HARRISON COUNTY CHIROPRACTIC HCC
2086 Old Highway 135 NW Ste 1 - Corydon, IN 47112
(812) 734-1020
harrisoncountychiropractic.com

Corydon Pain Management Clinic
2086 Old Highway 135 NW Ste 1 - Corydon, IN 47112
(812) 734-0303
corydonpainmanagement.com

## 1. PATIENT INFORMATION

Full Name _____ Today's Date _____ S.S.#_____ Age_____

DOB _____ Address _____ City _____ State ____ Zip _____

Height _____ Weight _____ Race _____ Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Preferred Language _____ Occupation _____ Where Employed _____

Home Phone _____ Cell Phone _____ Email _____

Preferred Method of Contact: Email / Phone / Mail

Primary Care Provider _____ Primary Care Practice Location _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed: Spouse's Name _____

Medical Insurance Carrier _____ Policy Number _____ Phone _____

## 2. HEALTH HISTORY

1. Skin, hair or nail problems ☐ Yes ☐ No
2. Mouth and/or throat problems ☐ Yes ☐ No
3. Nose and/or sinus problems ☐ Yes ☐ No
4. Ear problems ☐ Yes ☐ No
5. Eye problems ☐ Yes ☐ No
6. Breathing problems ☐ Yes ☐ No
7. Smoke tobacco ☐ Yes ☐ No
   Status: Every Day Smoker / Occasional Smoker
   Former Smoker / Never Smoked
   Start Date (Optional): _____
8. Heart/blood vessel problems ☐ Yes ☐ No
9. Blood/lymph node problems ☐ Yes ☐ No
10. Digestive problems ☐ Yes ☐ No
11. Genital problems (e.g. prostate, testicular, vaginal) ☐ Yes ☐ No
12. Urinary (including kidney or bladder) problems ☐ Yes ☐ No
13. Mental health problems ☐ Yes ☐ No
14. Gland and/or hormone problems ☐ Yes ☐ No
15. Allergy or immunity problems ☐ Yes ☐ No
16. Muscle, tendon or ligament problems ☐ Yes ☐ No
17. Bone or joint diseases ☐ Yes ☐ No

## FEMALES ADDITIONAL HEALTH HISTORY

18. Menstrual problems ☐ Yes ☐ No
19. Taken birth control pills ☐ Yes ☐ No
20. Currently pregnant ☐ Yes ☐ No
21. Breast problems ☐ Yes ☐ No

## 3. PAST HISTORY

22. List all diseases that you have had in the past, (including childhood diseases): _____

_____

23. Ever been diagnosed with a particular condition, such as diabetes, cancer, AIDS, etc.: _____

_____

24. Suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? ☐ Yes ☐ No

If yes, describe accident including date of accident: _____

25. List all surgeries (include appendix, tonsils, ear tubes, wisdom teeth):

_____ Date: _____

_____ Date: _____

_____ Date: _____

26. Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No

What? _____ When? _____

27. Medications: Please list all medications (prescription & non-prescription) you are currently taking or take on a occasional basis: _____

Medication Allergies: _____ Reaction: _____

28. Have you ever had cancer? ☐ Yes ☐ No If yes, describe: _____

_____

## 4. FAMILY HISTORY

29. Are there any diseases or conditions that are common among your family members (i.e., inherited diseases/conditions?

☐ Yes ☐ No _____

## 5. SOCIAL HISTORY

30. In what position do you usually sleep, and how well? _____

_____

31. Do you exercise on a regular basis? ☐ Yes ☐ No If yes, how? _____

32. How do you spend your spare time (hobbies, etc.)? _____

33. Your diet is: ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restrictive

34. Do you use: ☐ Caffeine ☐ Tobacco ☐ Nicotine ☐ Recreational Drugs ☐ Alcohol

35. Please describe your work:

Type: _____ ☐ Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Factory ☐ Homemaker

Physical Demands: _____ ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary

Stress Level: _____ ☐ High ☐ Medium ☐ Low

## 6. ADDITIONAL HISTORY

36. If there is any information about your health history that was not requested, please fill it in below: _____

_____

37. Please describe your current complaint. In other words, what brought you here? Is it related to an accident or injury?

_____

38. Who is your medical doctor? _____

39. Have you ever seen a chiropractor before? ☐ Yes ☐ No If yes, date? _____

40. Have you ever seen a physical therapist before? ☐ Yes ☐ No If yes, date? _____

41. Have you had previous treatment(s) for your current condition (check all that applies):

| | | |
|---|---|---|
| ☐ Physical Therapy | ☐ Biofeedback | ☐ Acupuncture |
| ☐ Occupational Therapy | ☐ Psychological Counseling | ☐ Massage |
| ☐ Chiropractic | ☐ Psychiatric Treatment | ☐ Trigger Point Injections |
| ☐ TENS | ☐ Bed Rest | ☐ Epidural Injections |

☐ I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patients Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____
Authorizing Care

NOTICE TO PATIENTS

We work hard to provide the best, most efficient and affordable chiropractic healthcare. In order to provide our high quality of service and efficiency we must keep our costs down. We do work for you. However, we do reserve the right to dismiss you as a patient if you miss more than 3 appointments without prior notice. This arrangement will allow our office to maintain a level of service to each and every patient, as each patient counts on our quality and efficiency of service and care.

Requests by patients for X-ray(s) will be processed in 24 hours. The patient is responsible for their X-ray(s) once they are released from Harrison County Chiropractic or Corydon Pain Management Clinic until they are returned.

# CONSENT FOR TREATMENT AND USE OF PROTECTED HEALTH INFORMATION

Chiropractors focus on dysfunctions that can result from irregularities of spinal structure or movement. Hands-on procedures are usually preferred by most chiropractors to determine structural and functional problems. Manipulation is used to promote normal bodily function thus correcting or preventing these structural deviations. Chiropractic "adjustment" refers to al variety of manual mechanical interventions. Chiropractic adjustments and other procedures are usually beneficial and seldom cause any harm to the patient. In most cases, there is gradual but satisfactory result from chiropractic treatment. Occasionally, the results are less than expected. In rare cases, however, unknown underlying defects, deformities, or pathologies may result in injury to the patient. I understand that results of chiropractic only treatment vary and I have disclosed all known latent pathological defects, illnesses, and deformities to my chiropractor.

_____ _____

Signature Date

I consent to diagnosis and the treatment options available to me and consent to receive services from Harrison County Chiropractic or Corydon Pain Management Clinic ("the Practice").

_____ _____

Signature Date

I consent to use by the Practice of the following methods to remind me of my appointments: a postcard mailed to my address, a message left on the voicemail of any telephone number provided by me to the Practice, or a message left with any individual answering any telephone number proved by me to the Practice.

_____ _____

Signature Date

Due to the needs of the Practice for medical documentation, training, and quality assurances, I consent to having any x-rays and treatment performed on me by the Practice videotaped. I also consent to having treatment performed in an open area, which may be visible to other patients. The Practice will accommodate any reasonable request to discuss matters in private with me.

_____ _____

Signature Date

I understand that Dr. Renee Tornatore is the owner of Harrison County Chiropractic and Corydon Pain Management Clinic and that (pursuant to IN code section 25-22.5-11) I am in no way obligated to do business with any of these separate entities. I have the right to choose to be referred to another healthcare facility. Upon my request, additional names of healthcare facilities will be provided.

_____ _____

Signature Date

# ASSIGNMENT OF BENEFITS FORM

Name of Policy Holder (print):_____

Social Security Number: _____

☐ Medicare is my primary insurance

☐ _____ is my primary insurance

☐ I am not seeking care in connection with an accident or injury

☐ Please apply my deductible to my individual deductible

I request that payment of authorized insurance benefits (including Medicare, if I am a Medicare beneficiary) be made on my behalf to Harrison County Chiropractic or Corydon Pain Management Clinic (the **"Provider"**) for any equipment or services provided to me by the Provider. I authorize the release of any medical or other information necessary to determine the extent of all benefits payable for related equipment or services on my behalf to (1) the Provider, (i) the Centers for Medicare and Medicaid Services (**"CMS"**), (ii) my insurance carrier, (iv) or other medical entity. A copy of this authorization will be sent to CMS, my insurance company, or other entity if requested. The original authorization will be kept on file by the Provider. I understand that this assignment will remain in effect until revoked in writing by me.

I understand that I am financially responsible to the Provider for any charges not covered by healthcare benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage.

If I am a Medicare beneficiary, I understand that Medicare does not pay for exams, x-rays, physical therapy treatments, or maintenance treatments and that I am responsible for paying for these services out-of-pocket. I also authorize payment of all medical benefits to apply to all occasions for primary and supplemental (Medigap) coverage to be paid to the Provider.

In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my healthcare insurer if the submitted claims or any part of them are denied for payment.

I understand that, by signing this form, I am accepting financial responsibility, as explained above, for all payment, equipment and services provided by the Provider. By signing this document, I also acknowledge that I have received a copy of the Provider's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

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 0-5. 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___ x 2) / (____Sections x 10) = _____ %ADL

## 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: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

# 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.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply 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_____

## 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.

**Comments**_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15