



Chad Brown, DC

Name _____ Sex: M F
Address _____ Apt. _____
City _____ State _____ Zip _____
Home Phone # _____ D.O.B. _____ Age _____
Cell Phone # _____ Cell Carrier _____
SS# _____ D. L. # _____
Marital Status: M S D W Sep. Height ____' ____" Weight _____ lbs.
E-mail _____ Occupation _____
Employer _____ Work Phone # _____ Ext. _____

IN CASE OF EMERGENCY, CONTACT _____
Phone #(H) _____ (W) _____ Relationship _____
Address _____
City _____ State _____ Zip _____

Referred to this office by _____
Nearest relative(not living with you) Name _____
Address _____
City, State, Zip _____

Electronic Communication Policy

We would like to contact you via emails and/or text messages for certain office communication, such as appointment reminders, office closings, etc. In accordance with HIPAA protocols, this provides us with the permission to contact you by the method(s) of your choice.

Please mark only one (1) answer:

- _____ I give my permission to receive text messages **and** email communications.
- _____ I give my permission to receive text messages, **but** not email communications.
- _____ I give my permission to receive email communications, **but** not text messages.
- _____ I do not want to receive text messages or emails.

Signature: _____ Date: _____

Patient Name _____ Birthdate _____ Age _____ Sex: M / F
Address _____ City _____ State _____ Zip _____

Phone () _____ Occupation _____ Employer _____

Cell Phone _____ Soc. Sec# _____ Height _____ Weight _____

Insurance _____ Marital Status _____ Spouse's Name _____ Spouse D.O.B. _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. Email : _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

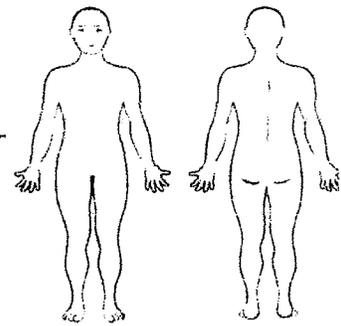
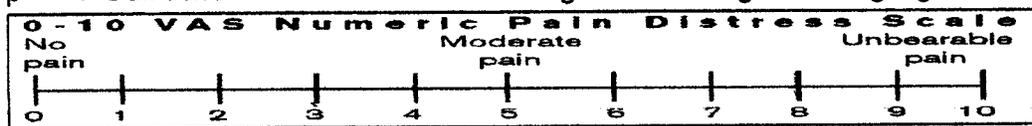
- Headache
- Neck Pain
- Mid-Back Pain
- Low Back Pain
- Other _____

Is this? Work Related Auto Related N/A

Date Problem Began _____ How Problem Began _____

What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling



How often are your symptoms present?

- (Occasional) 0 - 25%
- 26 - 50%
- 51 - 75%
- 76 - 100% (Constant)

In general would you say your overall health right now is:

- Excellent
- Very Good
- Good
- Fair
- Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? NO YES

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- Alcohol/Drug Dependence
- Recent Fever
- Diabetes
- High Blood Pressure
- Stroke (Date) _____
- Corticosteroid Use (Cortisone, Prednisone, etc.)
- Taking Birth Control Pills
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Cancer/Tumor (Explain) _____
- Prostate Problems
- Menstrual Problems
- Urinary Problems
- Currently Pregnant, # Weeks _____
- Abnormal Weight Gain Loss
- Marked Morning Pain/Stiffness
- Pain Unrelieved by Position or Rest
- Pain at Night
- Visual Disturbances
- Surgeries _____
- Osteoporosis
- Epilepsy/Seizures
- Other Health Problems (Explain) _____
- Tobacco Use - Type _____
- Frequency _____/Day
- Medications _____

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my Physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary. The HIPPA was provided.

Patient Signature _____ **Date** _____

REVIEW OF SYSTEMS: Circle Yes (Y) or No (N):

Constitutional

Recent weight loss Y N
 Fever Y N
 Chills Y N

Respiratory

Cough Y N
 Wheezing Y N
 Short of breath Y N

Gastrointestinal

Abdominal pain Y N
 Heartburn Y N
 Bloody stool Y N

Dermatology

Rashes Y N
 Sores Y N
 Blisters Y N
 Dry or sensitive skin Y N
 Hives Y N
 Suspicious moles Y N
 Suspicious lesions Y N
 Itching Y N

Endocrine

Excessive thirst Y N
 Excessive sweating Y N
 Excessive urination Y N

Allergy

Runny nose Y N
 Itchy eyes Y N
 Stuffy nose Y N

Psychology

Depression Y N
 Mood swings Y N
 Anxiety Y N

Urology

Frequent urination Y N
 Difficulty urinating Y N
 Blood in urine Y N

ENT

Nose bleeds Y N
 Sore throat Y N
 Change in voice Y N

Genitourinary (Female)

Pelvic pain Y N
 Irregular periods Y N
 Recurrent infections Y N

Hematologic/Lymphatic

Easy bruising Y N
 Swollen glands Y N
 Fatigue Y N

Cardiology

Palpitations Y N
 Chest pains/tightness Y N
 High blood pressure Y N
 Varicose veins Y N

Ophthalmology

Eye irritation Y N
 Blurred vision Y N
 Eye drainage Y N
 Visual changes Y N

Musculoskeletal

Muscle aches Y N
 Joint pain Y N
 Joint swelling Y N
 Joint stiffness Y N

Neurology

Dizziness Y N
 Headaches Y N
 Seizures Y N
 Weakness Y N

FAMILY HISTORY: Does anyone in your family have a history of diabetes, rheumatoid arthritis, heart problems, stroke, cancer or multiple sclerosis? If Yes, please specify _____

Has anyone in your family ever had a spine problem similar to the one you are currently experiencing? Please circle
 Mother Father Sister Brother Grandmother Grandfather

List **ALL** prescription and over-the-counter medications you are currently taking _____

Past surgeries _____

Past fractures/dislocations _____

Past car accidents _____

Past traumas _____

List **ALL** allergies _____

EXERCISE

None
 1-3 x / wk
 4-6 x / wk
 Daily

WORK ACTIVITY

Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

Smoking/Snuff
 Alcohol
 Coffee/Caffeine Drinks
 High Stress Level

Packs or cans/day _____
 Drinks/wk _____
 Cups/Day _____
 Reason _____

I authorize payment to the Brown Chiropractic Center. Brown Chiropractic Center may use and share your health information without your written authorization, for activities relating to treatment, payment, and health care operations. I have received a copy of the Notice of Privacy & Patient Rights for the Brown Chiropractic Center.

Signature _____ Date _____

Doctor comments/notes: _____

BCBS BCBS State UHC Aetna Cigna Medicare/Supp Humana(Medicare) Medicare/COB
 Medicaid/Ambetter/Magnolia/UHC Medicare/Medicaid CHIPS Self Pay Other _____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only 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 can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain.
- Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

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, for example 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 very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than one-half mile.
- Pain prevents me from walking more than one-quarter mile.
- 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 only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
 (Score ___ x 2) / (___ Sections x 10) = _____ %ADL

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 extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 -- Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep.
- Even when I take tablets I have less than 4 hours sleep.
- Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Social Life

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

Section 9 – Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain is bad but I manage journeys less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree 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 improvement is slow at the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments _____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

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 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.
- 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 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, for example 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 very light weights.
- I cannot lift or carry anything at all.

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain.
- 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.

Section 5-Headaches

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

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
 (Score x 2) / (Sections x 10) = %ADL

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 can't do any work at all.

Section 8 – Driving

- I 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 my car 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 moderately disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 hrs. 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 pain in my neck.
- 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.

Comments _____ %ADL