Swan Lake Chiropractic

724 Pearl Street, Boulder, CO 80302 | 303.449.3103 | swanlakechiro.com

Confidential Patient Case History

Name: _____ (*Preferred Name*): _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth: _____ Sex: □ Male □ Female | Sex at Birth: □ Male □ Female | Gender: _____

Cell: _____ Home Phone: _____ Work Phone: _____

How did you find us/Who referred you?: _____

Emergency Contact's Name & Phone: _____

Occupation: _____

The information you provide will help us determine the stressors which have affected your spine, nervous system, & overall health

Birth & Early Childhood (0-5 years)

Please list any traumas, injuries, surgeries, or significant illnesses you are aware of:_____

_____

School Age Years (6-18 years)

Please list any traumas, injuries, surgeries, or significant illnesses you are aware of:_____

_____

_____

Activities you participated in:_____

_____

_____

Adult Years (19 +)

Please list any traumas, injuries, surgeries, or recurring health issues:_____

_____

_____

Current medications, dosage, and frequency:_____

_____

Have you been to a chiropractor before? □ Yes □ No Last adjustment: _____

Reason for Today's Visit:

Please describe your symptoms: _____

_____

Pain level today on a scale of 1-10: _____

Average pain level since this started on a scale of 1-10: _____

When did this start?_____

Have you had this or a similar condition in the past? _____

How does this affect your life?_____

What are your goals in seeking care for this condition? _____

_____

How committed are you to your health? (please circle one): Very Somewhat Not very much

Please rate your overall stress on a scale of 1-10: _____

How many times a week do you spend at least 20 minutes exercising?_____

How many times per week do you sit for greater than 30 minutes?_____

Appointment Policy:

Our time together is important. Please do your best to arrive on time for all of your appointments. As we get to know your body and treatment priorities, your appointment time will decrease. If you arrive ***more than 5 minutes*** late to our scheduled time together, we may have to reschedule your appointment for another time or day.

Please initial that you have read and understand the appointment policy: _____

Consent to Treatment:

I give permission for Swan Lake Chiropractic to evaluate me and to give me medical treatment.
I understand that:

- Swan Lake Chiropractic will have to send my medical record information to my insurance company if I am electing to bill my insurance.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- That options exist for treatment; and, all treatments are choices between risks and benefits.
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient's Signature: _____ Date:_____

Responsible Party's Signature, if patient is a minor: _____ Date: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have been notified of my option to receive a copy of this office's Notice of Privacy Practices and that this practice abides by those policies.

_____ (Signature)

_____ (Date)

_____ FOR OFFICE USE ONLY _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtainment
- An emergency situation prevented us from obtainment
- Other (please specify):

_____

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ACCIDENT QUESTIONNAIRE

Name: _____ Today's Date: _____
Date and time of accident: _____ Location of Accident: _____

QUESTIONS ABOUT THE ACCIDENT CIRCUMSTANCES:

Year and make of the vehicle you were riding in: _____
Number of other vehicles involved: _____ Type of other vehicles (car, SUV, etc): _____
Speed of vehicles at impact: your vehicle: _____mph | vehicle #2: _____mph | vehicle #3: _____mph
Were you the driver of passenger? ☐ Driver ☐ Passenger
If passenger, where were you seated? ☐ passenger's seat ☐ rear seat, driver's side ☐ rear seat, passenger's side
Were you wearing a seat belt? ☐ yes ☐ no
Did your vehicle strike another vehicle? ☐ yes ☐ no
Did another vehicle strike yours? ☐ yes ☐ no
Did air bags deploy? ☐ yes ☐ no
Was your vehicle moving or stopped? ☐ moving ☐ stopped
Where was your vehicle hit? ☐ in the front ☐ in the rear ☐ on the driver's side ☐ on the passenger's side
What were the road conditions? ☐ dry ☐ wet ☐ icy ☐ snow-packed ☐ other: _____
How far did your car move after impact? Car lengths: _____ Feet: _____
Please describe the accident in your own words: _____
_____
_____

QUESTIONS ABOUT YOUR CIRCUMSTANCES AT IMPACT:

Did you anticipate the impact? ☐ yes ☐ no If yes, did you brace yourself before impact? ☐ yes ☐ no
Where were you looking? ☐ forward ☐ upward ☐ down ☐ to the left ☐ to the right
Were you looking in a mirror? ☐ yes ☐ no If yes, please describe: _____
What was your body position at time of impact? ☐ neutral ☐ forward ☐ rotated (right/left)
Which way were you turning? ☐ to the left ☐ to the right ☐ not turning at all
Did you strike another object? ☐ wheel ☐ dash ☐ window ☐ other: _____
Did you experience any of the following *at the time* of impact?
☐ cuts ☐ bruises ☐ abrasions ☐ dislocations ☐ bumps/ where: _____
☐ immediate dizziness ☐ nausea ☐ vision problems ☐ altered consciousness
☐ immediate head pain ☐ discharge from ears or nose ☐ loss of consciousness/how long: _____
☐ Immediate pain/where: _____

QUESTIONS ABOUT YOUR CIRCUMSTANCES AFTER THE ACCIDENT:

Did you ride in an ambulance? ☐ yes ☐ no Was your car drivable from the scene of the accident? ☐ yes ☐ no
Did you go to the hospital? ☐ yes ☐ no If yes, did you stay overnight? ☐ yes ☐ no
Was any imaging taken? ☐ yes ☐ no If yes, what kind/where on body? _____
Were you instructed on any of the following? ☐ use ice ☐ use heat ☐ other: _____
How did you feel that night? ☐ restless ☐ in pain ☐ stiff ☐ sore ☐ fine
How did you feel the next day: ☐ better ☐ same ☐ worse
Have you experienced anxiety since the accident? ☐ yes ☐ no
Have you experienced loss of memory? ☐ yes ☐ no
Have your complaints kept you from doing anything? ☐ yes ☐ no What: _____

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Patient Name: _____ Date: _____

Describe any pre-existing conditions you were experiencing at the time of impact:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

Did the seatbelt bruise you? ☐ Yes ☐ No If yes, where? _____

Were the police called? ☐ Yes ☐ No Was anyone cited? _____

Which of the following do you suffer from now, which you did not prior to the accident:

☐ Headaches	☐ Dizziness	☐ Difficulty concentrating
☐ Long Term Memory Loss	☐ Short term memory loss	☐ Amnesia
☐ Loss of consciousness at scene	☐ "Blackouts" since collision	☐ Forgetting ATM or other numbers
☐ Reading problems	☐ Writing problems	☐ Typing problems
☐ Apathy	☐ Irritability	☐ Sleep disturbances
☐ Personality changes	☐ Emotional difficulties	☐ Relationship difficulties
☐ Blurred Vision	☐ Sensitivity to light	☐ Vision changes
☐ Intolerance to Alcohol	☐ Intolerance to heat	☐ Intolerance to cold
☐ Impaired comprehension	☐ Impaired learning	☐ Attention impairment
☐ Loss of libido	☐ Missing periods of time	☐ Speech difficulties
☐ Concussion in collision	☐ Nausea	☐ Vomiting
☐ Extreme thirst since collision	☐ Fatigue	☐ Menstrual irregularities
☐ Tinnitus (ringing of ears)	☐ Noise intolerance	☐ Loss of coordination
☐ Bumping into objects in view	☐ Loss of balance	☐ Fluid in ears
☐ Hearing loss	☐ Vertigo (spinning sensation)	☐ Increased symptoms in crowds
☐ Anxiety	☐ Depression	☐ Change in personality
☐ Flashbacks to accident scene	☐ Intrusive thoughts of accident	☐ Nightmares since collision
☐ Unusual behavior since collision	☐ Social withdrawal	☐ Panic attacks
☐ Thoughts of death/suicide	☐ Weight loss / gain _____lbs	☐ Loss of taste / smell
☐ Blackouts with neck movements	☐ Dizziness with neck movements	☐ "Clunk" sound with moving neck
☐ Jaw pain	☐ Clicking in jaw	☐ Pain with chewing

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PAIN RATING & DRAWING

Patient Name: _____ Date: _____

When did the accident-related pain start? _____

What things are you unable to do or must modify to perform? _____

_____

What will bring on or intensify your pain? _____

_____

Within the last couple of days to a week, please rate your level of pain and frequencies
Pain Levels: Using a 0 – 10 pain scale (0 = no pain, 10 = most intense pain imaginable)

Rate your current level of pain _____, percent of the time at this level of pain _____%

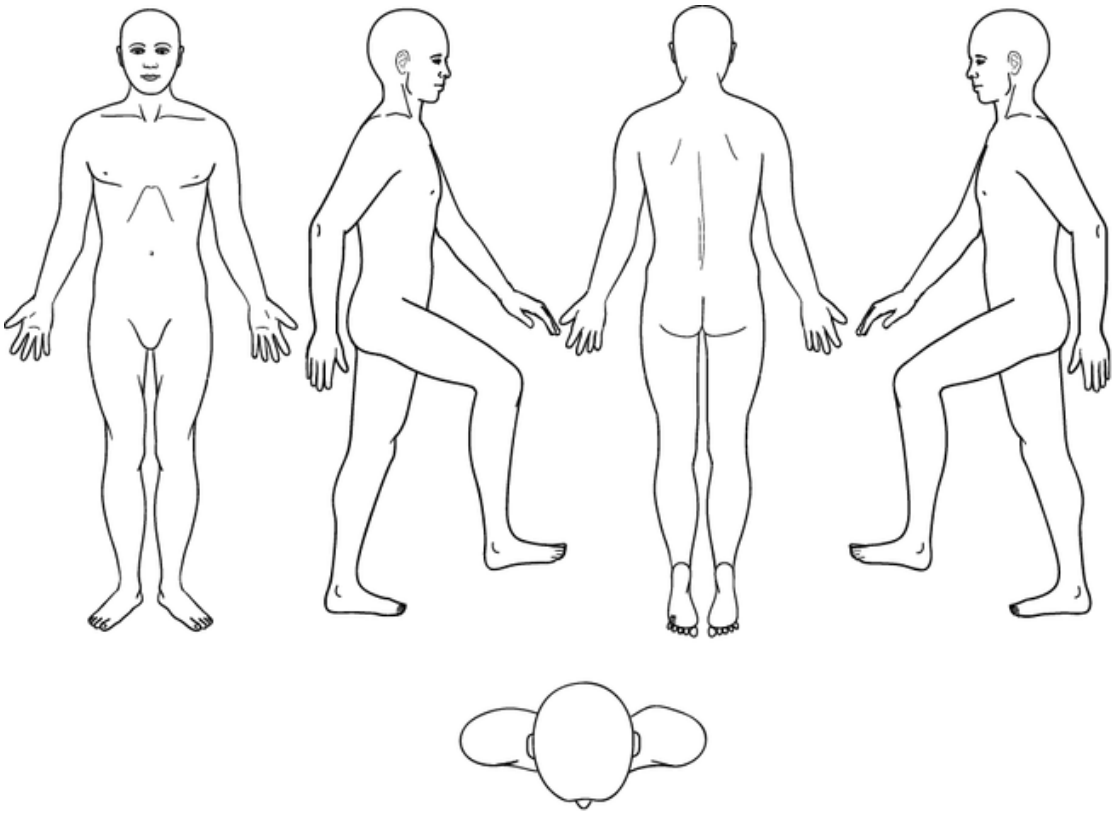
Rate your average pain level _____, percent of the time at this level of pain _____%

Rate the worst your pain gets _____, percent of the time at this level of pain _____%

Rate the lowest your pain gets _____, percent of the time at this level of pain _____%

KEY

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT	
X = PAIN	O = NUMBNESS OR TINGLING



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NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name: _____ Date: _____

Please read carefully:
This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE 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 one box, which most closely describes your problem right now.

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 (eg. washing, dressing)

- ☐ I can look after myself 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, 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 lifting heavy weights off the floor, but I can manage it they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me lifting heavy weights of the floor but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4: Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot 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: Headache

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal lot of difficulty in concentrating when I want to.

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 cannot do any work at all.

Section 8: Driving

- ☐ I can drive without any neck pain.
- ☐ I can drive as long as I want with slight pain in my neck.
- ☐ I can drive as long as I want with moderate pain in my neck.
- ☐ I cannot drive as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot 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 mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-5 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 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 cannot do any recreation activities at all.

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REVISED OSWESTRY BACK PAIN DISABILITY INDEX QUESTIONNAIRE

Patient Name: _____ Date: _____

Please read carefully:
This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE 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 one box, which most closely 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 (eg. washing, dressing)

- ☐ 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 or dressing without help.

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me 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. – eg, 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

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ 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 without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me sitting more than ½ hour.
- ☐ Pain prevents me sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6: Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ Pain prevents me from standing at all.

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 one-quarter.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ 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 my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, 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 at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

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HEADACHE DISABILITY INDEX

Patient Name: _____ Date: _____

INSTRUCTIONS: Please CIRCLE the correct response:

1.	I have a headache:	(1) 1 per month	(2) more than 1 per month	(3) more than 1 per week
2.	My headache is:	(1) mild	(2) moderate	(3) severe

Please read carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
			E1.	Because of my headaches I feel handicapped.
			F2.	Because of my headaches I feel restricted in performing my routine daily activities.
			E3.	No one understands the effect my headaches have on my life.
			F4.	I restrict my recreational activities (eg. sports, hobbies) because of my headaches.
			E5.	My headaches make me angry.
			E6.	Sometimes I feel that I am going to lose control because of my headaches.
			F7.	Because of my headaches I am less likely to socialize.
			E8.	My significant other, family or friends have no idea what I am going through because of my headaches.
			E9.	My headaches are so bad that I feel that I am going to go insane.
			E10.	My outlook on the world is affected by my headaches.
			E11.	I am afraid to go outside when I feel that a headache is starting.
			E12.	I feel desperate because of my headaches.
			F13.	I am concerned that I am paying penalties at work or at home because of my headaches.
			E14.	My headaches place stress on my relationships with family or friends.
			F15.	I avoid being around people when I have a headache.
			F16.	I believe my headaches are making it difficult for me to achieve my goals in life.
			F17.	I am unable to think clearly because of my headaches.
			F18.	I get tense (eg. muscle tension) because of my headaches.
			F19.	I do not enjoy social gatherings because of my headaches.
			E20.	I feel irritable because of my headaches.
			F21.	I avoid traveling because of my headaches.
			E22.	My headaches make me feel confused.
			E23.	My headaches make me feel frustrated.
			F24.	I find it difficult to read because of my headaches.
			F25.	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS: _____

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Please read our PAYMENT GUIDELINES and select one of the following options:

_____ Self Pay Plan – I, the patient, understand that I am responsible for all charges accrued from office visits. Payment is required when services are rendered. No third party is involved. A receipt or superbill can be generated for me to pursue my own reimbursement.

_____ Medical Insurance Plan – I hereby authorize the assignment of benefits to Swan Lake Chiropractic as well as the release of any medical information necessary for the payment of claims. I, the patient, am responsible for any co-pays or deductibles which are due at the time the services are rendered. If after 90 days Swan Lake Chiropractic is unsuccessful recovering monies from my insurance carrier, I understand that I am ultimately responsible for charges accrued from office visits, etc. I understand there are no guarantees that insurance will pay, and that Swan Lake Chiropractic will do everything possible to ensure proper processing of claims.

Insurance company name: _____

Claim number: _____

Adjustor's name and phone number: _____

How much med-pay $ do you have?: _____

I have read and understand the payment policy of Swan Lake Chiropractic Health Centre as explained in the PAYMENT GUIDELINES. I also acknowledge that all charges incurred in this office are ultimately my responsibility.

Name: _____ Date: _____

Signature: _____