

Pregnancy Questionnaire

Patient Name: _____ Date: _____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? Yes No

- If not, please tell us about your previous pregnancy and/or birth experience(s). (*Duration, interventions, etc*)

Do you plan to follow the same plan as your previous delivery? Yes No

- If no, what would you like to change?

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date?

Did you have any difficulty conceiving? Yes No

- If yes, please explain:

Have you ever used any form of hormonal or oral contraceptives? Yes No

- If yes, which ones, and for how long?

When was your last menstrual cycle?

What was your pre-pregnancy weight?

Current weight?

Have you experienced morning sickness? Yes No

- If yes, please explain:

CURRENT HEALTH CONDITIONS

What type of exercise(s) are you currently performing?

Please tell us about your current diet, and any dietary restrictions.

Have you taken any medications or supplements during your pregnancy? Yes No

- If yes, please explain:

Have you had any slips, falls, or other physical traumas during the pregnancy? Yes No

- If yes, please explain:

Have you had any major emotional stressors during your pregnancy? Yes No

- If yes, please explain:



YOUR BIRTH PLAN

Your top three goals for this pregnancy:

1. _____
2. _____
3. _____

Do you currently have a birth plan? Yes No

- If yes, please explain:

Are you taking any pre-natal or birthing classes? Yes No

- If yes, please explain:

Who is your OB/GYN or midwife?

Will they be present for delivery? Yes No

Who is your birth provider?

Do you intend to have a doula or birth coach present? Yes No

- If yes, please explain:

Do you wish to have a natural vaginal labor and delivery? Yes No

- If not, what concerns do you have?

YOUR POST-BIRTH PLAN

Do you plan on breastfeeding your child? Yes No

What do you intend to do for vaccines?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

What would you like to gain from chiropractic care during your pregnancy?

Are there any burning questions you want to be sure to ask today?



Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name	Last Name	Date
SS#	DOB	Sex <input type="radio"/> M <input type="radio"/> F
Marital Status	# of Children	Occupation
Street Address		Height
City, State, Postal Code		Weight
Email	Cell Phone	Other Phone
Emergency Contact	Emergency Relation	Emergency Phone
How did you hear about us?		
Who is your primary care physician?		
Date and reason for your last doctor visit:		
Are you also receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No - If yes, please name them and their specialty:		
Please note any significant family medical history:		

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Have you received care for this problem before? Yes No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? Suddenly Gradually Post-Injury

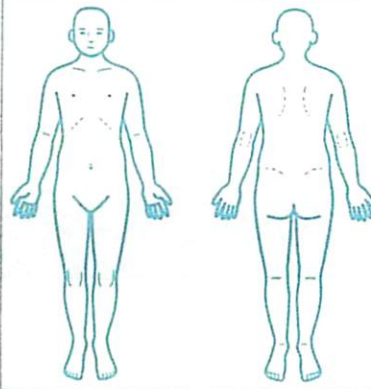
Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.

X= Current condition O= Past condition



YOUR HEALTH GOALS

Your top three health goals:

- _____
- _____
- _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? Resolve existing condition(s) Overall wellness Both

Have you ever visited a chiropractor? Yes No If yes, what is their name? _____

What is their specialty? Pain Relief Physical Therapy & Rehab Nutritional Subluxation-based Other _____

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? Yes No

-If yes, please explain: _____

Notable childhood injuries? Yes No If yes, please explain: _____

Youth or college sports? Yes No If yes, list major injuries: _____

Any auto accidents? Yes No If yes, please explain: _____

Exercise Frequency? None 1-3x per week 4-6x per week Daily

What types of exercise? _____

How do you normally sleep? Back Side Stomach Do you wake up: Refreshed and ready Stiff and tired

Do you commute to work? Yes No If yes, how many minutes per day? _____

List any problems with flexibility. (ex. Putting on shoes/socks, etc.) _____

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone? _____

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		Moderate		High		None		Moderate		High	
Alcohol	①	②	③	④	⑤		Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤		Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤		Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤		Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤		Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why _____

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		Moderate		High		None		Moderate		High	
Home	①	②	③	④	⑤		Money	①	②	③	④	⑤
Work	①	②	③	④	⑤		Health	①	②	③	④	⑤
Life	①	②	③	④	⑤		Family	①	②	③	④	⑤

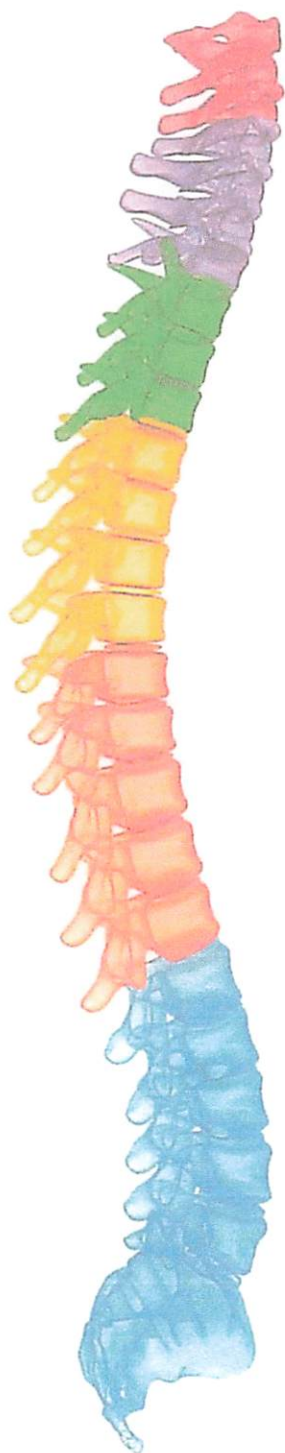
ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST PRESENT	PAST PRESENT		
Cervical	• Autonomic Nervous System	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/>	Stiff Neck & Shoulders
		<input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/>	Depression
		<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/>	Poor Metabolism & Weight Control
	Upper Thoracic	• Upper G.I.	<input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/>
• Respiratory System		<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	Functional Heart Conditions
• Cardiac Function		<input type="checkbox"/>	Asthma		
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/>	Fever	<input type="checkbox"/>	Blood Sugar Problems
Lower Thoracic	• Stress Response	<input type="checkbox"/>	Behavior Issues	<input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/>	Chronic Stress	<input type="checkbox"/>	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Sciatica & Radiating Pain
	• Gut-Immune System	<input type="checkbox"/>	Chronic's, Colitis & IBS	<input type="checkbox"/>	Lumbopelvic - SI Joint Pain
	• Major Hormonal Control	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Hamstring Tightness
		<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/>	Impotency	<input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: _____

Date: ____/____/____



Please check ALL insurance coverage that may be applicable in this case:

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

Primary Insurance: _____

Secondary Insurance: _____

AUTHORIZATION & 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, other health care providers, 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.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT:

BAKER FAMILY CHIROPRACTIC: I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the Doctor of Chiropractic named above and/or other assistants and/or licensed practitioners. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains, and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose and risks of the chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding according to the American Arbitration Association guidelines. I have read or have read to me the above explanation of the chiropractic treatments. I state that I have been informed and weighted the risks involved in chiropractic treatment at this health care office. I have decided that it is my best interest to receive chiropractic treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____	_____	____/____/20____
Printed Name of Patient	Signature	Date
_____	_____	____/____/20____
Signature of Representative (if applicable)	Witnessed (Employee)	Date

HIPAA Privacy Notice: This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact our Privacy Officer, Dr. Kate Baker, or any staff member in our office. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, www.bakerfamilychiroky.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. A copy of our Notice is readily available to you in our office at any time. At this time, you will be offered a full copy of our Notice. Please sign below that you have been made aware and would like to receive a copy or that you have been made aware of and are declining a copy at this time.

Request Copy
 Decline Copy

_____ /____/20____
Signature **Date**

Patient's Name _____ Number _____ Date _____

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 0-3. 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 $\times 2$) / (Sections $\times 10$) = %ADI

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: Fehring, *Physiotherapy* 1991; 62(3): 271-3, Hudson-Cook, in Roland, Jarner (eds.), *Back Pain New Approaches To Rehabilitation & Education*. Manchester Univ Press, Manchester 1982: 197-204

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.

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.

Scoring: Questions are scored on a vertical scale of 0-6. Total scores are multiplied 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

Comments _____

PATIENT INFORMATION ACCESS CONSENT

I, _____ (print patient name), give the staff of Baker Family Chiropractic permission to discuss the selected content with the person/people listed below. If I decide to change this permission for any reason, for any person listed below, I acknowledge that it will be my responsibility to make the staff aware of the changes I wish to make to my consent. This consent will remain in effect unless I notify the staff of Baker Family Chiropractic.

I, _____ (print patient name) ***DO NOT*** give the staff of Baker Family Chiropractic permission to discuss the content of my appointments, financial information, or medical care with anyone else at this time.

Patient Signature (or guardian) _____ Date _____

(Print Name) (Relationship) (Phone Number)

- 1. Make/change appointments Yes ____ No ____
- 2. Discuss financials Yes ____ No ____
- 3. Discuss medical care Yes ____ No ____

(Print Name) (Relationship) (Phone Number)

- 1. Make/change appointments Yes ____ No ____
- 2. Discuss financials Yes ____ No ____
- 3. Discuss medical care Yes ____ No ____

(Print Name) (Relationship) (Phone Number)

- 1. Make/change appointments Yes ____ No ____
- 2. Discuss financials Yes ____ No ____
- 3. Discuss medical care Yes ____ No ____

