Grove Chiropractic **CONFIDENTIAL CASE HISTORY**

Date:_____

Name:_____ Home Phone:_____

Address: _____ City _____ Zip _____

E-Mail Address _____ Cell Phone:_____

Age: _____ Birth date _____ Marital Status: M S W D

Occupation: _____ Employer _____

Work Phone: _____ Can you take calls at work ? Yes No

Spouse Name: _____ How many Children ?_____

Ages of Children _____ How were you referred to our office? _____

Family Medical Doctor _____ Phone Number _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office ? YES NO

HISTORY OF PRESENT ILLNESS: Reviewed with Patient _____

Chief Complaint: Purpose of this appointment: _____

Date Symptoms appeared or accident date: _____

Have you ever had the same or similar condition ? Yes No _____

What makes your condition **worse**: _____

What makes your condition **better**: _____

Is the pain (Circle all that apply) Constant —Aggravated by movement—Come and Go—Getting Worse—Same

Are you experiencing any: (Circle) Weakness—Radiating Pain—Dizziness—Nausea—Vomiting—Blurred Vision

Please indicate the area(s) of pain or complaint you are currently experiencing on the diagram below.

Using the Pain Scale Below 0-10 mark next to the area of pain or complaint the number (0-10) that corresponds with your level of pain or complaint.

PAIN SCALE

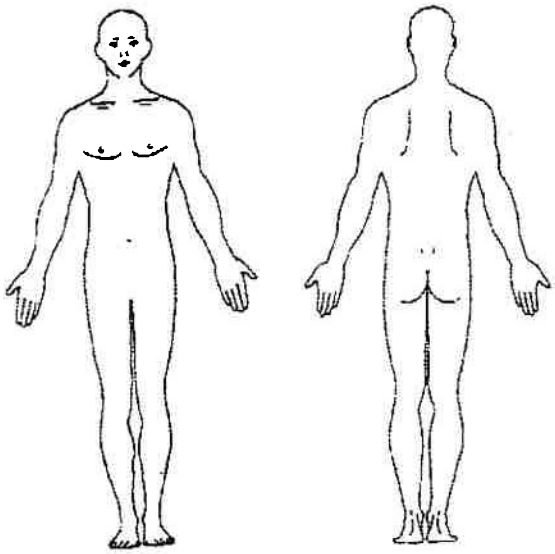
0 1 2 3 4 5 6 7 8 9 10

NO PAIN **UNBEARABLE**

On the diagram to the right please mark your areas of pain OR complaint, using the following symbols.

Please include all affected areas.

++	**Numbness**	##	**Weak**
XX	**Burning**	**	**Dull Aching**
00	**Pins & Needles**	==	**Other** _____
//	**Sharp**		



Please circle all the activities that you find difficult to do NOW due to your discomfort.

-Sleep through the night	-Crawl on all fours	-Push or pull vacuum or lawn mower
-Get out of bed	-Carry laundry basket, groceries, or child	-Turn door knob
-Make your bed	-Open a heavy door	-Wash windows or walls
-Bathe yourself	-Sit in a chair for 30 minutes	-Shovel snow or dirt
-Wash, comb or dry hair	-Sit and work at a desk for 1 hour	-Bend over to clean bathtub
-Bend over a sink for 10 min.	-Use pencil, scissors, screwdriver or pliers	-Get up from low seat
-Go to the bathroom	-Cross legs	-Lift heavy suitcase (about 40 lbs.)
-Put on socks, shoes, clothing	-Reach in front or overhead to high shelf	-Walk for one mile
-Walk up one flight of stairs	-Stand for 30 minutes	-Enjoy hobbies or social activities
-Walk down one flight of stairs	-Travel on journeys that take over 1 hour	-Enjoy sexual activities

How long has it been since you really felt good? _____

WOMEN ONLY: Are you pregnant or is there any possibility that you may be pregnant?
Yes_____ No_____ Uncertain_____

Patient Health Information Consent form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, that patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to use by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented
5. For you security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right ot refuse to give care. I have read and understand how my PHI will be used and I agree to these policies and procedures.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____
Name of Patient

_____
Signature of Patient Date

Doctor's Signature: _____ Date: _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your problem/ problems have affected your ability to manage everyday activities. For each item below, please circles the number which most closely describes your condition right now.

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date