PATIENT INTAKE FORM

ALL INFORMATION IS CONFIDENTIAL

BILAN CHIROPRACTIC

Patient Name:_____
(Last) (First) (MI)

Date:_____ **How were you referred to us?**_____

Mailing address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Business Phone:**_____ **Cell Phone:**_____

What type of case is responsible for today's problem? ◻ Workman's Compensation ◻ Auto Accident ◻ Personal Insurance ◻ Other

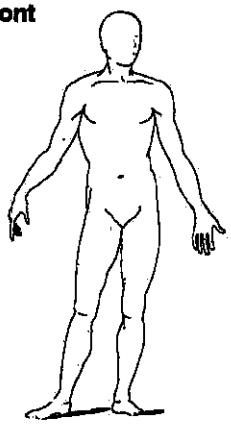
Are you personally insured? ◻ Yes ◻ No **Are we going to be billing your personal insurance?** ◻ Yes ◻ No

Insurance Company:_____

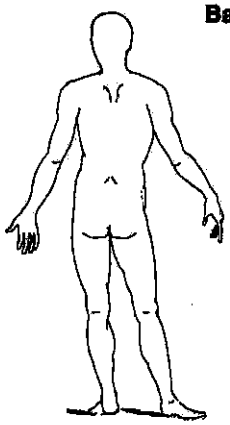
Policy ID:_____ **Group No.:**_____

Indicate on the drawings below where you have pain/symptoms:

Front



Back



You will have to answer questions about <u>each</u> of the different areas indicated on the above figures.

NECK

How often do you experience your symptoms?

◻ Constantly (76-100% of the time) ◻ Frequently (51-75% of the time) ◻ Occasionally (26-50% of the time) ◻ Intermittently (1-25% of the time)

How would you describe the type of pain?

◻ Sharp ◻ Numb ◻ Dull ◻ Tingly ◻ Diffuse
◻ Sharp with motion ◻ Achy ◻ Shooting with motion ◻ Burning ◻ Stabbing with motion
◻ Shooting ◻ Electric like with motion ◻ Stiff ◻ Other:_____

How are your symptoms changing with time? ◻ Getting Worse ◻ Staying the Same ◻ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

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

How much has the problem interfered with your work?

◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

How much has the problem interfered with your social activities?

◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

Who else have you seen for your problem?

◻ Chiropractor ◻ Neurologist ◻ Primary Care Physician ◻ ER physician ◻ Orthopedist
◻ Massage Therapist ◻ Physical Therapist ◻ Other:_____ ◻ No one

How long have you had this problem?_____

How do you think your problem began?_____

Do you consider this problem to be severe? ◻ Yes ◻ Yes, at times ◻ No

What aggravates your problem?

◻ Bending ◻ Sleeping ◻ While at Work ◻ Driving a Car ◻ Climbing Stairs
◻ Working at a computer ◻ Flexing and extending ◻ Standing Up ◻ Golfing ◻ Stress
◻ Playing Tennis ◻ Traveling ◻ Running ◻ Walking ◻ Sitting
◻ Other:_____

What alleviates your problem? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

_____

Mid Back

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Frequently (51-75% of the time) □ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly □ Diffuse
□ Sharp with motion □ Achy □ Shooting with motion □ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion □ Stiff □ Other:_____

How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

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

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ Other:_____ □ No one

How long have you had this problem?_____

How do you think your problem began?_____

Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

What aggravates your problem?

□ Bending □ Sleeping □ While at Work □ Driving a Car □ Climbing Stairs
□ Working at a computer □ Flexing and extending □ Standing Up □ Golfing □ Stress
□ Playing Tennis □ Traveling □ Running □ Walking □ Sitting
□ Other:_____

What alleviates your problem? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

_____

Low Back

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Frequently (51-75% of the time) □ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly □ Diffuse
□ Sharp with motion □ Achy □ Shooting with motion □ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion □ Stiff □ Other:_____

How are your symptoms changing with time? □ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

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

How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist
□ Massage Therapist □ Physical Therapist □ Other:_____ □ No one

How long have you had this problem?_____

How do you think your problem began?_____

Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

What aggravates your problem?

□ Bending □ Sleeping □ While at Work □ Driving a Car □ Climbing Stairs
□ Working at a computer □ Flexing and extending □ Standing Up □ Golfing □ Stress
□ Playing Tennis □ Traveling □ Running □ Walking □ Sitting
□ Other_____

What alleviates your problem? _____

What concerns you the most about your problem; what does it prevent you from doing?_____

What is your: **Age:** _____ **DOB:** _____ **Gender:** **M** **or** **F**

Marital Status: □ S □ M □ W □ D **How many children?**_____ **Name of** □ **Spouse or** □ **Parent:**_____

Email Address: _____ **Emergency Contact:**_____

Occupation: _____ **Employer:**_____

How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	
□	□	Headaches
□	□	Neck Pain
□	□	Upper Back Pain
□	□	Mid Back Pain
□	□	Low Back Pain
□	□	Shoulder Pain
□	□	Elbow/Upper Arm Pain
□	□	Wrist Pain
□	□	Hand Pain
□	□	Hip Pain
□	□	Upper Leg Pain
□	□	Knee Pain
□	□	Ankle/Foot Pain
□	□	Jaw Pain
□	□	Joint Pain/Stiffness
□	□	Arthritis
□	□	Rheumatoid Arthritis
□	□	Cancer
□	□	Tumor
□	□	Asthma
□	□	Chronic Sinusitis

Past	Present	
□	□	High Blood Pressure
□	□	Heart Attack
□	□	Chest Pains
□	□	Stroke
□	□	Angina
□	□	Kidney Stones
□	□	Kidney Disorders
□	□	Bladder Infection
□	□	Painful Urination
□	□	Loss of Bladder Control
□	□	Prostate Problems
□	□	Abnormal Weight Gain/Loss
□	□	Loss of Appetite
□	□	Abdominal Pain
□	□	Ulcer
□	□	Hepatitis
□	□	Liver/Gall Bladder Dis.
□	□	General Fatigue
□	□	Muscular Incoordination
□	□	Visual Disturbances
□	□	Dizziness

Past	Present	
□	□	Diabetes
□	□	Excessive Thirst
□	□	Frequent Urination
□	□	Smoking/Tobacco Use
□	□	Drug/Alcohol Depend.
□	□	Allergies
□	□	Depression
□	□	Systemic Lupus
□	□	Epilepsy
□	□	Dermatitis/Eczema/Rash
□	□	HIV/AIDS
□	□	Other:_____
		For Females Only
□	□	Birth Control Pills
□	□	Hormonal Replacement
□	□	Pregnancy

List all prescription medications you are currently taking: _____

List all of the over-the-counter medications or supplements you are currently taking:_____

List all surgical procedures you have had: _____

What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half the day	□ A little of the day

□**Performs Manual Labor** □ **Travels frequently**

What activities do you do outside of work?_____

Have you ever been hospitalized? □ No □ Yes **If yes, why:**_____

Have you seen a Chiropractor before? □ No □ Yes **How long ago?**_____

If yes, what was the result of treatment? □ Great □ Good □ Fair □ Mixed □ Poor

Have you had significant past trauma? □ No □ Yes **Are you current with pap smears/prostate exam?** □ No □ Yes

Anything else pertinent to your visit today? _____

In exchange for Bilan Chiropractic P.C.'s (clinic) forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows: I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and my self. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjustors responsible for claims filed by me, administrative agencies, the Alaska Workers' Compensation Board and my attorneys. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative, and direct my legal representative that at the time of final judgment, and final disposition or settlement this assignment shall have priority over all others not entitled by law to superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company, employer or legal representative shall be paid directly to the clinic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all of my indebtedness, I will remain liable to Bilan Chiropractic P.C. for the balance, including finance charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, charged directly to me, and that I am personally responsible for payment and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such event, I agree that this assignment will remain effective until all sums I owe Bilan Chiropractic P.C. are fully paid.

Patient Signature or Legal guardian's signature:_____ **Date:**_____

Patient's Social Security No.:_____-_____-_____ (Needed if we are billing an insurance)

On the Job Injury (Worker's Compensation)

Employer Name:_____ Employer Address:_____

Contact Person:_____ Date Injured:_____ Hour of Injury:_____ a.m./p.m.

Who is your Worker's Compensation carrier? _____ Claim No.:_____

Name of Adjuster:_____ Phone No.:_____ Extn:_____

Where are you hurting as a result of your current injury?_____

How did your injury occur? _____

Where were you working when you were injured (Location)?_____

Did you require post-accident hospitalization? ☐ No ☐ Yes If yes, name of hospital: _____

Have you lost any days of work? ☐ No ☐ Yes Dates:_____ Date last worked:_____

Did you report this injury to your foreman or employer? ☐ No ☐ Yes

Do you have an attorney that has advised you in this case? ☐ No ☐ Yes

Attorney's name:_____ Address:_____ Phone:_____

Personal Injury (Auto Collision/Other) Essential Information

Date of accident:_____ Hour:_____ a.m./p.m.

Name of insurance company you wish to receive the billing for payment:_____

Adjuster:_____ Claim No.:_____

Address:_____ Phone:_____ Extn: _____

Have they authorized payment for medical/chiropractic expenses? ☐ No ☐ Yes

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ No ☐ Yes

Did your injuries occur in the course of employment ("on the job")? ☐ No ☐ Yes

Where are you hurting as a result of your current injury?_____

How did your injury occur? _____

Have you lost any days of work? ☐ No ☐ Yes Dates:_____ Date last worked:_____

Was a police report filled out? ☐ No ☐ Yes

Do you have an attorney that has advised you in this case? ☐ No ☐ Yes

Attorney's name:_____ Address:_____ Phone:_____

Auto Collision

Location of accident:_____

Name of insurance company covering the vehicle that you were a passenger/driver in:_____

Name of insurance company covering the other vehicle:_____

To help us better understand the effects of the accident on your body (spine), please complete the following questions:

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian

Were you struck from: ☐ Behind ☐ Right side ☐ Left side ☐ Front ☐ Auto was parked

Did your car strike the other (s) involved? ☐ No ☐ Yes OR Did the other car strike yours? ☐ No ☐ Yes

Was your car stationary at the time of impact? ☐ No ☐ Yes

If no, approximately how fast was your car going? ☐ Under 5 mph ☐ 10-20 mph ☐ 25-40 mph ☐ Over 40 mph

Was the other car stationary at the time of impact? ☐ No ☐ Yes

If no, approximately how fast was their car going? ☐ Under 5 mph ☐ 10-20 mph ☐ 25-40 mph ☐ Over 40 mph

Did you require post-accident hospitalization? ☐ No ☐ Yes If yes, name of hospital: _____

Was any other person injured?_____

Anything bizarre happen? (like glasses jerked off face, etc.) _____

Name of the owner of other vehicle (if more than one vehicle was involved)_____

The Revised Oswestry Disability Index (for low back pain/dysfunction)

Patient name: _____ File #_____ Date:_____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

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

SECTION 2-PERSONAL CARE

- ☐ 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 increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases 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 causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I 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 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 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.
- ☐ 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 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

SECTION 6-STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

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 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ 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, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9-TRAVELLING

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

SECTION 10-CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

The Neck Disability Index

Patient name: _____ File#_____ Date:_____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that 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 off the floor, 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 to, 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.

SECTION 5-HEADACHES

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

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 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 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 (3-5 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 neck pain at all.
- ☐ 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 few of my 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.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.