PATIENT INFORMATION SHEET

Osage County Chiropractic & Physical Therapy

PATIENT:

Last Name _____ First Name_____ Middle_____

Gender: ☐ **M** ☐ **F** Date of Birth _____ - _____ - _____ Age: _____ SS# _____ - _____ - _____

Home Address _____ Apt _____

City _____ State _____ Zip Code _____

Home Phone # _____ - _____ - _____ Cell Phone # _____ - _____ - _____

E-mail Address _____

Employer_____ Work Phone # ____ - _____ - _____

INSURANCE POLICY HOLDER:

Last Name _____ First Name_____ Middle_____

Gender: ☐**M** ☐**F** Date of Birth _____ - _____ - _____ Relationship to patient: _____

Address if different than above:

Home Address _____ Apt _____

City _____ State _____ Zip Code _____

Home Phone # ____ - ____ - _____ Cell Phone # ____ - ____ - _____ Work Phone # ____ - ____ - _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone # ____ - ____ - _____

Copay/Deductible/Co-ins are due at the time of service

How will you pay your portion? ☐**CHECK** ☐**CASH**

Assignment and Release

I the undersigned certify that I (or my dependent) have insurance coverage with –

_____

and assign directly to Dr. Monte Kuder all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the release of this signature on all insurance submissions.

_____

Responsible Party Signature Date

Cannot be typed – hand written only. This document must be signed upon arrival for your appointment.

ACCIDENT INFORMATION

Is condition due to an accident: ☐YES ☐NO Date of accident _____

Type of accident: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation

2. Please list the areas for which you are seeking treatment today. (Such as neck, back, hip, etc., include right, left, front or back)

_____

3. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other:_____

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER physician ☐ Orthopedist ☐ Other: _____
☐ Massage Therapist ☐ Physical Therapist ☐ No one

10. How long have you had this problem? _____. When is the most recent flare up_____

11. How do you think your problem began?_____

12. Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

What aggravates your problem_____

What alleviates your problem_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height _____ Weight _____ Date of Birth # _____ - _____ - _____

Occupation _____

16. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Lupus ☐ Cancer
☐ Diabetes ☐ Heart Problems ☐ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss			
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite			
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	**For Females Only**		
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	Birth Control Pills
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Hormonal Replacements
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Pregnancy
☐	☐	Cancer	☐	☐	General Fatigue			
☐	☐	Tumor	☐	☐	Muscular Incoordination			
☐	☐	Asthma	☐	☐	Visual Disturbances			
☐	☐	Chronic Sinusitis	☐	☐	Dizziness			

☐ Other: _____

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do?

Sit:	☐ Most of the day	☐ Half the day	☐ A little of the day
Stand:	☐ Most of the day	☐ Half the day	☐ A little of the day
Computer work:	☐ Most of the day	☐ Half the day	☐ A little of the day
On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day
Drives:	☐ Most of the day	☐ Half of the day	☐ A little of the day

☐ **Perform manual labor:** ☐ **Read a lot** ☐ **Travel frequently**

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ☐ No ☐ Yes

if yes, why _____

26. Have you had significant past trauma? ☐ No ☐ Yes

27. Anything else pertinent to your visit today? _____

Signature _____ **Date** _____

Cannot be typed – hand written only. This document must be signed upon arrival for your appointment.

Osage County Chiropractic & Physical Therapy

Authorization to Discuss Private Health Information PHI

To Comply with HIPAA regulations, please list any person(s) other than your doctor or insurance company that may be in contact with our office regarding your care. If they are not listed, we will not provide any health or financial information.

1. _____Relationship_____

2. _____Relationship_____

Acknowledgment of Receipt of Privacy Notice

I have chosen not to receive a copy of OCC's Privacy Practice _____(initials)
OR
I would like a copy of OCC's Privacy Practices _____(initials)

Appointment Reminder

As a courtesy, we will provide a one-day reminder call as confirmation of your upcoming appointment. *This is to give you an opportunity to confirm your appointment or reschedule if needed.* **Please tell us at this time if you are unable or no longer need the appointment so that we many offer that time to another patient**

CANCELLATION AND NO SHOW POLICY

Our mission at Osage County Chiropractic and Physical Therapy is to help you get back to an active and healthy lifestyle. If you have a conflict that prevents you from attending your scheduled appointment or you no longer need the appointment, please alert us promptly. Please be advised that we utilize a cancellation and no show policy. **A no-show or cancellation less than 8 hours notice will result in a $40 charge to your account. Insurance will not cover this charge.**

I understand the policy information above. _____(Initials)

Patient Signature _____ Date _____

REVISED LOW BACK PAIN QUESTIONNAIRE OSWESTRY

Name:_____ **Date:** _____ **File #:** _____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem 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 moderately increasing
- ☐ 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 ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ 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 ½ hour.
- ☐ Pain prevents me from sitting 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 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
- ☐ I cannot stand for longer than 10 minutes without increasing pain
- ☐ I avoid standing because it increases the pain immediately.

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 ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ 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
- ☐ Pain has restricted my social life and I do not go much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my 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 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 prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 - Changing Degrees 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 slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

NECK DISABILITY INDEX

Name:_____ **Date:**_____ **File #:** _____

This questionnaire helps us to understand how much your neck 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
- ☐ 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.
- ☐ 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 - 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 5 - Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – Concentration
- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty in concentrating.
- ☐ I have a great deal of difficulty in concentrating.
- ☐ I cannot concentrate at all.

SECTION 7 – 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 (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 8 – Driving
- ☐ I can drive without any neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

SECTION 9 - Reading
- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I cannot read at all due to pain.

SECTION`` 10 – Recreation
- ☐ I have no neck pain during recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreation activities due to neck pain.