



# 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:

If a patient fails to appear at the time of their appointment and has not contacted our office with **at least 3 hours' notice**, they will be considered a No Show. Because we understand life happens and obstacles come up that are beyond your control, we will not charge any fee for the first No Show. We will contact you for a credit card number to keep on file so we have means of collecting a fee if it happens a second time.

Any patient who fails to appear at their appointment or who cancels/reschedules within a 3-hour period for a second (or more) time(s), or who is **more than 5 minutes late** for their appointment will be charged our full adjustment rate of \$60. The fee will be charged immediately on the card on file.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. In such instances, please contact us before the appointment and we will waive the No Show fee when appropriate.

Please sign 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: \_\_\_\_\_



**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):

\_\_\_\_\_



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: \_\_\_\_\_



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

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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:**

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



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 \_\_\_\_\_%

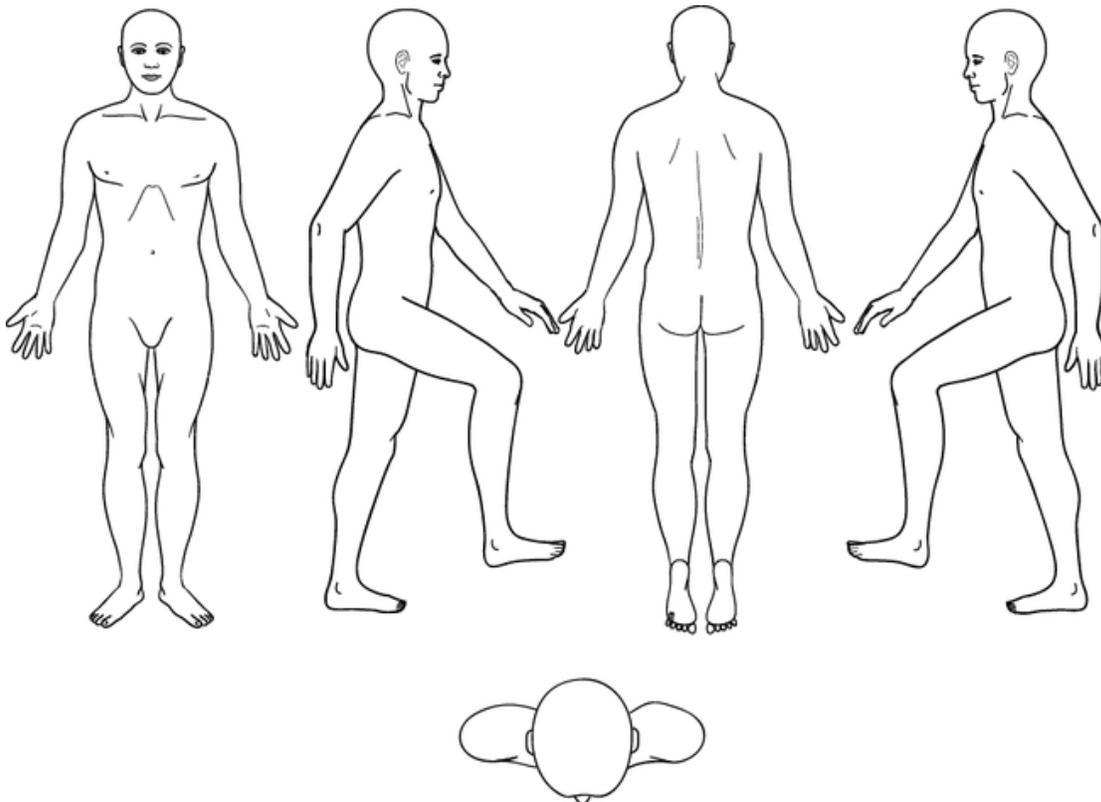
Rate the lowest your pain gets \_\_\_\_\_, percent of the time at this level of pain \_\_\_\_\_%

**KEY**

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

X = PAIN

O = NUMBNESS OR TINGLING





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.



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.



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

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: \_\_\_\_\_



## Swan Lake Chiropractic

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

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: \_\_\_\_\_