Porter & Clark Chiropractic 29100 Gateway Blvd., Ste 100 Flat Rock, MI 48134
Phone: 734-379-9200 Fax: 734-379-9229

ABOUT YOU

Patient Name: ______________________________ **Date:** ________________

What you prefer to be called: ________________ **Birthdate:** ___/___/___ **Age:** _______

Gender: **Male**____ **Female** _____ **Social Security #:** ______________________

Mailing Address: ______________________ **City:** __________ **State:** _____ **Zip:** _______

Cell Phone #: ____________________ **Home Phone #:** ____________________

Marital Status: (circle one) M S W D **Spouse's Name:** ____________________

Occupation: ____________________ **Employer:** ____________________

Do you have children? (circle one) Yes No **If yes, how many?** ____________________

How did you hear about our office? ________________ **Referred by:** ______________

What is your current weight: _______ **lbs., and height,** _______ **Ft.** _______ **In.**

Exercise? (circle one) Yes No **Are you on a special diet?** (circle one) Yes No **Since:** __________

Use of Alcohol: (circle one) Never Rarely Moderate Daily

Use of Caffeine: (circle one) Never Rarely Moderate Daily

Use of Tobacco: Never Previously, but quit_______ Current packs/day_______
How long? ____________

Use of Drugs: Never Type/frequency____________________

For women: **Are you taking Birth Control?** (circle one) Yes No

Are you pregnant? (circle one) Yes No **How Long?** ____ **Nursing?** (circle one) Yes No

Is there a chance you *could* be pregnant? (circle one) Yes No

OFFICE USE ONLY:

BP: __________

Pulse: ________

IN CASE OF AN EMERGENCY

Who should we contact? ____________________ **Relation:** ____________________

Home Phone #: ____________________ **Work Phone #:** ____________________

Who is your Medical Doctor? ____________________ **Phone #:** ____________________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.
- Our policy requires payment in full for all services rendered at the time of visit.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge receipt of a copy of the office 'Notice of Patient Privacy Policy' and the Doctor Patient Relationship Form

Signature: ______________________________ **Date:** ________________

(circle one) Adult Patient Parent or Guardian Spouse

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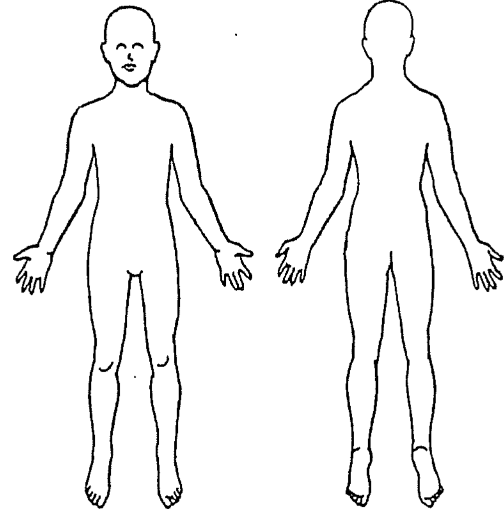
Patient Name: ______________________________ **Date:** ________________

Are you here because of: work related injury Yes____ No ____ auto accident Yes____ No____

What is your chief complaint? ____

____

*****Instructions: On the body diagram, please indicate ALL areas of pain or discomfort with an "X"*****



When did this start? ____________________

How did it start? ____________________

Have you had this similar condition before?

N or Y: (please explain if yes) ____________________

____

____

How bad is your pain/ache? (circle one) 0 1 2 3 4 5 6 7 8 9 10 (0 – no pain & 10 – most pain)

How frequent is your problem? ____constant ____frequent ____occasional ____comes & goes

Do you ever have: ____neck pain ____mid back pain ____lower back pain ____headaches

Do you feel your condition is getting: ____worse ____better ____no change

How would you describe the pain or symptoms? (circle all that apply)

Aching	Dull	Pulsating	Stabbing	Tightness	Pounding
Burning	Excruciating	Radiating	Stiffness	Weakness	Shooting
Cramping	Numbness	Sharp	Throbbing	Diffuse	Tingling

What functional activities are affected by this problem? (circle all that apply)

Bending	Climbing stairs	Getting in or out of car	Lifting	Chores
Sitting	Yard work	Looking over shoulder(s)	Standing	Walking
Driving	Exercise	Raising arm(s)	Work	Cooking
Laying down	Running	Sleep (fall or stay asleep)	Reading	Athletic activities

What makes it better? (circle all that apply)

Activity	Massage	Pain medication	Nothing	Resting
Heat	Standing	Sitting	Immobilization	
Ice	Walking	Stretching	Elevation	

Please list any previous illnesses and major injuries

Year: _______ Type: ___________________ Residual Problem: ____

Year: _______ Type: ___________________ Residual Problem: ____

Year: _______ Type: ___________________ Residual Problem: ____

Year: _______ Type: ___________________ Residual Problem: ____

Please list any surgeries and hospitalizations

Year: _______ Type: ___________________ Residual Problem: ____

Year: _______ Type: ___________________ Residual Problem: ____

Year: _______ Type: ___________________ Residual Problem: ____

Year: _______ Type: ___________________ Residual Problem: ____

Please list all known allergies

____

____

FAMILY MEDICAL HISTORY

Has any relative ever had the following: (please circle all that apply)

Heart Problems:	Father	Mother	Brother	Sister	Other
High Blood Pressure:	Father	Mother	Brother	Sister	Other
Arthritis:	Father	Mother	Brother	Sister	Other
Diabetes:	Father	Mother	Brother	Sister	Other
Stroke:	Father	Mother	Brother	Sister	Other
Cancer:	Father	Mother	Brother	Sister	Other
Osteoporosis:	Father	Mother	Brother	Sister	Other
Blood Clots:	Father	Mother	Brother	Sister	Other

Do you have a self-history of cancer? _______

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ____ **Date:** ____________________

(circle one) Adult Patient Parent or Guardian Spouse

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DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physicians procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use it inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Chiropractic Physicians are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your Chiropractic Physicians may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment or health care, if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from : latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractic physician. The patient should look to the correct specialist of the proper diagnostic and clinical procedures. The Chiropractic Physician provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of VSS or VSC since there are so many variables; it is difficult to predict the time schedule or efficiency of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond chiropractically may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

The Patient should discuss any questions or problems with the doctor before signing this statement of policy

Signature: ______________________________ **Date:** ______________

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With regards to Insurance Payment to our Office

It is important that you be informed that our professional service are rendered and charged to you, not the Insurance company. Our services are offered on the basis that any amount not paid by the Insurance company is your responsibility.

When we call to verify your insurance coverage with your Insurance carrier, it is never a guarantee of payment. Insurance carriers for their own reasons may not pay the percentage that they state to us when we call them.

When we tell the patient the total charges and what their portion is, it is just an estimated amount. We cannot guarantee that your insurance carrier will pay their percentage, each Insurance carrier looks at claims individually. The patient may have a deductible that needs to be met. We try to obtain as much information from your Insurance carrier as we can. It is ultimately the paitent's responsibility to know their Insurance plan.

We cannot gurantee payment from your Medical Insurance.

Regardless of Insurance, the balance is ultimately the patient's responsibility.

Patient or responsible parties signature

____ Date ____________________

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HIPAA Authorization form for Family Members/Friends

I, ___________________________, give permission for Porter and Clark Chiropractic to release any and all of my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	***Relationship:***
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Health Information to be disclosed (Check all that apply):

____ My complete health record (including but not limited to diagnose, lab tests, prognosis, treatment, and billing, for all conditions) OR

____ My complete health record, as above, with the exception of the following information: (check as appropriate):

____ Other (please specify) ____
____

This information may be used to enable to persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons

This authorization shall be effective until (Check one):

____ All past, present, and future periods, OR

____ Date or event: ____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing)

Print Name: ________________________________ Date: ____________________

Signature: ________________________________ Date: ____________________

PORTER & CLARK CHIROPRACTIC
29100 Gateway Blvd., Ste 100
Flat Rock, MI 48134

734-379-9200

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Porter & Clark Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. ______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

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734-379-9200

Notice of Patient Privacy Policy

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 or any staff member in our office.

Our Privacy Officer is Brittany Davidson.

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.porterandclarkchiropractic.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. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

  For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us

in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.
We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include

government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if

  we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (l) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.
- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.
  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

- **Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to: http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf*

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Brittany Davidson you may contact our Privacy Officer, or any staff member, including MaryJo Hounshell at the following phone number 734-379-9200 or our website www.porterandclarkchiropractic.com for further information about the complaint process.

This notice was published and becomes effective on March 28, 2016

Review of Systems

Check Any That Apply

Do you have any of these **OVERALL CONDITIONS?**		*Are you having problems with* **EARS, NOSE, OR THROAT?**		*Are you having any* **HEART-RELATED ISSUES?**	
Unable to transfer	☐	Cold/Flu	☐	Heart attack	☐
Unable to walk without assistance	☐	Loose teeth or wear dentures	☐	Heart murmur	☐
Unable to lie flat	☐	Earaches	☐	Pacemaker	☐
Use supplemental oxygen	☐	Hearing loss	☐	Palpitations/fluttering	☐
Other special needs (note below)	☐	Ringing in the ears	☐	High blood pressure	☐
Headaches	☐	Sinus problems	☐	Rapid heart rate	☐
Fatigue	☐	Nasal congestion	☐	Irregular heart rhythm	☐
Weakness	☐	Sore throat	☐	Chest pain or pressure	☐
Insomnia	☐	Hoarseness	☐	Shortness of breath	☐
Weight gain/loss	☐	Vertigo	☐	Swelling hands, feet, ankles	☐
Pregnant or possibly pregnant	☐	Recurrent nose bleeds	☐		
Night sweats	☐	Difficulty swallowing	☐		
Nursing a child	☐		☐		

Are you having any **RESPIRATORY PROBLEMS?**		*Are you having any* **INTESTINAL PROBLEMS?**		*Are you having any* **GENITAL/URINARY PROBLEMS?**	
Coughing Blood	☐	Blood in Stools	☐	Prostate problems	☐
Chronic Cough	☐	Stomach Pain	☐	Frequent urination	☐
Shortness of Breath	☐	Black Tarry Stools	☐	Blood in urine	☐
Asthma	☐	Constipation	☐	Pain with urination	☐
Bronchitis	☐	Decreased Appetite	☐	Urinary discharge	☐
Emphysema	☐	Diarrhea	☐	Genital sores	☐
Pneumonia	☐	Food Intolerance	☐	Abnormal menstruation	☐
Tuberculosis	☐	Heartburn	☐		
		Jaundice	☐		
		Nausea	☐		
		Vomiting	☐		

Are you having any **SKIN PROBLEMS?**		*Are you having any* **ENDOCRINE PROBLEMS?**		*Are you having any* **NEUROLOGIC PROBLEMS?**	
Skin rash	☐	Enlarged glands in neck	☐	Dementia	☐
Abnormal lesions	☐	Bulging eyes	☐	Involuntary movements	☐
Hives	☐	Heat or cold intolerance	☐	Balance problems	☐
Sores	☐	Increased thirst	☐	Vertigo	☐
	☐	Increased urination	☐	Fainting	☐
				Memory problems	☐
				Numbness of extremities	☐
				Seizures	☐
				Tingling	☐
				Tremors	☐

Are you having any **MENTAL HEALTH PROBLEMS?**		*Are you having any* **MUSCULOSKELETAL PROBLEMS?**		*Are you having any* **HEMATOLOGIC PROBLEMS?**	
Depression	☐	Joint pain/stiffness/redness	☐	Enlarged lymph nodes	☐
Nervousness	☐	Back pain	☐	Tender lymph nodes	☐
Tension/Irritability	☐	Muscle pain	☐	Easy bleeding or bruising	☐
Excessively elevated mood	☐	Muscle wasting	☐	Blood transfusion	☐
Hallucinations	☐	Easily broken bones	☐		

COMMENTS:

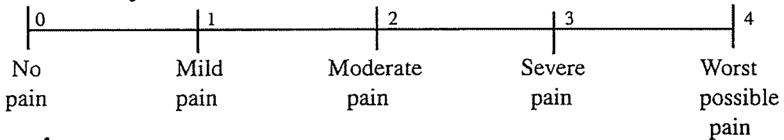
NAME: **DOB:** **SIGNATURE:**

Functional Rating Index

For use with <u>Neck and/or Back Problems</u> only.

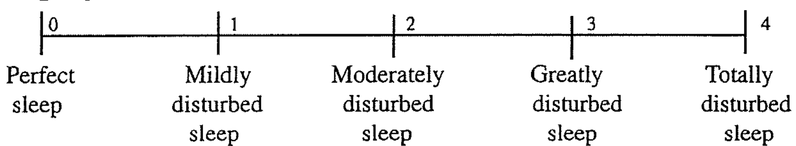
In order to properly assess your condition, we must understand how much your **<u>neck and/or back problems</u>** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



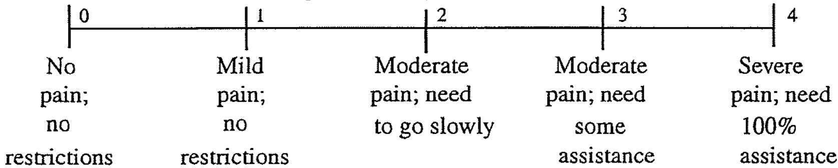
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



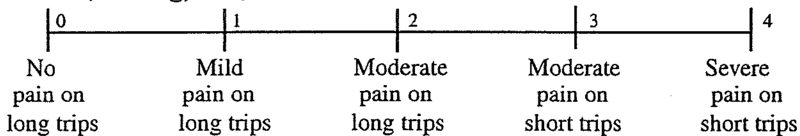
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



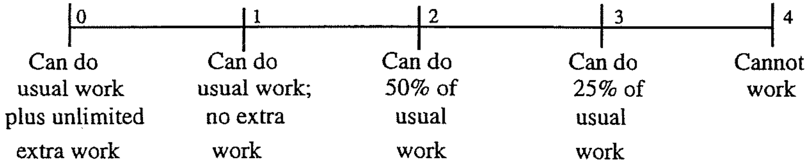
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



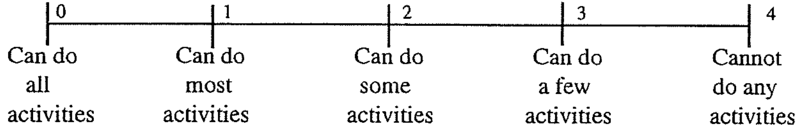
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



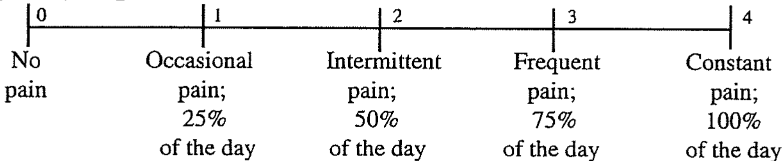
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



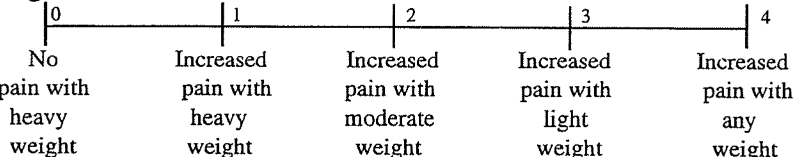
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



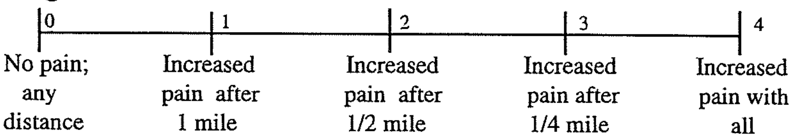
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



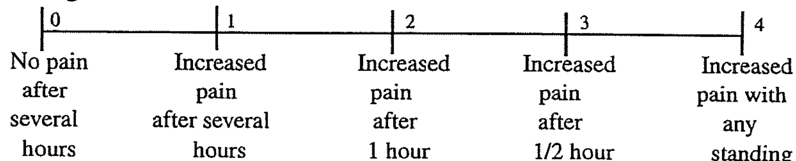
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________________
PRINTED

____
Signature

____
Date

Total Score ________

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