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Name _____ Date _____ SSN _____

Address _____ City / Zip Code _____

Employer _____ Occupation _____ Work Phone _____

DOB _____ Age _____ Gender M / F Email _____ Cell Phone _____
(PLEASE PRINT CLEARLY)

How did you hear about *61 Degrees North Chiropractic*? _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary_____

Secondary _____ Third _____ Fourth _____

On a scale of **1** to **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number:***

Primary or chief complaint is:	0	1	2	3	4	5	6	7	8	9	10
Second complaint is:	0	1	2	3	4	5	6	7	8	9	10
Third complaint is:	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint is:	0	1	2	3	4	5	6	7	8	9	10

When did the problem(s) begin?_____When is the problem at its worst? ❑AM ❑PM ❑Mid-day ❑Late PM

How long does it last? ❑ It is constant **OR** ❑ I experience it on and off during the day **OR** ❑ It comes and goes throughout the week

How did the injury happen? _____

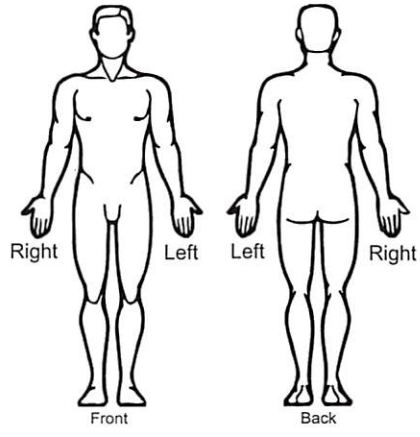
Condition(s) ever been treated by anyone I the past ❑ No ❑ Yes **If yes**, when: _____ by whom? _____

How long were you treated? _____ What were the results? _____

Name of previous Chiropractor? _____ ❑ **N/A**

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL

Is your problem the result of ANY type of accident? ❑ Yes ❑ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about? _____

CONTINUED ON BACK

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑Yes ❑No ***If yes***, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried? ❑Yes ❑No ***If yes***, please state **what type** of treatment: _____, and who provided it? _____ **How long ago?** _____ What were the results? ❑Favorable ❑Unfavorable ***If unfavorable***, please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: _____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P = P**ast **C = C**urrently **N = N**ever:

____ Broken Bone ____ Dislocations ____ Tumors ____ Rheumatoid Arthritis ____ Fracture ____ Disability ____ Cancer
____ Heart Attack ____ Osteo Arthritis ____ Diabetes ____ Cerebral Vascular ____ Hepatitis ____ Shingles ____ HIV / AIDS
____ Stroke ____ Pacemaker ____ Dizziness ____ Tuberculosis ____ Loss of Balance ____ Alcohol / Drug Abuse
____ Psychiatric Problems

Please identify **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO?	TYPE OF CARE RECEIVED	BY WHOM?
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

SOCIAL HISTORY

1. Smoking: ❑Cigars ❑Pipe ❑Cigarettes ❑Other How Often? ❑Daily ❑Weekends ❑Occasionally ❑Never
2. Alcoholic Beverages: consumption occurs ❑Daily ❑Weekends ❑Occasionally ❑Never
3. Recreational Drug Use: ❑Daily ❑Weekends ❑Occasionally ❑Never
4. Hobbies - Recreational Activities - Exercise Regime: how does your present problem affect? (See ADL form)

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ❑Yes ❑No
If yes, whom? ❑Grandmother ❑Grandfather ❑Mother ❑Father ❑Sister(s) ❑Brother(s) ❑Son(s) ❑Daughter(s)
Have they ever been treated for their condition? ❑Yes ❑No ❑I don't know
2. Any other hereditary conditions the doctor should be aware of? ❑No ❑Yes: _____

FOR WOMEN ONLY:
Are you taking birth control? ❑Yes ❑No Are you pregnant? ❑Yes ❑No ***If yes,*** how long? _____ Nursing? ❑Yes ❑No

_____ _____
SIGNATURE OF PATIENT DATE PRINTED NAME OF PATIENT

_____ _____
DOCTOR'S SIGNATURE DATE FORM IS REVIEWED

Consent for Purposes of Treatment & Healthcare Operations

In this document, "I" and "my" refer to the patient

I consent to the use of disclosure of my protected health information by **61 Degrees North Chiropractic** for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by **61 Degrees North Chiropractic** may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. **61 Degrees North Chiropractic** is not required to agree to the restrictions that I may request. However, if **61 Degrees North Chiropractic** agrees to a restriction that I request, the restriction is binding on **61 Degrees North Chiropractic.** I have the right to revoke this consent, in writing, at any time, except to the extent that **61 Degrees North Chiropractic** has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. this protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may obtain a copy of the *Notice of Privacy Practices* of **61 Degrees North Chiropractic** and understand that I have a right to read the *Notice of Privacy Practices* prior to signing this document. The *Notice of Privacy Practices* describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **61 Degrees North Chiropractic.** This *Notice of Privacy Practices* also describes my rights and duties of **61 Degrees North Chiropractic** with respect to my protected health information.

61 Degrees North Chiropractic reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may obtain a revised notice of privacy practices by calling the office of **61 Degrees North Chiropractic** and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. Our office sends thank you cards for referrals, sends periodic newsletters, posts names on a referral board, and participates in other non-private contact. If you prefer not to participate in this, please let **61 Degrees North Chiropractic** know.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain — worst possible pain

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain — worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain — worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain — worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain — worst possible pain

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES	EFFECT			
Carry Children / Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climb Stairs	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lift Children / Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Read / Concentrate	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Getting Dressed	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sexual Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Static Sitting	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Static Standing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard Work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Washing / Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sweeping / Vacuuming	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dishes	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Laundry	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Garbage	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Other: _____	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Patient signature: _____ Today's Date: ___/___/___