before your pain began?  
No depression/tension Severe depression/tension  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10
15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?  
No problems Severe problems  
0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:**

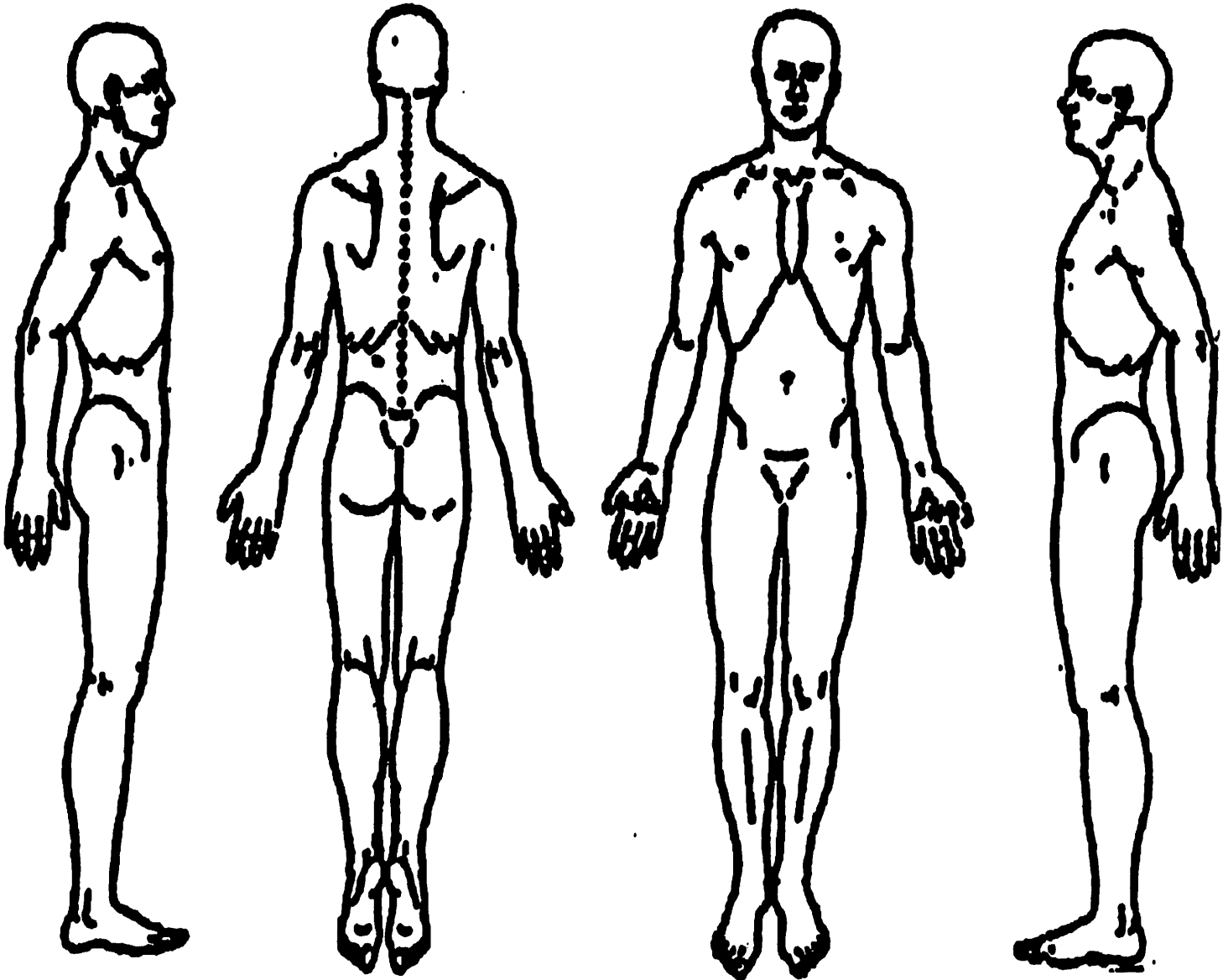
\_\_\_\_\_  
With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

# Welcome to Mulholland Chiropractic Center, LLC

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## *Pain Diagram*

This is a Pain Diagram. We would like you to "draw in" the areas of pain you are experiencing, with arrows pointing to the affected areas. Number them in order of severity, with the first one (#1) being the worst problem you have right now, and progressing to the least problem.



## *Specific History Questions*

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Condition #** \_\_\_\_\_

**1. Where specifically are you having your problems?** Please fill in the pain diagram above, labeling the areas affected in order of importance, with 1 being the most important, 2 being the second most important, etc. Print and fill out one of these Specific History Questions for each problem you're having.

**2. How would you describe the onset of this problem?** Abrupt (happened all at once) or progressive (happened slowly over a period of time). Please circle one.

**3. When did this problem start?** \_\_\_\_\_

**4. What caused this problem?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please skip the next questions if they do not apply;**

- If this is a **work accident**, did you notify your employer? Yes / No (circle one)
- Was an accident report filled out? Yes / No (circle one)
- Did you go to the hospital? Yes / No (circle one)
- Were you able to finish your shift? Yes / No (circle one)
- If this is a **motor vehicle accident**, were you the driver or a passenger? (Circle one)
- Were you wearing your seat belts at the time of the accident? Yes / No (circle one)
- Were you aware of the impending accident before it happened? Yes / No (circle one)
- Did you suffer any loss or alteration of consciousness at the time of the accident?
- Yes / No (circle one)
- Did you go to the hospital after the accident? Yes / No (circle one)

**5. How would you best describe this pain?**

Constant or Intermittent (circle one)

Sharp or Dull (circle one)

Quality (check all that apply):  achy,  burning,  tingling,  stiff,  numb,  shooting,  electric,

stabbing,  diffuse,  other \_\_\_\_\_

**6. How would you grade this pain at its worst on a 1-10 scale? (circle a number)**

(least possible pain) 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

**7. Does this pain radiate? Yes / No (circle one)**

**8. What makes this condition worse? (Check all that apply)**

Lifting,  sitting,  coughing,  sneezing,  bending,  standing,  walking,  sleeping,  reaching,

work activities,  household duties,  sports/recreational activities,  other \_\_\_\_\_

**9. What makes this condition better? (Check all that apply)**

prescription medications,  over-the-counter medications,  stretching,  exercising,  massage,

walking,  rest,  heat,  ice,  analgesic cream,  nothing,  other \_\_\_\_\_

**10. What activities are you now finding difficult or impossible to do? (Check all that apply).**

working a full day,  working to my full capacity,  sleeping through the night,  doing things with my

family,  performing recreational activities to my full capacity,  moving to my full ranges of motion,  lifting

things to my full capacity,  other \_\_\_\_\_

**11. Have you seen anyone else for this? (Check all that apply)**

- a family doctor,  an orthopedist,  an internist,  a primary care physician,  an emergency room physician,  a massage therapist,  a physical therapist,  an acupuncturist,  a chiropractor,  no one,  other \_\_\_\_\_

**12. Please list anything else you think your doctor should know.** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for full payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
4. I understand that I will be required to give at least 24 hour notice for cancellation of manual therapy appointments. If 24 hour notice is not given and the appointment is missed, you will be personally charged for the time scheduled. If you are late for your appointment, you will still be charged for the length of the original appointment time.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Thank you for your assistance.

Welcome to our office. Please answer the following questions so we can better help you.

## *General History Questions*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. **Male / Female** (circle one)
2. **How old are you?** \_\_\_\_\_ **What is your date of birth?** \_\_\_\_\_
3. **Where do you currently work?** \_\_\_\_\_
4. **Have you lost any time from work because of this?** Yes / No (circle one)
5. **If yes, how much?** \_\_\_\_\_
6. **Have you used tobacco in any form in the last five years?** Yes / no (circle one)
7. **If yes, how much and of what?** \_\_\_\_\_
8. **Have you consumed alcohol in the last five years?** Yes / No (circle one)
9. **If yes, how many drinks per day/week/month/year?** (Circle one) \_\_\_\_\_
10. **Do you personally have a history of any of the following conditions?** (Please check all that apply)
  - the same or similar symptoms as now  Cancer  seizures  migraines  shingles  tumors
  - Osteoporosis  herpes  diabetes  depression/anxiety  neuropathy  high blood pressure
  - high cholesterol  HIV/AIDS  broken bones  hepatitis  bruise easily  insomnia
  - heart problems/pacemaker  blood clots  skin conditions  TMJ disorders  nothing  rashes
  - Flu/viruses  other \_\_\_\_\_
11. **Do you have a history of significant trauma?** (This means prior motor vehicle accidents, prior work injuries, prior sports injuries that required or probably should have been treated, significant slips and falls that required treatment or probably should have been treated, etc.?) Yes / No (circle one)

**12. If yes, please list what type of accident** (car accident, a slip and fall, a work accident, sports injuries, or other), how long ago, and if you still's experience some residual problems as a result of that accident:

Type?	How long ago?	Residuals? (Yes / No)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**13. Have you had any prior surgeries?** Yes / No (circle one)

**14. If yes, please check all that apply:**

**Bone/joint:** Right / Left,  neck,  mid back,  low back,  right shoulder,  right elbow,  right wrist/hand,  right hip,  right knee,  right ankle/foot,  left shoulder,  left elbow,  wrist/hand,  left hip,  left knee,  left ankle/foot,  TMJ  other \_\_\_\_\_

**Organ:**  gallbladder,  appendix,  hysterectomy,  thyroid,  gastric/stomach,  diverticulitis/Crohn's,  heart valves,  bypass,  stents,  ulcers,  eyes,  nose,  sinuses,  prostate,  carpal tunnel syndrome,  wisdom teeth,  other \_\_\_\_\_

**15. Do you take prescription medications?** Yes / No (circle one)

**16. If yes, for which of the following conditions?** (check all that apply)

asthma,  high blood pressure,  migraines,  high cholesterol,  diabetes,  thyroid,  stomach/intestines,  arthritis/joint pain,  depression,  cancer,  inflammation,  pain,  blood thinners,  water pills,  other \_\_\_\_\_

**17. Do you take vitamins or supplements or other nutrients specifically for a particular problem?** Yes / No (circle one)

**18. If yes, for which of the following conditions? (Check all that apply)**

- asthma,  high blood pressure,  migraines,  high cholesterol,  diabetes,  thyroid, stomach/intestines,
- arthritis/joint pain,  depression,  cancer,  inflammation,  pain,
- other \_\_\_\_\_

**19. Do you take general, nonspecific vitamin supplements? Yes / No (circle one)**

**20. Do you have any allergies? Yes / No (circle one)**

**21. If yes, to what? (Please fill in the blanks)**

Latex: \_\_\_\_\_

Lotions/oils: \_\_\_\_\_

Foods: \_\_\_\_\_

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

Environmental (dogs/cats, dust, etc.) \_\_\_\_\_

Seasonal: Yes / No (circle one)

**22. Do you have a family history of any of the following (This means your mother, father, brothers or sisters affected under the age of 60)? (Check all that apply)**

- bone or joint problems,  arthritis,  significant allergies (which would have required treatment),
- similar symptoms that I currently have,  diabetes,  cancer,  benign tumors,  high blood pressure,
- heart disease before the age of 60,  depression,  seizures,  other \_\_\_\_\_

**23. If applicable, is there any chance that you may be pregnant? Yes / No (circle one)**