

PATIENT INFORMATION

DATE: _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

E-mail Address _____ Fax _____

Age _____ Date of Birth ____/____/____ Race _____ Marital Status S W D M - Spouse _____

Occupation _____ Employer _____ Work Phone _____

Employer's Address _____ City _____ Zip _____

How many children? _____ Names and Ages _____

Nearest Relative _____ Phone _____

Address _____ City _____ State _____ Zip _____

How were you referred to our office? _____

Family Medical Doctor _____

When doctors work together it benefits you - may we have permission to update your physician regarding your care here? _____

Please check any and all insurance coverage that may be applicable in this case:

____ Major Medical ____ Worker's Compensation ____ Medicare ____ Auto Accident

____ Medical Savings Account & Flex Plans ____ Other

Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Landin and/or Landin Chiropractic Care. I authorize Dr. Landin and/or Landin Chiropractic Care to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. ***I understand that I'm responsible for all costs of chiropractic care, regardless of insurance coverage and if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.*** _____ PATIENT INITIALS

The patient understands and agrees to allow Landin Chiropractic Care to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Patient/Guardian Signature _____ Date _____

Chiropractic Case History

	Complaint #1	Complaint #2	Complaint #3
Today you have the following physical complaints:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Describe:	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Burning <input type="checkbox"/> Electric <input type="checkbox"/> Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Burning <input type="checkbox"/> Electric <input type="checkbox"/> Shooting	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Achy <input type="checkbox"/> Throbbing <input type="checkbox"/> Numb <input type="checkbox"/> Burning <input type="checkbox"/> Electric <input type="checkbox"/> Shooting
How often do you feel this pain/complaint?	<input type="checkbox"/> Constantly <input type="checkbox"/> On & Off <input type="checkbox"/> Daily <input type="checkbox"/> # times per week <input type="checkbox"/> # times per month	<input type="checkbox"/> Constantly <input type="checkbox"/> On & Off <input type="checkbox"/> Daily <input type="checkbox"/> # times per week <input type="checkbox"/> # times per month	<input type="checkbox"/> Constantly <input type="checkbox"/> On & Off <input type="checkbox"/> Daily <input type="checkbox"/> # times per week <input type="checkbox"/> # times per month
How long have you had this pain?	_____	_____	_____
Since it began, is it getting:	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same	<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same
What makes it better?	_____	_____	_____
What makes it worse?	_____	_____	_____
Is there a time of day this is better or worse?	_____	_____	_____
Does the pain radiate or travel anywhere?	_____	_____	_____
On a scale of 1 - 10 Rate your discomfort	1 2 3 4 5 6 7 8 9 10 1 = Slight 10 = Excruciating	1 2 3 4 5 6 7 8 9 10 1 = Slight 10 = Excruciating	1 2 3 4 5 6 7 8 9 10 1 = Slight 10 = Excruciating
How have you taken care of this and how has it worked for you?	_____	_____	_____
	_____	_____	_____
This issue is affecting my:	<input type="checkbox"/> sleep <input type="checkbox"/> job <input type="checkbox"/> energy <input type="checkbox"/> childcare <input type="checkbox"/> marriage <input type="checkbox"/> sex <input type="checkbox"/> activity <input type="checkbox"/> urination <input type="checkbox"/> digestion <input type="checkbox"/> range of motion	<input type="checkbox"/> sleep <input type="checkbox"/> job <input type="checkbox"/> energy <input type="checkbox"/> childcare <input type="checkbox"/> marriage <input type="checkbox"/> sex <input type="checkbox"/> activity <input type="checkbox"/> urination <input type="checkbox"/> digestion <input type="checkbox"/> range of motion	<input type="checkbox"/> sleep <input type="checkbox"/> job <input type="checkbox"/> energy <input type="checkbox"/> childcare <input type="checkbox"/> marriage <input type="checkbox"/> sex <input type="checkbox"/> activity <input type="checkbox"/> urination <input type="checkbox"/> digestion <input type="checkbox"/> range of motion
GOALS	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please check the type of care desired (you may choose more than one)

Relief Prevention Correction of the Cause
 Let Dr. Landin choose for me

Doctor's Notes:

OWESTRY - Back/Leg Disability Index

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 (washing, dressing, etc.)

- I can look after myself normally but it is very painful.
- I can look after myself normally but it is very painful.
- 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 my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

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

Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9 – Social Life

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No
- Yes (if yes, please state the type of treatment you have received)

PATIENT

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

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

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

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

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they're conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Reading

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

Section 5 – Headaches

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

Section 6 – Concentration

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

Section 7 – Work

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

Section 8 – Driving

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

Section 9 – Sleeping

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

Section 10 – Recreation

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

0-4	No disability
5-14	Mild disability
15-24	Moderate disability
25-34	Severe disability
> 35	Complete disability

PATIENT: _____ DATE: _____

HISTORY OF PRESENT AND PAST ILLNESS:

Date symptoms appeared/accident happened: _____ Is this due to: ___ Auto Accident ___ Work Other _____

Have you ever had the same or a similar condition? ___ YES ___ NO If yes, when _____

Days lost from work: _____ Date of last physical examination: _____ WOMEN: Are you pregnant? ___ YES ___ NO

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? ___ YES ___ NO If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies of any kind? ___ YES ___ NO If yes, describe: _____

Do you have any Congenital Condition? ___ YES ___ NO If yes, describe: _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **NOW** or **P** if you have had these conditions **PREVIOUSLY**.

		Any Family Members?		Any Family Members?
Headaches _____	Frequency _____	_____	Loss of Balance/Dizziness _____	_____
Neck Pain _____	_____	_____	Fainting _____	_____
Stiff Neck _____	_____	_____	Loss of Smell/Taste _____	_____
Sleeping Problems _____	_____	_____	Pinched Nerve _____	_____
Back Pain _____	_____	_____	Unusual Bowel Patterns _____	_____
Nervousness _____	_____	_____	Feet/Hands Cold _____	_____
Tension _____	_____	_____	Kidney Problems _____	_____
Irritability _____	_____	_____	Ulcers _____	_____
Chest Pains/Tightness _____	_____	_____	Muscle Spasms _____	_____
Liver Problems _____	_____	_____	Frequent Colds _____	_____
Shoulder/Neck/Arm Pain _____	_____	_____	Fever _____	_____
Numbness in Fingers _____	_____	_____	Sinus Problems _____	_____
Numbness in Toes _____	_____	_____	Diabetes _____	_____
High Blood Pressure _____	_____	_____	Indigestion Problems _____	_____
Difficulty Urinating _____	_____	_____	Joint Pain/Swelling _____	_____
Weakness in Extremities _____	_____	_____	Menstrual Difficulties _____	_____
Breathing/Asthma/Emphysema _____	_____	_____	Weight Loss/Gain _____	_____
Fatigue _____	_____	_____	Depression _____	_____
Lights Bother Eyes _____	_____	_____	Loss of Memory _____	_____
Ears Ring _____	_____	_____	Scoliosis _____	_____
Broken Bones/Fractures _____	_____	_____	Circulation Problems _____	_____
Rheumatoid Arthritis _____	_____	_____	Seizures/Epilepsy _____	_____
Excessive Bleeding _____	_____	_____	Low Blood Pressure _____	_____
Osteoarthritis _____	_____	_____	Osteoporosis _____	_____
Pacemaker _____	_____	_____	Heart Disease _____	_____
Stroke _____	_____	_____	Cancer _____	_____
Ruptures (Disc, other) _____	_____	_____	Coughing Blood _____	_____
Eating Disorder _____	_____	_____	Alcoholism _____	_____
Drug Addiction _____	_____	_____	Neuritis _____	_____

SOCIAL HISTORY: Please indicate beside each activity whether you engage in it: OFTEN = O SOMETIMES = S NEVER = N

_____ Vigorous Exercise	_____ High Stress Activity	_____ Family Pressures
_____ Moderate Exercise	_____ Caffeine	_____ Financial Pressures
_____ Alcohol Use	_____ Tobacco Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other _____	

PATIENT _____

SUBJECTIVE PAIN ASSESSMENT – RATE YOUR PAIN BELOW

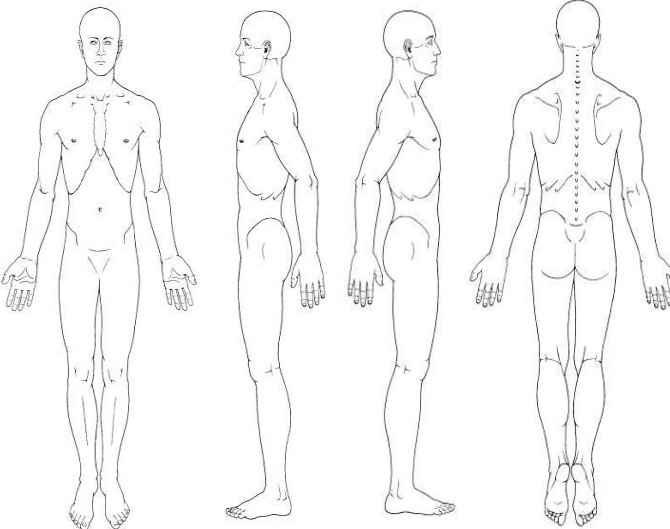
On the drawing indicate the location & type of pain you are experiencing with the letter noted below **(use only one BOX per visit)**.

(Example: *ST between your shoulders means you have stabbing pain between your shoulders*)

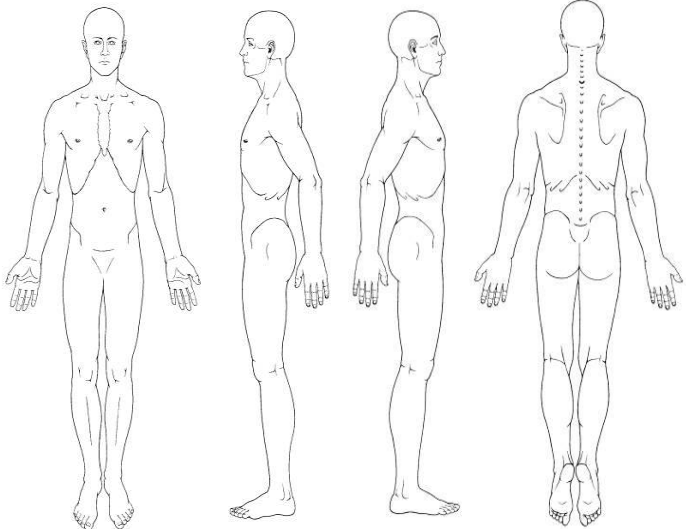
A=Ache B=Burning N=Numbness P=Pins and Needles ST=Stabbing SP=Spasm T=Throbbing

PAIN SCALE: Please circle the number that best describes your overall pain:											
0	1	2	3	4	5	6	7	8	9	10	10+
NONE	LITTLE			MODERATE			SEVERE			EXCRUCIATING	

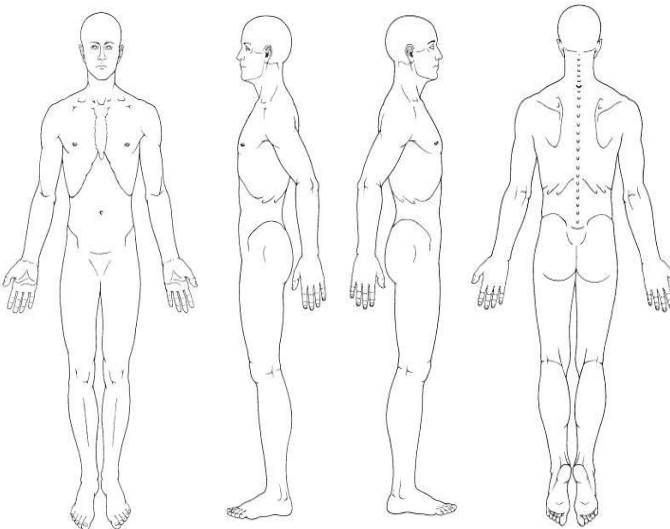
DATE _____
____ Initial Exam ____ Re-Exam ____ New Problem



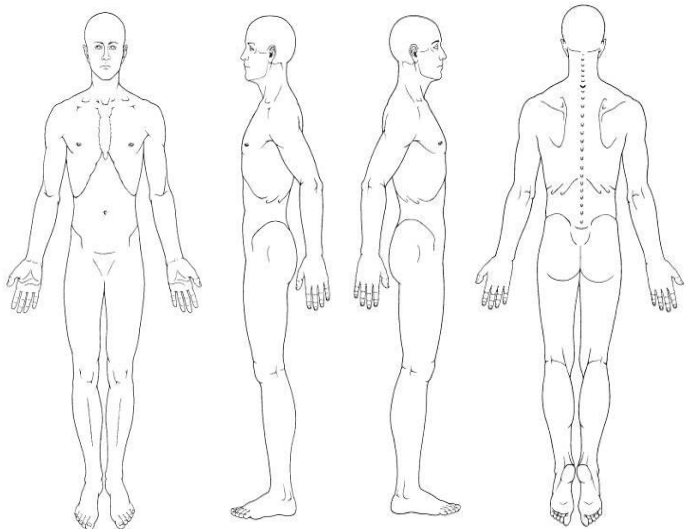
DATE _____
____ Initial Exam ____ Re-Exam ____ New Problem



DATE _____
____ Initial Exam ____ Re-Exam ____ New Problem



DATE _____
____ Initial Exam ____ Re-Exam ____ New Problem



PATIENT HEALTH INFORMATION CONSENT FORM (HIPAA)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. HIPAA Regulations specific to Landin Chiropractic Care - I authorize Landin Chiropractic Care to:

Provide my care in a "semi-open environment"	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leave phone messages for me on home cell phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Post my photo in the office or on the website	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Share my chiropractic success story	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. The following person(s) have my permission to receive my personal health information:

I have read the Privacy Notice and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature Date

Failure to agree with certain terms of this notice may prevent us from acceptance of your case.