PATIENT HEALTH RECORD

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Birth date: _____ Age: _____ Male _____ Female _____

Cell phone: _____ Home phone: _____

Work phone: _____ Email: _____

Occupation: _____ Employer: _____

Primary care physician: _____ City: _____

Marital Status: ❑ M ❑ S ❑ W ❑ D Number of children: _____ Spouse's name: _____

Are you insured? ❑ Y ❑ N Insurance Company: _____

Social Security #: _____ Is this visit the result of a work or auto injury? ❑ Y ❑ N

REASON FOR THIS VISIT

* Describe the purpose of this visit: _____

* How did this condition begin? _____

* When did this condition begin? _____

* What makes it Better? (rest, ice, heat, positioning, etc.) _____

* What makes it Worse? (sitting, standing, walking, bending, lifting, etc.) _____

* Does the pain
❑ Stay in one spot ❑ Travel to other areas

* Type of Pain
❑ Sharp/Shooting ❑ Ache ❑ Pins and needles
❑ Burning ❑ Numbness ❑ Other

* Describe this condition
❑ Getting worse ❑ Stays constant ❑ Comes and goes

* Please rate your pain (10 being the worst)
1 2 3 4 5 6 7 8 9 10

* Has this condition occurred before? ❑ Yes ❑ No Please explain: _____

* Have you ever seen other doctors for this condition? ❑ Yes ❑ No

Doctor's Name(s): _____

Types of treatment: _____

Did it help? ❑ Yes ❑ No ❑ Temporary relief

Any other recent health concerns? _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

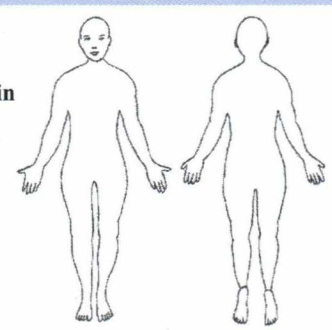
Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Reason for those visits? _____

Doctor's name _____

Approximate date of last visit _____

Mark the location of your pain



MEDICATIONS I NOW TAKE

- ❑ High Blood Pressure Medication
- ❑ Anti-anxiety Medicine
- ❑ Blood Thinners
- ❑ Muscle Relaxers
- ❑ Pain Killers
- ❑ Over the counter pain relievers

(Advil, Tylenol, Aleve, Ibuprofen)

- ❑ _____
- ❑ _____

❑ Smoker ❑ Past ❑ Present

How much? _____

HEALTH CONDITIONS

Please check each of the diseases or conditions you have now or have had in the past.

- ❑ Dizziness
- ❑ Headache
- ❑ Neck pain
- ❑ Numbness in arms/legs/hands
- ❑ Pain in arms/legs/hands
- ❑ Lower back pain
- ❑ HIV/AIDS
- ❑ Heart surgery/pacemaker
- ❑ Heart attack/stroke
- ❑ High/Low blood pressure
- ❑ Arthritis
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Cancer/Chemotherapy
- ❑ Joint replacement _____

* For women:

Are you pregnant? ❑ Y ❑ N

Are you taking birth control pills? ❑ Y ❑ N

Date of last menstrual cycle: _____

❑ Other(s): _____

❑ Please list surgeries and dates: _____

_____

Our Privacy Policy

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health insurance information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for operational purposes.
- Videotaping of a visit may be done to ensure quality control.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to certain individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure or your health information please let us know in writing. We are not required to agree to your restrictions.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing.

I have read your consent policy and agree to its terms. Initial _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will perform an examination and x-rays, if necessary, to determine a diagnosis and make treatment recommendations. If treatment is initiated, the doctor will use his/her hands or a mechanical device in an attempt to restore normal function to your joints and muscles. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or other soft tissue techniques may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation and/or ancillary procedures. Extremely rare complications could include muscle strain, ligamentous sprain, injury to intervertebral discs, rib fracture, or nerve injury. A small minority of patients may notice stiffness or soreness with the first few treatments. The ancillary procedures/hot packs could produce skin irritation, burns, or minor complications.

Other treatment options which could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation or damage to the stomach, liver, kidneys, ulcers or other side effects in a significant number of cases.
- Medical care prescription anti-inflammatory drugs, muscle relaxers and analgesics. Risks of these drugs include the above mentioned side effects and patient dependence on narcotics.
- Surgery, in conjuction with medical care, adds the risks of adverse reaction to anesthesia, death, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and cause chronic pain cycles. It is quite probable that a delay of treatment will complicate your condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the 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.

Initial _____

I understand that all services are to be paid in full at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable. I authorize the use of this signature on any insurance submissions.

Signature: _____ Date: _____

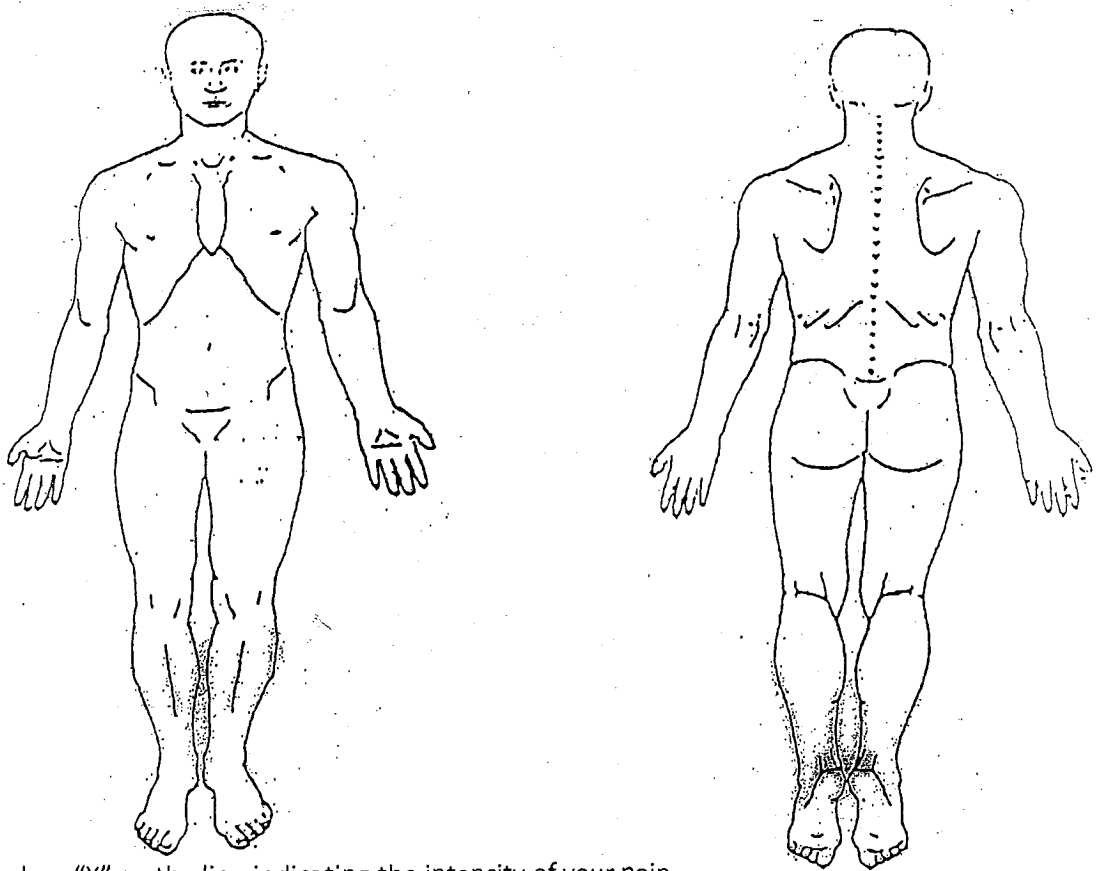
PERRON FAMILY CHIROPRACTIC

Patient Name:
Date:
Patient DOB:
Patient Acct #:

PAIN DIAGRAM

Please mark the areas on the pictures below that correspond to the areas of your body where you feel the described sensations. Use the appropriate symbols. Mark the areas of radiation. Including all affected areas.

Numbness	*Pins & Needles*	*Burning*	*Aching*	*Stabbing*
----------	*oooooooooooo*	*xxxxxxx*	*AAAAA*	*////////*
----------	*oooooooooooo*	*xxxxxxx*	*AAAAA*	*////////*



Mark an "X" on the line indicating the intensity of your pain.

Neck
No Pain _____ *Worse Possible Pain*
0 1 2 3 4 5 6 7 8 9 10

Mid-Back
No Pain _____ *Worse Possible Pain*
0 1 2 3 4 5 6 7 8 9 10

Low Back
No Pain _____ *Worse Possible Pain*
0 1 2 3 4 5 6 7 8 9 10

Headaches
No Pain _____ *Worse Possible Pain*
0 1 2 3 4 5 6 7 8 9 10

Other
No Pain _____ *Worse Possible Pain*
0 1 2 3 4 5 6 7 8 9 10

Patient Name:
Date:
Patient DOB:
Patient Acct #:

Perron Family Chiropractic
990 Pleasant Street
Brockton, MA 02301

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History *(Record one diagnosis in your family history and the affected*				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____

PERRON FAMILY CHIROPRACTIC

Patient Name:

Date:

Patient DOB:

Patient Acct #:

IF YOU ARE HAVING BACK PAIN PLEASE FILL OUT THIS FORM

REVISED OSWESTRY INDEX

Name: _____ **Date:** _____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately Increasing.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

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

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

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 (e.g. on a table)
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Patient Name:
Date:
Patient DOB:
Patient Acct #:

SECTION 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 – Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- ☐ My social life is normal and gives me no 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, e.g. dancing....
- ☐ Pain has restricted my social life and I do not go out much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9 – Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.

SECTION 10 – Changing Degrees of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

From Vernon H, Minor S. JMPT 1991; 14(7);409-415

PERRON FAMILY CHIROPRACTIC

Patient Name:

Date:

Patient DOB:

Patient Acct #:

IF YOU ARE HAVING NECK PAIN PLEASE FILL OUT THIS FORM

NECK DISABILITY INDEX

Name: _____ **Date:** _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

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 worst imaginable at the moment.

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

- ☐ 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 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.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 - Headaches

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

Patient Name:
Date:
Patient DOB:
Patient Acct #:

SECTION 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 8 – Driving

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

SECTION 9 – Sleeping

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

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

From Vernon H, Minor S. JMPT 1991; 14(7);409-415

PERRON FAMILY CHIROPRACTIC, 990 Pleasant St., Brockton, MA 02301 (508) 588-1300

Patient Name: ***IF YOU HAVE A HEADACHE*** Patient DOB:

Date: ***PLEASE FILL OUT THIS FORM*** Patient Acct #:

HEADACHE DISABILITY INDEX

Patient Name: _____ **Date:** _____

INSTRUCTIONS: Please **CIRCLE** the correct response:

1. I have headache: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one per week
2. My headache is: (1) mild (2) moderate (3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES, or 'NO' to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
____	_____	____	E1	Because of my headaches I feel handicapped.
____	_____	____	F2	Because of my headaches I feel restricted in performing my routine daily activities.
____	_____	____	E3	No one understands the effect my headaches have on my life.
____	_____	____	F4	I restrict my recreational activities (eg, sports, hobbies) because of my headaches.
____	_____	____	E5	My headaches make me angry.
____	_____	____	E6	Sometimes I feel that I am going to lose control because of my headaches.
____	_____	____	F7	Because of my headaches I am less likely to socialize.
____	_____	____	E8	My spouse (significant other) or family and friends have no idea what I am going through because of my headaches.
____	_____	____	E9	My headaches are so bad that I feel that I am going to go insane.
____	_____	____	E10	My outlook on the world is affected by my headache.
____	_____	____	E11	I am afraid to go outside when I feel that a headache is starting.
____	_____	____	E12	I feel desperate because of my headaches.
____	_____	____	F13	I am concerned that I am paying penalties at work or at home because of my headaches.
____	_____	____	E14	My headaches place stress on my relationships with family or friends.
____	_____	____	F15	I avoid being around people when I have a headache.
____	_____	____	F16	I believe my headaches are making it difficult for me to achieve my goals in life.
____	_____	____	F17	I am unable to think clearly because of my headaches.
____	_____	____	F18	I get tense (eg, muscle tension) because of my headaches.
____	_____	____	F19	I do not enjoy social gatherings because of my headaches.
____	_____	____	E20	I feel irritable because of my headaches.
____	_____	____	F21	I avoid traveling because of my headaches.
____	_____	____	E22	My headaches make me feel confused.
____	_____	____	E23	My headaches make me feel frustrated.
____	_____	____	F24	I find it difficult to read because of my headaches.
____	_____	____	F25	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

_____
Examiner

With permission from: Jacobson GP, Ramadan NM, et al, *The Henry Ford Hospital headache disability inventory (HDI).* Neurology 1994;44:837-842.