KENKEL FAMILY CHIROPRACTIC
CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name: _____ Phone: _____

E-mail address: _____ Fax # _____ Cell Phone _____

Address: _____

Purpose of this appointment: _____

Is this the same problem you were originally under care for? ( ) Yes ( ) No

If yes, are there any additional symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

PART B

Occupation: _____ Employer: _____

Employer's address: _____ Work Phone: _____

Spouse: _____ Spouse's Employer: _____

PART C

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of (16%).

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

Date Signed: _____ Signature: _____

Health Insurance Coverage ( ) Yes ( ) No

Company: _____

PATIENT UPDATE FORM

1. What is your major symptom? _____

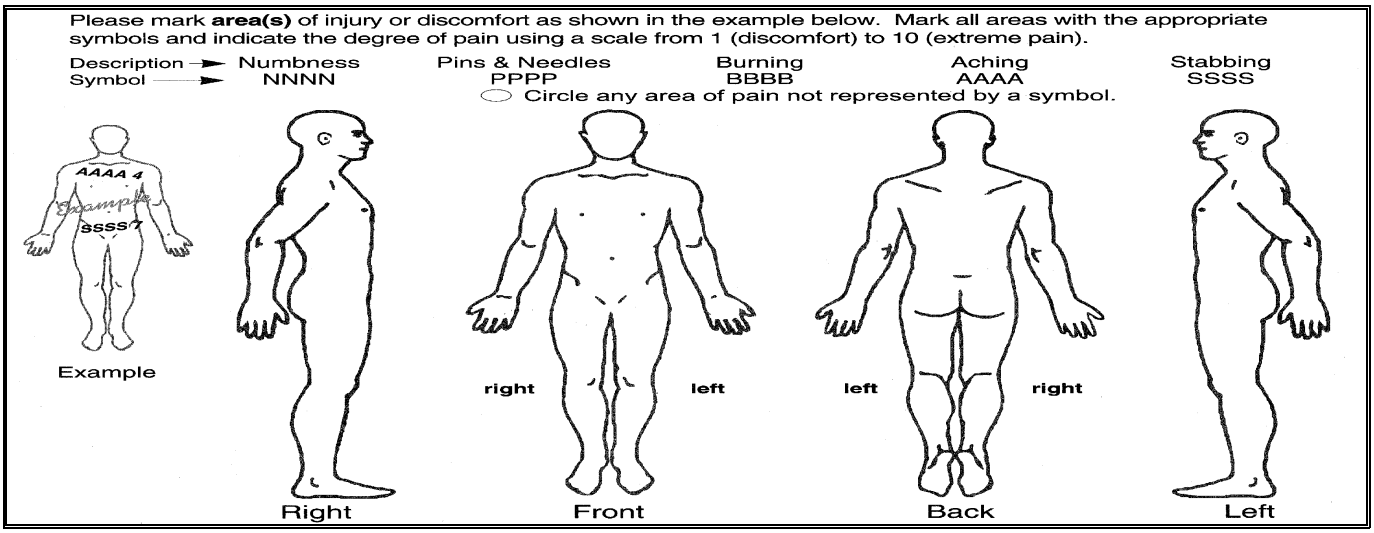
2. When was the first time you noticed this problem?_____

   How did it originally occur/injury?_____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

3. How frequent is the condition? Constant _____ Frequent ____ Intermittent ____ Occasional ___

4. Severity of condition? Severe ____ Moderately/Severe ____ Moderate ___ Mod/Mild ____ Mild ____



5. Are there any other conditions or symptoms that may be related to your major symptom/ pain radiate?

   Yes _____ No _____. If yes, describe _____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

6. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

   Lifting _____ Twisting _____ Other _____

7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____

   _____. If no, what have you tried to do that has not helped? _____

8. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____

   _____

9. List any major accidents you have had other than those that might be mentioned above: _____

   _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____

    _____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____

Patient Signature _____ **Date** _____

In office use only:
Height _____ Weight _____ B/P ____/_____
Diagnosis 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____
Onset date: _____

Doctor's Signature _____ Date _____

Patient Name: _____ Date: _____

Injuries/ Surgeries in past Description Date

Falls/Injuries_____

Accidents _____

Surgeries/Illness_____

Family History: Do any of your family members suffer from any of the following:
__ Arthritis __ High Blood Pressure __High Cholesterol __Diabetes __ Depression
__ Heart Disease __ Cancer __ Chronic Pain __ Other: _____, _____

REVIEW OF SYSTEMS

Have you in the Past (P) or currently (C) suffer from any of the following symtoms/condtions?

General Symptoms	***Mental Health***	***Bowel/ Bladder***
Decreased Activity Level ___	Irritability ___	Frequent Urination ___
Fever ___	Depression ___	Urgency ___
Chills ___	Disturbed Sleep __	Trouble start or stopping ___
Fatigue ___	Suicidal Thoughts ___	Erectile Dysfunction ___
Night Sweats ___	Anxiety ___	Nocturia/Bedwet ___
Loss of Appetite ___	Nervousness ___	Burning with urination ___
Weight Loss ___		Losing control/incontinence __
Weight Gain ___		Bowel Dysfunction ___
Loss of Energy ___		Sexual Dysfunction ___

Vision	***Heart/ Lungs***	***Stomach***
Blurred Vision ___	Chest Pain ___	Nausea ___
Double Vision ___	Palpitations ___	Vomitting ___
Vision Loss ___	Fainting ___	Diarrhea ___
Eye Pain ___	Shortness of Breath ___	Constipation ___
Work Glasses/ Contacts ___	Ankle Swelling ___	
	Coughing ___	
	Wheezing ___	

Joint/ Neurological	***Skin***	***Immunity/ Endocrine***
Joint Pain ___	Rash ___	Enlarged Lymph Nodes ___
Joint Weakness ___	Itching ___	Hives ___
Muscle Weakness ___	Dryness ___	Hay Fever ___
Seizures ___	Lesions ___	Persistent Infections ___
Abnormal sensory Arm/ Leg __	Open Wound/ Infection ___	Diabetes ___
Loss of Memory ___	Hair/Nail Changes ___	Thyroid Disorder ___

Signature_____ Date_____
Doctor's Signature_____ Date_____

Patient Name: _____ Date: _____

Oswestry (Low Back/Back Pain) Disability Index

Section 1 – Pain Intensity

- ❑ Pain comes and goes and is mild.
- ❑ Pain is mild and does not vary.
- ❑ Pain comes and goes and is moderate.
- ❑ Pain is moderate and does not vary much.
- ❑ Pain comes and goes and is severe.
- ❑ Pain is severe and does not vary much.

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

- ❑ Does not change habits to avoid pain.
- ❑ Does not change habits/Some Pain.
- ❑ Does not change habits/Increases Pain.
- ❑ Changes habits/Increases Pain.
- ❑ Unable to do some personal care without help.
- ❑ Unable to wash or dress without help.

Section 3 - Lifting

- ❑ Lifts heavy weight with no pain.
- ❑ Lifts heavy weights with pain.
- ❑ Cannot lift heavy weights off the floor.
- ❑ Can lift heavy weights from a table.
- ❑ Can lift light weights from a table.
- ❑ Can lift only very light weights.

Section 4 – Walking

- ❑ Pain does not prevent walking.
- ❑ Cannot walk more than 1mile.
- ❑ Cannot walk more than 1/2 mile.
- ❑ Cannot walk more than 1/4 mile.
- ❑ Can walk only with crutches.
- ❑ Bedridden and must crawl to the toilet.

Section 5 – Sitting

- ❑ Can sit in any chair as long as desired.
- ❑ Can sit only in a favorite chair for as long as desired.
- ❑ Can sit no more than 1 hour.
- ❑ Can sit no more than ½ hour.
- ❑ Can sit no more than 10 minutes.
- ❑ Cannot sit at all due to pain.

Section 6 – Standing

- ❑ Can stand for an unlimited time without pain.
- ❑ Some pain standing/doesn't increase with time.
- ❑ Cannot stand for more than 1 hour.
- ❑ Cannot stand for more than ½ an hour.
- ❑ Cannot stand for more than 10 minutes.
- ❑ Cannot stand at all.

**Please fill out the back side of questionnaire.

Section 7 – Sleeping

- ❑ No pain in bed.
- ❑ Gets pain in bed but sleeps well.
- ❑ Normal sleep reduced by 1/4.
- ❑ Normal sleep reduced by 1/2.
- ❑ Normal sleep reduced by 3/4.
- ❑ Cannot sleep at all due to pain.

Section 8 – Traveling

- ❑ Travel without pain.
- ❑ Travel causes some pain, but not made worse.
- ❑ Causes extra pain/No changes in form.
- ❑ Causes pain/Uses alternate travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain restricts travel, except if lying down.

Section 9 – Social Life

- ❑ Normal and causes me no extra pain.
- ❑ Normal but causes extra pain.
- ❑ Limits energetic interests.
- ❑ Pain limits/doesn't go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ Pain restricts all social life.

Section 10 - Changing Degree of Pain

- ❑ Pain is rapidly improving.
- ❑ Pain fluctuates but is improving.
- ❑ Improvement is slow.
- ❑ Pain level is unchanged.
- ❑ Pain is gradually worsening.
- ❑ Pain is rapidly worsening.

Patient Signature: _____ Date: _____

Patient Name: _____ Date: _____

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 the 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

Neck Disability Index

Section 1 – Pain Intensity

- ❑ No pain at the moment.
- ❑ Mild pain at the moment.
- ❑ Moderate pain at the moment.
- ❑ Fairly severe pain at the moment.
- ❑ Very severe pain at the moment.
- ❑ Worst imaginable pain at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ❑ Personal care is normal without extra pain.
- ❑ Personal care normal, with extra pain.
- ❑ Personal care painful/slow and careful.
- ❑ Manage most personal care with some help.
- ❑ Needs help everyday in most aspects of care.
- ❑ Difficulty dressing and washing/stays in bed.

Section 3 – Lifting

- ❑ Lifts heavy weights with no pain.
- ❑ Lifts heavy weights with pain.
- ❑ Can lift heavy weights from a table.
- ❑ Can lift light weights from a table.
- ❑ Can lift only very light weights.
- ❑ Cannot lift or carry anything.

Section 4 – Reading

- ❑ No pain while reading.
- ❑ Slight pain while reading.
- ❑ Moderate pain while reading.
- ❑ Moderate pain prevents reading.
- ❑ Severe pain prevents reading.
- ❑ Cannot read at all.

Section 5 – Headaches

- ❑ No headaches at all.
- ❑ Slight, infrequent headaches.
- ❑ Moderate, infrequent headaches.
- ❑ Moderate, frequent headaches.
- ❑ Severe, frequent headaches
- ❑ Constant headaches

**Please fill out back side of questionnaire.

Section 6 – Concentration

- ❑ Can concentrate without difficulty.
- ❑ Can concentrate with slight difficulty.
- ❑ Can concentrate with fair difficulty.
- ❑ Can concentrate with a lot of difficulty.
- ❑ Can concentrate with extreme difficulty.
- ❑ Cannot concentrate at all.

Section 7 – Work

- ❑ Work is unrestricted.
- ❑ Can do usual work, but no more.
- ❑ Can do most usual work, but no more.
- ❑ Cannot do usual work.
- ❑ Can hardly do any work.
- ❑ Cannot do any work.

Section 8 – Driving

- ❑ Can drive without neck pain.
- ❑ Driving causes slight neck pain.
- ❑ Driving causes moderate neck pain.
- ❑ Cannot drive as long due to moderate neck pain.
- ❑ Can hardly drive at all due to severe neck pain
- ❑ Neck pain prevents driving.

Section 9 – Sleeping

- ❑ No difficulties sleeping.
- ❑ Sleep is mildly disturbed.
- ❑ 1-2 hours loss of sleep.
- ❑ 2-3 hours loss of sleep.
- ❑ 3-5 hours loss of sleep.
- ❑ 5-7 hours loss of sleep.

Section 10 – Recreation

- ❑ Recreation is not affected.
- ❑ Some neck pain, but does not affect activity.
- ❑ Some activity is affected by pain.
- ❑ Most activity is affected by pain.
- ❑ Activity severely restricted by pain.
- ❑ Unable to do any activity

Patient Signature: _____ Date: _____