

BOUTROS CHIROPRACTIC & WELLNESS

INJURY CARE-NUTRITION-REHABILITATION

APPLICATION FOR TREATMENT

Date _____

Name _____ Age _____ Birthdate _____

Please circle : Male or Female Social Security # _____

Address _____ City _____ State _____ ZIP Code _____

Home Phone Number _____ Mobile Phone # _____ Email Address _____

How did you hear about us? _____ Who referred you? _____

Check if you are: Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Employer _____ Occupation _____

Emergency contact _____ Phone # _____ Relationship _____

Please circle one : Cash Medicare Commercial/Group Auto Workers Comp

Who is responsible for your bill? Self _____ Spouse _____ Employer _____ Insurance _____ Other _____

Primary Insurance: _____ ID _____ Group _____

Secondary Insurance: _____ ID _____ Group _____

Primary care physician: _____ Phone # _____

How and when did the symptoms first occur: _____

Is this accident related? Yes No Employment Related? Yes No

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed _____ Date _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Boutros Chiropractic & Wellness for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed _____ Date _____

Fees are payable at the time x-rays, examination and treatments are received unless other arrangements are made in advance. X-rays remain the property of this clinic. I hereby give permission for treatment.

Signature of Patient _____ Date _____

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Please describe the principal health problems for which you came to this office. _____

How and when did symptoms first occur? _____

List any other doctors seen for these problems _____

List diagnosis(es) and type of treatment(s) _____

Does this interfere with your normal living and work? Yes____ No____ In what way? _____

Have you lost any days of work? Yes____ No____ Dates _____

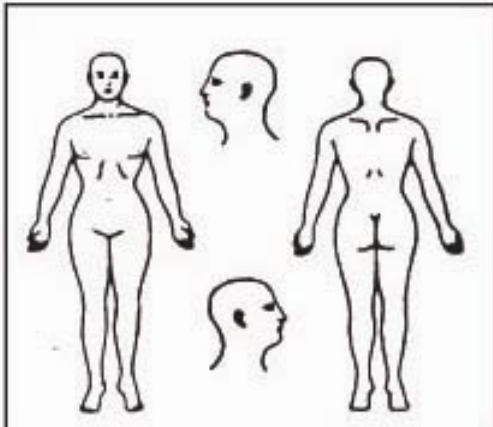
Have you had similar symptoms or injuries before? Yes____ No____ If yes, explain _____

List the names of any relatives that have or have had a similar problem _____

List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones)

List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.) _____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. _____
2. _____
3. _____
4. _____

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Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of the privacy policy for Boutros Chiropractic & Wellness.

This notice is effective as of the date shown below. This authorization will expire seven years following the last date of service received with our facility.

I acknowledge and authorize Boutros Chiropractic & Wellness to use or disclose my health information in a manner described within the privacy policy notice, as well as to protect my privacy rights according to the standards set forth in the privacy notice.

Patient Name Printed

Date

Patient Name Signature

Boutros Chiropractic & Wellness
Representative Witness

Date

PATIENT HEALTH QUESTIONNAIRE

Name _____ Date _____

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, check that symptom in the Present column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain Loss	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Muscular In-coordination
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke (Date) _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	Have You or Your Family Had:		
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R_____ L_____)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (date)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Back Problems
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headaches
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)	Do you have a permanent disability rating? Yes__ No__		
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	Location _____		
<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder problems	Date rating received ? Rating Percentage _____		
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			

Present Weight _____ **Pounds** **Height** _____ **Feet** _____ **Inches**

Please check any of the following that apply to you

<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # births _____	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco ___ packs/day
<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills, Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol ___ drinks/day/week/month
<input type="checkbox"/>	<input type="checkbox"/>	Medication (list if not listed elsewhere)	<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
		_____	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft drinks
		_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ cups/cans per day
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgical Procedures (List if not described elsewhere) _____			

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition

Signature

Date

BOUTROS CHIROPRACTIC & WELLNESS

INJURY CARE-NUTRITION-REHABILITATION

General Pain Index Questionnaire

We would like to know how much your pain presently *prevents* you from doing what you would normally do. Regarding each category, please indicate the *overall* impact your present pain has on your life, not just when the pain is at its worst.

Please *circle the number* which best describes how your typical level of pain affects these six categories of activities.

1. Family/at -home responsibilities such as yard work, chores around the house or driving the kids to school -

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
completely able to function totally unable to function

2. Recreation including hobbies, sports or other leisure activities –

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
completely able to function totally unable to function

3. Social activities including parties, theater, concerts, dining –out and attending other social functions with friends -

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
completely able to function totally unable to function

4. Employment including volunteer work and homemaking tasks -

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
completely able to function totally unable to function

5. Self -care such as taking a shower, driving or getting dressed -

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
completely able to function totally unable to function

6. Life -support activities such as eating and sleeping -

_____ 0 1 2 3 4 5 6 7 8 9 10 _____
completely able to function totally unable to function

PATIENT NAME _____ DATE _____

Score _____ [60]

Benchmark -5 = _____

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FILL THIS IF YOU HAVE NECK PAIN

Name _____ Activities/Sports _____ #Hours Per week _____

Copenhagen Neck Functional Disability Scale

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday activities. In response to each question, please mark the one box that applies to you.

	Yes	Occasionally	No
1. Can you sleep at night without neck pain interfering?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Can you manage daily activities without neck pain reducing activity levels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Can you manage daily activities without help from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Can you manage putting your clothes on in the morning without taking more time than usual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Can you bend over the sink to brush your teeth without getting neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you spend more time than usual at home because of your neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you prevented from lifting objects weighing 5-10 pounds due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you reduced your reading activity due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been bothered by headaches during the time you have had neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel that your ability to concentrate is reduced due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you prevented from participating in your usual leisure time activities due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you remain in bed longer than usual due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you feel neck pain has influenced your emotional relationship with your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had to give up social contact with other people during the past two weeks due to neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you feel that neck pain will influence your future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name _____

Score _____ [30]

Date _____

Benchmark -4 = _____

BOUTROS CHIROPRACTIC & WELLNESS

INJURY CARE-NUTRITION-REHABILITATION

OSWESTRY INDEX QUESTIONNAIRE

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

SECTION 1 - PAIN INTENSITY

- My pain is mild to moderate. I do not need pain killers.
- The pain is bad, but I manage without taking pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain.

SECTION 2 - PERSONAL CARE

- 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 causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – WALKING

- I can walk as far as I wish.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can walk only if I use a cane or crutches.
- I am in bed or in a chair for most of every day.

SECTION 5 – SITTING

- I can sit in any chair for as long as I like.
- I can sit in my favorite chair only, but for as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes
- Pain prevents me from sitting at all.

SECTION 6 – STANDING

- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing more than 1/2 hour.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7 – SLEEPING

- Pain does not prevent me from sleeping well.
- I sleep well but only when taking medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- Social life is normal and causes me no extra pain.
- Social life is normal, but increases the degree of pain.
- Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- Pain has restricted my social life, and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 9 - SEXUAL ACTIVITY

- Sexual activity is normal and causes no extra pain.
- Sexual activity is normal, but causes some extra pain.
- Sexual activity is nearly normal, but is very painful.
- Sexual activity is severely restricted by pain.
- Sexual activity is nearly absent because of pain.
- Pain prevents any sexual activity at all.

SECTION 10 – TRAVELING

- I can travel anywhere without extra pain.
- I can travel anywhere, but it gives me extra pain.
- Pain is bad, but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to necessary journeys under ½ hr.
- Pain prevents traveling except to the doctor/hospital.

PATIENT NAME _____

DATE _____

SCORE _____ [50]

BENCHMARK -5 = _____

BOUTROS CHIROPRACTIC & WELLNESS

INJURY CARE-NUTRITION-REHABILITATION

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Name _____ Date _____

Date of accident: _____

Type of vehicle you were in: _____

Other vehicle type: _____

Were you the driver? _____

If you were the passenger, where were you sitting? _____

Were you wearing a seatbelt? _____ Were you wearing a lap belt? _____

Did your vehicle have an airbag? _____ If so, did it deploy? _____

What were the road conditions? (wet, dry, icy, gravel, pavement) _____

Type of impact? (side, front, rear-end) _____

Was your vehicle stopped or moving at the moment of impact? _____

How much damage was sustained by the vehicles in the accident? _____

Was your vehicle drivable after the accident? _____

Were you aware the accident was going to happen? _____

Did you brace yourself? _____

How many vehicles in the collision? _____

Were you knocked unconscious? _____

How did you feel immediately following the collision? _____

How did you feel hours or days later? _____

Did you go to the emergency room? _____ If so, what was done at the ER? _____

Have you had any treatments before coming to my office today? _____ If so, what? _____

How did you respond to this treatment? _____

Have you lost time from work due to this accident? _____

Did this accident occur in the course of your work? _____

Have you had an automobile accident in the past? _____ If so, what areas of the body were injured? _____

What symptoms were you having before this collision? _____

Have you retained an attorney? _____ If so, name and address _____