PATIENT NAME _____

DATE _____ Doctor_____

CONSULTATION QUESTIONNAIRE

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____
   _____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS _____ EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature _____ Date _____

Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Emergency Contact:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

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

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that 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.

The patient understands and agrees to allow this chiropractic office 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. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

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? π Yes π No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? π Yes π No

If yes, describe:_____

Do you have any allergies of any kind? π Yes π No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

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**.

N = Now P = Previously

Headaches_____ Frequency _____
Neck Pain _____
Stiff Neck _____
Sleeping Problems _____
Back Pain _____
Nervousness _____
Tension _____
Irritability _____
Chest Pains/Tightness _____
Dizziness _____
Shoulder/Neck/Arm Pain _____
Numbness in Fingers _____
Numbness in Toes _____
High Blood Pressure _____
Difficulty Urinating _____
Weakness in Extremities _____

Loss of Balance _____
Fainting _____
Loss of Smell _____
Loss of Taste _____
Unusual Bowel Patterns _____
Feet Cold _____
Hands Cold _____
Arthritis _____
Muscle Spasms _____
Frequent Colds _____
Fever _____
Sinus Problems _____
Diabetes _____
Indigestion Problems _____
Joint Pain/Swelling _____
Menstrual Difficulties _____

PATIENT NAME _____

DATE _____ Doctor_____

Breathing Problems _____
Fatigue _____
Lights Bother Eyes _____
Ears Ring _____
Broken Bones/Fractures _____
Rheumatoid Arthritis _____
Excessive Bleeding _____
Osteoarthritis _____
Pacemaker _____
Stroke _____
Ruptures _____
Eating Disorder _____
Drug Addiction _____
Gall Bladder Problems _____
Ulcers _____

Weight Loss/Gain _____
Depression _____
Loss of Memory _____
Buzzing in Ears _____
Circulation Problems _____
Seizures/Epilepsy _____
Low Blood Pressure _____
Osteoporosis _____
Heart Disease _____
Cancer _____
Coughing Blood _____
Alchoholism _____
HIV Positive _____
Depression _____

SOCIAL HISTORY

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

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

PATIENT NAME _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Office Use Only
☐ 1
☐ 4-5
☐ >5

Patient #:_____

Pain Drawing

Name:_____ Date:_____

Date of Birth:_____ Examiner:_____

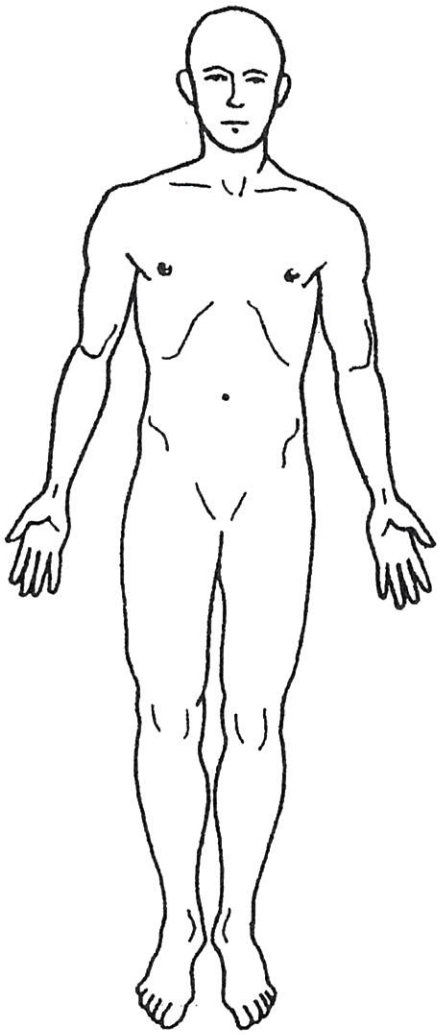
TELL US WHERE YOU HURT.

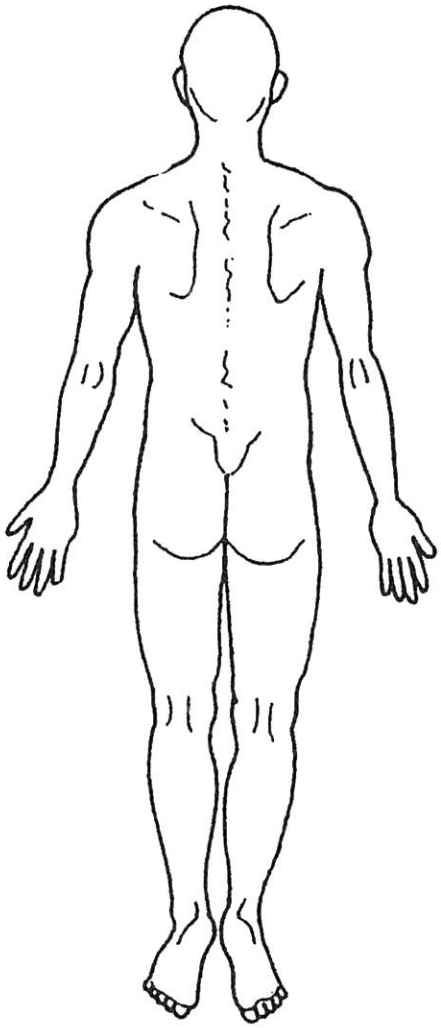
Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~





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

---

1 - What is your pain RIGHT NOW?

No pain	0	1	2	3	4	5	6	7	8	9	10 worst possible pain

2 - What is your TYPICAL or AVERAGE pain?

No pain	0	1	2	3	4	5	6	7	8	9	10 worst possible pain

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

No pain	0	1	2	3	4	5	6	7	8	9	10 worst possible pain

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

No pain	0	1	2	3	4	5	6	7	8	9	10 worst possible pain

OTHER COMMENTS:

_____

_____

_____

Examiner

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

Neck and/or Back Pain and Disability Index

Patient Name: _____ Date:_____

Please read instructions carefully.
If the statement applies to your neck or arms, circle N.
If the statement applies to your middle or lower back, hips or legs, circle MB or LB.

Pain Intensity **N** **MB** **LB**

- 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 unbearable at the moment.

Personal Care (washing, clothing, grooming, etc) **N** **MB** **LB**

- I can normally look after myself without extra pain
- I can look after myself normally but it does cause extra pain
- It is painful to look after myself and I must be slow and careful
- I need some help but manage most of my personal care
- I need help every day in most aspects of personal care
- I need help washing and dressing and mostly have to stay in bed

Lifting **N** **MB** **LB**

- I can lift heavy objects without any pain
- I can lift heavy objects but it causes extra pain
- Pain prevents me from lifting heavy objects off the floor but I can lift them if they are placed on a table
- Pain prevents me from lifting any heavy object
- I can manage medium or light objects
- I can lift only very light objects
- I cannot lift or carry anything at all

Reading **N** **MB** **LB**

- I can read as much as I want without any neck pain
- I can read as much as I want with only slight neck pain
- I can read as much as I want with moderate neck pain
- I can't read as much as I want to because of moderate neck pain
- I can hardly read at all because of the severe neck pain it causes
- Reading is not an option for me due to my severe neck pain

Headaches **N** **MB**

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

Patient Name:_____ Date: _____

Work **N** **MB** **LB**

- I can do as much work as I want
- I can do only my usual work and nothing more
- I can do most of my usual work but no more
- I cannot do my usual work

Driving/Travel **N** **MB** **LB**

- I can drive / travel without any increase in pain
- I can drive/travel with slightly increased pain
- I can drive/travel with moderate pain
- I can hardly drive/travel due to severity of pain
- I can't drive/travel due to the pain

Sleep **N** **MB** **LB**

- 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 (3-4 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Recreation **N** **MB** **LB**

- I am able to engage in all rec activity with no increased pain
- I am able to engage in all rec activity with some pain
- I am able to engage in most rec activity, but not all due to pain
- I am able to engage in only a few rec activities due to pain
- I can't do any rec activity due to pain

Walking **N** **MB** **LB**

- Pain does not prevent me from walking
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than 1/2 mile
- Pain prevents me from walking more than 1/4 mile
- Pain prevents me from walking w/o use of cane, walker, or crutches
- I cannot walk and am in bed most of the time

Sitting **N** **MB** **LB**

- I can sit in any chair as long as I want
- I can sit only in my favorite chair as long as I want
- Pain prevents me from sitting more than 1 hour
- Pain prevents me from sitting more than 30 min
- Pain prevents me from sitting more than 10 min
- Pain prevents me from sitting at all

Standing **N** **MB** **LB**

- I can stand as long as I want with no pain
- I have some pain while standing, but it does not increase with time
- I cannot stand for longer than 1 hour without increased pain
- I cannot stand for longer than 1/2 hour without increased pain
- I cannot stand for longer than 10 minutes without increased pain
- I cannot stand at all because it increases my pain right away

INFORMED CONSENT

PATIENT NAME _____

Clinic Name _____

Doctor's Name _____

Address _____

Phone _____ Fax _____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Ivey-O'Sullivan Health Care
201 S Dean St
Spartanburg, SC 29302
p 864.583.3967
f 864.585.5554

Name:
Address:

Authorizations and Releases

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

Initial _____

Signature _____ Date _____