RESULTS CHIROPRACTIC INC.

YEARLY PATIENT UPDATE FORM

We thank you for your cooperation in keeping your records up-to-date.

TODAY'S DATE: _____

PATIENT NAME: _____ **SSN:** _____
(If you prefer not to provide your whole SSN, please provide the last four digits)

DATE OF BIRTH: _____ **AGE:** _____ **Male**___ **Female**___
Married___ **Single**___ **Divorced**___ **Separated**___ **Other**___

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL:** _____
CARRIER: _____ _____
(If you provide us with your cell phone number and/or home phone numbers, please provide us with the carrier's name, i.e. Verizon, AT&T, Sprint, etc. In providing this information, your signature below gives us permission to Text Message appointment reminders and other messages as may be appropriate.)

E-MAIL ADDRESS: _____
EMERGENCY CONTACT: _____ **PHONE:** _____

WORK PHONE: _____ **(Permission to call? yes no)**

EMPLOYER NAME: _____

ADDRESS: _____

PRIMARY PHYSICIAN NAME: _____ **PHONE:** _____

SPOUSE'S NAME: _____ **DOB:** _____ **SS#** _____

SPOUSE'S EMPLOYER NAME: _____ **Occupation:** _____

ADDRESS: _____

PHONE: _____ **(Permission to call? yes no)**

PLEASE PROVIDE THE STAFF WITH YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE WHEN RETURNING THIS INFORMATION TO THE DESK. THANK YOU.

PATIENT OR LEGAL REPRESENTATIVE'S SIGNATURE: _____

IF PATIENT IS A MINOR, YOUR NAME & RELATIONSHIP: _____

_____

Rev 11/01/2017

RESULTS CHIROPRACTIC INC.

A Family Wellness Center

JOHN S URBAN III DC, CCSP and LETTY L URBAN DC, DICCP

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing him/her/their, any and all records and reports, including x-rays and photostatic copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment, or opinion concerning that I may have had in the past, now have, or may have in the future.

Please forward all requested reports, x-rays and/or information to Results Chiropractic Inc. A copy of this release of information shall be as valid as the original.

_____
Signature

_____
Date of Birth

I give my permission to release information regarding myself to _____, which I may revoke in writing at any time.

_____
Signature

HIPPA

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 HIPPA NOTICE that is available to you at the front desk before signing this consent. If there should be anyone you do not want to receive your medical records, please inform our office staff.

By signing below I also release Results Chiropractic Inc. from any responsibility should I choose to engage in electronic exchange of information (texting, email, etc.) with any of the providers of service at Results Chiropractic Inc. regarding myself, minor, or other individual of which I have guardianship, ie, if such personal information is intercepted by anyone other than the mail recipient.

Patient's Signature _____ Date_____
Guardian's Signature Authorizing Care _____ Date_____
Initial here _____ if our office can use your name on our web site/newsletter.

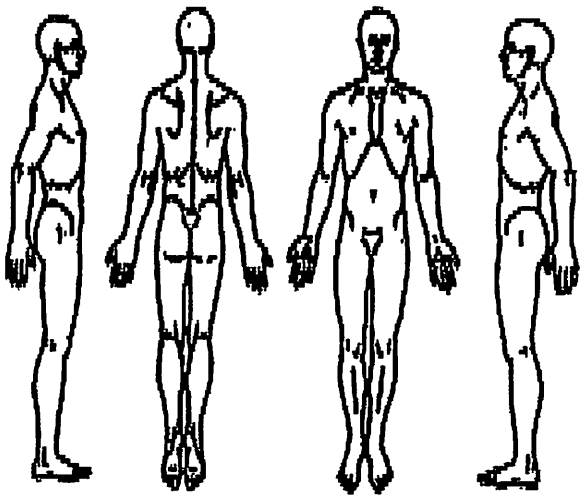
Correspondence Address: P O Box 235 – Beverly OH 45715
Two Locations: 643A STRT 821 Bldg 4 - Marietta OH 45750 and 519 Fifth Street – Beverly OH 45715
(740) 678-2700
(740) 678-2777 FAX

PATIENT INTAKE FORM

Patient Name: _____ DOB:_____ Today's Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation Other_____

2. Indicate on the drawings below where you have pain/symptoms



PLEASE CIRCLE AREAS OF PROBLEM AND/OR CONCERN:

Headache	Leg Rt / Lt
Jaw	Rt / LtKnee Rt / Lt
Neck	Rt / LtAnkle Rt / Lt
Upper Back	Foot Rt / Lt
Shoulder Rt / Lt	Other _____
Arm Rt / Lt	_____
Elbow Rt / Lt	
Wrist Rt / Lt	Rank of Importance: _____
Hand Rt / Lt	_____
Mid Back	_____
Low Back	_____
Hip Rt / Lt	_____

Additional Information:_____

3. How often do you experience your symptoms?

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

4. How would you describe the type of pain?

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

5. How are your symptoms changing with time?

- □ Getting Worse
- □ Staying the Same
- □ Getting Better

Please Describe: _____

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem and/or concern?

PROBLEM	PAIN LEVEL
1 _____	0 1 2 3 4 5 6 7 8 9 10
2 _____	0 1 2 3 4 5 6 7 8 9 10
3 _____	0 1 2 3 4 5 6 7 8 9 10
4 _____	0 1 2 3 4 5 6 7 8 9 10

7. How much has the problem interfered with your work?

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

8. How much has the problem interfered with your social activities?

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

9. Who else have you seen for your problem?

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

10. How long have you had this problem?

Year(s)_____ Month(s)_____ Week(s)_____ Day(s)_____

DOCTOR'S USE ONLY

11. How do you think your problem(s) began?

_____

_____

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

13a. What aggravates your problem(s)? _____ _____

13b. What alleviates your problem(s)?_____

14. What concerns you the most about your problem(s); what does it prevent you from doing?

_____

15. What is your occupation? **Professional** **White Collar** **Tradesperson** **Teacher** **Homemaker** **Truck Driver**
Student **Retired** **Unemployed** **Other**_____

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

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

18. Indicate if you have any immediate family members with any of the following: Please circle all that apply
MOTHER:: Alive or Deceased Birth Year_____
Diabetes High BP Stroke Cancer Osteoporosis Scoliosis Arthritis Auto-Immune Disorder Heart Problems
ALS Lupus Rheumatoid Arthritis

FATHER:: Alive or Deceased Birth Year_____
Diabetes High BP Stroke Cancer Osteoporosis Scoliosis Arthritis Auto-Immune Disorder Heart Problems
ALS Lupus Rheumatoid Arthritis

19. 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		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			Current Due Date: _____
□	□	Cancer	□	□	General Fatigue			# of Children _____
□	□	Tumor	□	□	Muscular Incoordination			# of Miscarriages _____
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all surgical procedures you have had with the date of the procedure:

_____

_____

_____

21. 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 of the day	◻ A little of the day

22. What activities do you do outside of work?

_____

23. Have you ever been hospitalized? ◻ No ◻ Yes
If yes, why _____

24. Have you seen a chiropractor before? ◻ No ◻ Yes How long ago? _____
What was the result? _____

25. Habits:
Smoking: _____ Packs/Day _____ Coffee/Caffeine Drinks: _____ Cups/Day _____
Alcohol: _____ Drinks/Week _____ High Stress Level: _____ Reason _____

26. Have you had significant past trauma? ◻ No ◻ Yes Please Describe: _____

27. Date of Last: Physical Exam _____ Spinal Xray _____ Blood/Urine Test _____
Chest Xray _____ Dental Xray _____ MRI / CT / Bone Scan _____

28. PLEASE LIST ALL MEDICATIONS AND ALLERGIES (OR PROVIDE A LIST TO STAFF).

_____
_____
_____
_____
_____
_____
_____
_____

(ALLERGIES) _____

29. Please List all Supplements: _____

30. Anything additional pertinent to your visit today? _____

31. Who may we thank for referring you to our office? _____

32. Would you like to have electronic access to your health information? Yes No Initials: _____

Patient Signature (or parent/guardian if minor) _____ Date: _____

OFFICE USE ONLY: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____

Oswestry Index Scores: Neck: _____ Low Back: _____

INFORMED CONSENT DISCUSSED _____ (INITIALS)

Doctor's Signature: _____ Date: _____

RESULTS CHIROPRACTIC INC.
A Family Wellness Center
Terms of Acceptance/Informed Consent

When we accept you as a patient into our practice, it is important that you understand the objectives of our care:
Chiropractors provide an unique service that other healthcare providers do not offer: the location and correction of vertebral subluxations (spinal nerve stress in your body). A vertebral subluxation is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. Subluxations can cause disease or loss of proper body function.

Chiropractors spend years studying how to locate and correct this destructive condition, first by analyzing your body structure (especially your spine) using various methods. Second, we correct or adjust your subluxations by using specialized techniques (spinal adjustment). When your spine and nervous system are free from the deep stress of vertebral subluxations you function more efficiently and your natural healing ability, your inner healer, will better communicate through your body.

We do not medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing, you always need a body free from subluxations.

If, during the course of our chiropractic spinal examination, we encounter unusual findings, we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. We will cooperate with you and with them in your goals.

To summarize: the purpose of chiropractic care is not to treat the diseases or conditions, not to suppress symptoms, nor to perform surgery, but rather to make your body function better by removing spinal nerve stress (subluxations). Therefore, we do not prescribe surgery or medications. If you wish to decrease or stop medications you should discuss that with your medical doctor.

Our objective is to eliminate a major interference to the expression of your physical/emotional health and healing vertebral subluxations so that your natural healing ability and your inner healer may function without this severe form of stress.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly and mutual understanding between the provider and patient.

I authorize the performance of any necessary diagnostic tests and treatments, which usually include chiropractic manipulation (CMT) for my condition(s). Like most health care procedures, CMT carries with it some risks. Unlike other medical treatments, the serious risks associated with CMT are extremely rate. Included are soreness or initial increased pain symptoms. More rare is dizziness, nausea or flushing, susceptibility of fracture with conditions like osteoporosis. Herniated or bulged discs may worsen even with CMT---it is important to notify the doctor of changes in symptoms. Extremely rare is a risk of a certain type of stroke, although this risk is the same with primary medical care and is associated with the nature of neck pain and headache presented by the patient.

Notice to Medicare Patients

Relative Contraindications: Do you have any of the following conditions?

☐ Joint Hypermobility, ☐ Osteoporosis/Osteopenia, ☐ Benign Bone Tumors, ☐ Bleeding Disorders, ☐ Blood Thinners, ☐ Progressive Radiculopathy

NOTE: If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust may be contraindicated in your condition. By signing below, you consent to care and agree to inform this office if another healthcare provider tells you that you have one of these conditions.

Absolute Contraindications of given area: Do you have any of the following conditions?

☐ Rheumatoid Arthritis, ☐ Spinal Cancer, ☐ Ankylosing Spondylitis, ☐ Ligament Laxity, ☐ Joint Dislocation, ☐ Recent/Unstable Joints, ☐ Unstable/Missing Dens at C2, ☐ Spinal/Joint Infection, ☐ Myelopathy/Cauda Equina Syndrome, ☐ Vertebrobasilar Insufficiency Syndrome, ☐ Arterial Aneurysm

NOTE: If you currently have, or have had, one of the above listed conditions, Medicare requires that we advise you that spinal manipulation and other forms of dynamic thrust is absolutely contraindicated in the region of the spine that is affected. By signing below, you agree to inform this office if another healthcare provider tells you that you have one of these conditions.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: _____ Date: _____

FRONT RANGE CENTER for BRAIN & SPINE SURGERY, P.C.
1313 Riverside Ave., Ft. Collins, CO 80524
(970) 493-1292

Oswestry Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please check the box for *the one statement* in each section that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that *most closely* describes your present-day situation. Thank you.

Patient name _____ Date _____

Please check one box in each section.

Section 1–Pain Intensity

- ☐ 0 I have no pain at the moment.
- ☐ 1 The pain is very mild at the moment.
- ☐ 2 The pain is moderate at the moment.
- ☐ 3 The pain is fairly severe at the moment.
- ☐ 4 The pain is very severe at the moment.
- ☐ 5 The pain is the worst imaginable at the moment.

Section 2–Personal Care (washing, dressing, etc.)

- ☐ 0 I can look after myself normally without causing extra pain.
- ☐ 1 I can look after myself normally, but it causes extra pain.
- ☐ 2 It is painful to look after myself; I am slow and careful.
- ☐ 3 I need some help but manage most of my personal care.
- ☐ 4 I need help every day in most aspects of self-care.
- ☐ 5 I do not get dressed; I wash with difficulty and stay in bed.

Section 3–Lifting

- ☐ 0 I can lift heavy weights without extra pain.
- ☐ 1 I can lift heavy weights, but it gives me extra pain.
- ☐ 2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned—for example on a table.
- ☐ 3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4 I can lift only very light weights.
- ☐ 5 I cannot lift or carry anything at all.

Section 4–Reading

- ☐ 0 I can read as much as I want to with no pain in my neck.
- ☐ 1 I can read as much as I want to with slight pain in my neck.
- ☐ 2 I can read as much as I want with moderate neck pain.
- ☐ 3 I can't read as much as I want because of moderate neck pain.
- ☐ 4 I can hardly read at all because of severe pain in my neck.
- ☐ 5 I cannot read at all.

Section 5–Headaches

- ☐ 0 I have no headaches at all.
- ☐ 1 I have slight headaches that come infrequently.
- ☐ 2 I have moderate headaches that come infrequently.
- ☐ 3 I have moderate headaches that come frequently.
- ☐ 4 I have severe headaches that come frequently.
- ☐ 5 I have headaches almost all the time.

Score: ____ (50) Benchmark -5 = _____

Section 6–Concentration

- ☐ 0 I can concentrate fully when I want to with no difficulty.
- ☐ 1 I can concentrate fully when I want to with slight difficulty.
- ☐ 2 I have a fair degree of difficulty in concentrating when I want to.
- ☐ 3 I have a lot of difficulty in concentrating when I want to.
- ☐ 4 I have a great deal of difficulty in concentrating when I want to.
- ☐ 5 I cannot concentrate at all.

Section 7–Work

- ☐ 0 I can do as much work as I want to.
- ☐ 1 I can only do my usual work, but no more.
- ☐ 2 I can do most of my usual work, but no more.
- ☐ 3 I cannot do my usual work.
- ☐ 4 I can hardly do any work at all.
- ☐ 5 I can't do any work at all.

Section 8–Driving

- ☐ 0 I can drive my car without any neck pain.
- ☐ 1 I can drive my car as long as I want with slight pain in my neck.
- ☐ 2 I can drive my car as long as I want with moderate pain in my neck.
- ☐ 3 I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ 4 I can hardly drive at all because of severe pain in my neck.
- ☐ 5 I can't drive my car at all.

Section 9–Sleeping

- ☐ 0 I have no trouble sleeping.
- ☐ 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ 2 My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ 3 My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ 4 My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ 5 My sleep is completely disturbed (5-7 hours sleepless).

Section 10–Recreation

- ☐ 0 I am able to engage in all my recreation activities with no neck pain at all.
- ☐ 1 I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ 2 I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ 3 I am able to engage in a few of my recreation activities because of pain in my neck.
- ☐ 4 I can hardly do any recreation activities because of pain in my neck
- ☐ 5 I can't do any recreation activities at all.

The Revised C stry Disability Index (for low back ıı/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.