Stone BridgeWellness

NEW PATIENT INTAKE FORM

Please complete in its entirety:

Name: _____ Today's Date: _____
Last First Middle Initial

Address:
_____
Street Apt #.

_____
City State Zip

Social Security #: _____Date of Birth: _____ Age: _____ Marital Status:_____

Home Phone: _____ Work Phone:_____

Email: _____

Cell phone: _____ Cell phone carrier: _____

Emergency contact: _____ Phone: _____Relationship: _____

Your Employer: _____

Employment address: _____

Occupation: _____ Business Phone #:_____

Is this visit routine/accident/illness/other: _____

If accident, date: _____State: _____ Open Claim? _____

REFERRED TO OUR OFFICE BY: _____

RESPONSIBLE PARTY INFORMATION

Name (Guarantor):
_____
Last First Middle

Relationship to Patient: _____ Phone: _____

Address:
_____
Street City State Zip

Employer: _____ Address: _____ Phone: _____

Name of Insurance:_____ID#_____ Group #_____

Stone BridgeWellness

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below:

1. _____ I hereby authorize Stone Bridge Wellness to provide Chiropractic Services to me.
2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Stone Bridge Wellness.
3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.
4. _____ I hereby assign all chiropractic benefits, including Major Medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Stone Bridge Wellness.
5. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application, I affirm under penalty that I have given true, complete information.

Dated this _____ day of _____, 20_____.

_____
Patient Signature

_____
Guarantor Signature

_____
Guarantor's Relationship to Patient

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ Date of Birth: _____
Patient's Full Name

to any chiropractic treatment deemed advisable, if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature: _____Witnessed by: _____
(Parent or Guardian)

Stone BridgeWellness

Personal Health History

Patient: Date of Birth:

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

O F C

Muscle / Joint
- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General
- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular
- ☐ ☐ ☐ Low blood press.
- ☐ ☐ ☐ High blood press.
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeat
- ☐ ☐ ☐ Swelling of ankles

O F C

Genitourinary
- ☐ ☐ ☐ Freq. urination
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Prostate trouble

Eye, Ear, Nose & Throat
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain

Gastrointestinal
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult Digest.
- ☐ ☐ ☐ Gallbladder
- ☐ ☐ ☐ Stomach Pain
- ☐ ☐ ☐ Vomiting

Skin
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Skin rash
- ☐ ☐ ☐ Varicose veins

O F C

Pain or numbness in
- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Difficult breathing

Women only
- ☐ ☐ ☐ Cramps/backache
- ☐ ☐ ☐ Heavy flow
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Menstrual Pain

Check any of the following conditions you currently have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Lumbago
- ☐ Multiple sclerosis
- ☐ Pacemaker
- ☐ Stroke
- ☐ Ulcers

Describe chiropractic problem: _____

_____

How long have you had this condition? Is it getting worse? ☐ Yes ☐ No
Does it bother your (check appropriate box): ☐ Work ☐ Sleep ☐ Other (please specify)
What seemed to be the initial cause?
Have you seen a chiropractor before? ☐ Yes ☐ No If yes, how long ago? _____ For what reason?
Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason?

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If yes, for major surgery? ☐ Yes ☐ No For serious injury? ☐ Yes ☐ No
Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when?
Indicate the drugs do you now take? ☐ Birth control pills ☐ Tranquilizers ☐ Pain Killers ☐ Other (specify)
Do you wear: ☐ heel lifts? ☐ sole lifts? ☐ inner soles? ☐ area supports? ☐ negative heels? ☐ platform shoes?
What is the age of your mattress? Is it ☐ comfortable? ☐ uncomfortable?
How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify)

Have you ever:

- Had a broken bone: ___Yes ___ No. If yes, explain briefly:_____
- Been hospitalized: ___ Yes ___ No. If yes, explain briefly: _____
- Had strains or sprains __ Yes ___ No. If yes, explain briefly: _____
- Used a cane, crutch or other support ___Yes ___ No. Explain: _____
- Been struck unconscious: ___Yes ___No. Explain: _____

When did you last have:

- Spinal Xray: ___ Never ___ 0-6 Months ___6-18 Months ___ Longer
- Spinal Exam ___ Never ___ 0-6 Months ___ 6-18 Months ___ Longer
- Physical Exam: ___ Never ___ 0-6 Months ___ 6-18 Months ___Longer

Habits:

	None	Light	Moderate	Heavy
- Alcohol:				
- Coffee:				
- Tobacco:				
- Drugs:				
- Exercise:				
- Sleep:				
- Water:				

FOR WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No If yes, how many months?
How many children do you have?

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

_____

_____

_____

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

_____ _____

Patient (or Guardian) Signature Date

REVISED OSWESTRY DISABILITY

Name _____ Date____/____/_____ File #_____

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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 severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ 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 increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase 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 gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can 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 without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

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 immediatley.

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 nights 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 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling 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 overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Form by N. Hudson- Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR. Eds. Back Pain.
Manchester University Press 1989: 187-204

Revised Oswestry (Patient Name: _____)

Age:_____Date of Birth:_____ Occupation:_____

How long have you had these symptoms? _____years ____months _____weeks

Is this your first episode of these symptoms? _____yes ___no

PLEASE USE THE LETTERS TO DESIGNATE THE AREAS OF DISCOMFORT:

A = Ache	B = Burning	N = Numbness
P = Pins and needles	S = Stabbing	O = Other