

Name: _____ DOB: _____ Date: _____

Confidential Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU!

Name _____ Date of Birth _____ Sex M F
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 E-mail Address _____
 Social Security Number _____ Occupation _____
 Marital Status M S D W Spouse's Name _____
 Children's Names & Ages _____
 Who referred you to us? _____
 How else did you hear about us? _____

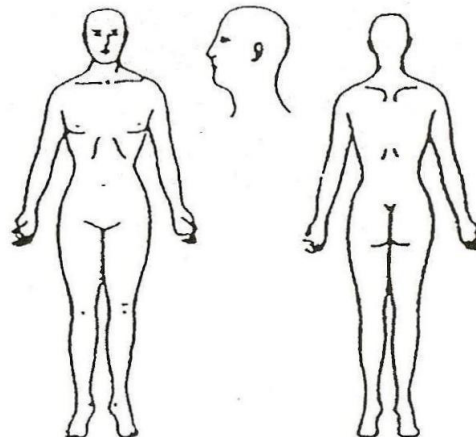
Health History Questionnaire

1. What brings you into this office (e.g. want to be healthier, backache, heartburn, etc.)?

2. If you are experiencing a symptom:
 - a. When did it begin? _____
 - b. How did it happen? _____
 - c. How often does it affect you? constant intermittent
 - d. Symptom severity is currently: mild moderate severe
 - e. Symptom is currently: increasing decreasing not changing
 - f. Symptom is worse in the: morning afternoon night same all day
 - g. If there is pain, is it: sharp dull ache shooting tingling radiating stabbing other _____
 - h. What makes the symptom better? nothing sitting lying down walking moving
bending/twisting other _____
 - i. What makes the symptom worse? nothing sitting lying down walking moving
bending/twisting other _____
 - j. How have you treated the symptom? ice heat medication other _____
 - k. Have you seen another provider for this complaint? yes no
If so, who: Chiropractor MD Osteopath Specialist other _____
When and what was their treatment _____
 - l. Has this condition affected your: sleep work chores family/social life leisure other _____
 - m. Have you had this or similar conditions in the past? _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles Stabbing ////



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3. What do you hope to gain from this office?
 improved general health symptom relief increased productivity positively change my life other _____
4. Have you suffered injuries in the past? yes no
 car accident date _____ falls date _____ hospitalization date _____
 fracture date _____ sprain/strain date _____ other _____
5. Do you have a family history of:
 heart disease cancer arthritis diabetes lung conditions high blood pressure
 stroke/vascular problems kidney or liver conditions other _____
6. Do you have a family physician? Name: _____
7. Please list any disease or condition with which you have been diagnosed _____

8. Please list any medications or supplements that you are currently taking _____

9. Please list any surgical operations and dates _____

Modified Oswestry Pain Disability Questionnaire

Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Personal Care (e.g., Washing, Dressing)

- I can take care of myself normally without causing increased pain.
- I can take care of myself normally, but it increases my pain.
- It is painful to take care of myself, and I am slow and careful.
- I need help, but I am able to manage most of my personal care.
- I need help every day in most aspects of my care.
- I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting

- I can lift heavy weights without increased pain.
- I can lift heavy weights, but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., 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.

Social Life

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

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 moderate.
- The pain is moderate and does not vary much.
- The pain is severe but comes and goes.
- The pain is severe and does not vary much.

Walking

- Pain does not prevent me from walking any distance.
- 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.
- I can walk only with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

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 for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Standing

- I can stand as long as I want without increased pain.
- I can stand as long as I want, but it increases my pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 1/2 hour.
- Pain prevents me from standing for more than 10 min.
- Pain prevents me from standing at all.

Traveling

- I can travel anywhere without increased pain.
- I can travel anywhere, but it increases my pain.
- My pain restricts my travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under 1/2 hour.
- My pain prevents all travel except for visits to the doctor/chiropractor or hospital.

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Sleeping

- Pain does not prevent me from sleeping well.
- I get pain in bed, but it does not prevent me from sleeping.
- Because of pain, my normal night's sleep is reduced by less than one-quarter.
- Because of pain, my normal night's sleep is reduced by less than one-half.
- Because of pain, my normal night's sleep is reduced by less than three-quarters.
- Pain prevents me from sleeping at all.

Employment / Homemaking

- My normal homemaking / job activities do not cause pain.
- My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job/ homemaking chores.

Review of Systems

Past Present

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck or back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm, shoulder, elbow, wrist or hand pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg, hip, knee, ankle or foot pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling or stiffness of joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness, loss of sensation, or tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | General fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Troubled sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear noises or ringing |
| <input type="checkbox"/> | <input type="checkbox"/> | Hard of Hearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Earache |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Fluid |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath or wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough or chronic sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Runny nose or post nasal drip |
| <input type="checkbox"/> | <input type="checkbox"/> | Throat soreness or hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic ear or throat infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of taste or appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal weight gain or loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat or cold intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful or frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disorder or stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver or gallbladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable bowel or colitis |

Past Present

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloating or gas |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn or indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pains or angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer or non-cancerous tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (or Rheumatoid arthritis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Current Weight _____

Women Only

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast soreness or lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual cramping |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent yeast or fungal infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes |



Name: _____ DOB: _____ Date: _____

Women Only (cont.)

Duration of cycle _____ Duration of flow _____
 Menstrual flow: Heavy Moderate Light
 Last period _____
 No. Pregnancies _____ No. Births _____
 Contraception Type _____

Men Only

Prostate problems
 Erectile dysfunction
 Testicular pain

Please list any other health concerns you have that you would like the doctor to be aware of _____

Thank you!

OFFICE FINANCIAL POLICY

For your convenience, we accept cash, check, Visa and MasterCard. We also offer Care Credit plans, a private financing company that allows you to make interest free payments and/or defer or spread payments over an extended period of time.

1. If you do not have insurance: All payments are expected at the time of service or by a prepaid wellness plan. Any other payment arrangements must be made with the billing department prior to the services being rendered. Date of service discounts will only apply when payment is received that day; payments received beyond that day will be subject to the full standard rate. Patients who do not have insurance will be denied care if payment has not been received for two or more past visits.

2. If you have insurance: All co-payments are expected at the time of service. Patients who have a co-payment will be denied care if co-payment has not been received for two or more past visits.

All deductible plans will first be submitted to your insurance company and, following receipt of benefits, a statement of your responsibility will be sent to you. In order to avoid accumulating an unmanageable balance, individual accounts are not allowed to exceed \$200 and family accounts cannot surpass \$300. Chiropractic care will not be rendered if balances exceed these amounts. We welcome periodic payments while we wait to hear back from your insurance company in order to keep your account balance manageable.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

<p>Who is responsible for this account? _____ Relationship to Patient _____</p> <p>Do you plan to have insurance claims submitted for your care at our office? Y / N</p> <p><i>Please note: Your signature on this intake form denotes that you understand you are responsible for all charges whether or not paid by insurance. You authorize the doctor(s) to release all information necessary to secure the payment of benefits. You authorize the use of your signature here on all insurance submissions. Please answer the following questions:</i></p> <p>What company services your primary insurance? _____</p> <p>Who is the policyholder for this plan?</p> <p>Name: _____ DOB: _____ SSN: _____</p> <p>Do you have a secondary insurance? Company: _____</p> <p>Who is the policyholder for this plan?</p> <p>Name: _____ DOB: _____ SSN: _____</p> <p>Do you have any other insurance benefits that you would like to use? _____</p> <p>If you utilize MEDICARE benefits, do have a Medicare Advantage Plan? Company name: _____</p> <p>If you utilize MEDICARE benefits, do you have a supplemental plan? Company name: _____</p>
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Patient's signature: _____ **Date:** _____

Parent/ Guardian signature: _____

Cornerstone Chiropractic Staff: _____