SHP Spinal Health Professionals

General Patient Information

Name _____ **Date** _____
First Name *Middle* *Last*

Address _____

City, State, Zip _____

Social Security # _____ - _____ - _____ **Driver's License #** _____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Date of Birth _____ **Age** _____ **Preferred Language** _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

Home Phone # _____ **Work Phone #** _____ **Cell Phone #** _____

Email _____ *Email will be used to update you on clinic events, updates, appointment reminders and statements.*

Occupation _____ **Employed By** _____

Is your visit due to an accident? ☐ Yes ☐ No **If yes, was the accident related to:** ☐ Work ☐ Auto

Emergency Contact *(Name)* _____ **Phone #** _____

Primary Care Physician *(Name)* _____ **Clinic** _____

Who may we thank for referring you to our office? ☐ Patient Referral _____

☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ Website ☐ Screening ☐ Other _____

Responsible Party

Complete this section if you are not the patient, but are responsible for the account.

Name _____ **Relationship to Patient** _____

Phone # _____ **Address** _____

Email _____

SHP Spinal Health Professionals

General Patient Information

Informed Consent to Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy, rehabilitation, and diagnostic x-rays on myself or the patient named below for whom I am legally responsible, by the doctor(s) of Spinal Health Professionals.

I understand that at any time I have the opportunity to discuss with the doctor(s) and/or other office or clinic personnel the purpose and benefits of chiropractic adjustments and other treatments that may be outlined in my future treatment plan. Furthermore, I understand that at any time I may have the opportunity to discuss alternatives to such treatments with the doctor(s) and/or office staff.

Though chiropractic adjustments are usually beneficial and seldom cause any problems, I understand and am hereby informed that, like any health care related procedure, there are some risks to treatment. Risks include, but are not limited to fractures, disc injuries, strokes, dislocations, and sprains.

Nutritional recommendations are provided solely to support good nutrition with the intent of supporting the physiological and biochemical processes of the human body, and not to diagnose, treat, cure, or prevent any disease or condition. Be advised that any nutritional program recommended by Spinal Health Professionals is not intended as a primary therapy for any disease.

I understand that chiropractic, like all health care, is not an exact science and that every patient responds to care differently, therefore, reputable practitioners cannot fully guarantee my results. I acknowledge that no guarantee or assurance has been made or will be made by anyone regarding the chiropractic treatments that I have requested and authorized. I have had the opportunity to read this form and understand it's full meaning to my satisfaction. By signing below I acknowledge and give consent to treatment.

I understand that Spinal Health Professionals may, as an appointment reminder, call to remind me of appointments and I should advise the front office in writing if I do not wish to receive these reminders.

Patient Printed Name _____

Patient Signature _____ **Date** _____

Consent of a Minor

I hereby authorize the doctor(s) of Spinal Health Professionals to care for my son/daughter.

If Patient is a Minor:

Parent / Guardian Signature _____ **Date** _____

SHP Spinal Health Professionals

General Patient Information

X-Ray Assignment Agreement & Consent

I understand that the doctor may submit my x-rays to a radiologist for a second opinion radiological evaluation and analysis by a specialist. I also understand that the fee for such expenses will be submitted to my insurance company, health care provider, attorney or worker's compensation carrier for payment. If I am paid directly by an insurance carrier or through legal settlement, I will be responsible for the amount due. If the radiologist does not receive a reply to a case status information request from the above mentioned, I will be billed directly for the amount of service.

I also consent to use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me and for the Practice's general health care operations purposes.

I understand that I have the right to request a restriction of the use and disclosure of my Protected Health Information for the purposes of treatment, payment or health care operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance of this consent. I acknowledge that I have received, reviewed, understand and agree to this agreement and consent, and the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date Patient/Guardian's Signature

_____

Print Patient Name

If female patent needing lumbar/pelvic x-ray:

I understand that if I am pregnant and have x-rays taken that expose my lower torso to radiation, it is possible to injure the fetus. This form hereby advises me that the 10 days following the onset of a menstrual periods are generally considered to be safe for x-ray exams. With those factors in mind, I am advising my doctor(s) of the following:

☐ Yes ☐ No ☐ Unsure I am pregnant.

☐ Yes ☐ No ☐ Unsure I could be pregnant.

☐ Yes ☐ No ☐ Unsure I am late with my menstruation.

☐ Yes ☐ No ☐ Unsure I am taking oral contraceptives.

☐ Yes ☐ No ☐ Unsure I am late with my menstruation.

☐ Yes ☐ No ☐ Unsure I am taking oral contraceptives.

SHP Spinal Health Professionals

Authorization to *Release Protected Health Information*

Patient Name _____ Social Security # _____ Date of Birth _____

☐ This will authorize Spinal Health Professionals to request information from: _____

☐ This will authorize Spinal Health Professionals to release records to:

_____
Name / Organization

_____
Street Address

_____
City State Zip

The following information is to be released *(check appropriate boxes):*

☐ Discharge Summary	☐ Operative Report	☐ EKG / ECHO Reports
☐ Counselor's Discharge Summary	☐ Pathology Reports	☐ Emergency Department Reports
☐ History and Physical Exam	☐ X-ray / Radiology Reports	☐ Psychological Tests
☐ Consultation Reports	☐ Laboratory Reports	☐ Other *(specify)* _____
☐ Hospital Outpatients / Clinic Notes	☐ Films	☐ Other *(specify)* _____

For the following date(s) of treatment or condition: _____
(Specify dates of treatment or condition)

I am requesting this information be released for the following purpose:

☐ Continued care with another provider	☐ Insurance claim purposes	☐ Personal use
☐ Attorney review	☐ Other	☐ _____

- With exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here: ☐
  Please indicate any restrictions *(specify)*: _____
- I understand I may revoke this authorization by written request at any time to the address listed at the bottom of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time as specified here: _____
  This expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand there may be a retrieval and copy charge associated with the release.
- I understand that once information is released pursuant to this authorization, Spinal Health Professionals cannot prevent the redisclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid. A copy that has not been altered will be considered as valid as original.
- Except for research-related treatment, Spinal Health Professionals will not condition treatment on my signing this authorization.

_____
Signature of Patient / Authorized Person *(if authorized person is signing, please also print name)* | Authorized Person's authority to sign *(parent, guardian, power of attorney, etc.)* | Date

Reason patient is unable to sign: ☐ Minor ☐ Deceased ☐ Other _____

To facilitate the efficiency of our electronic health records and to reduce waste, we respectfully request all records be faxed or emailed to our clinic if possible. Thank you for your cooperation with this.

4228 Power Dr. NW, Bemidji, MN 56601 · **Phone:** (218) 444-2117 · **Toll Free:** 1-866-749-DISC (3472) · **Fax:** (218) 444-2317 · **Email:** info@spinalhealthprofessionals.com

SHP Spinal Health Professionals

General Patient Information

Confidential Health Questionnaire

Name_____

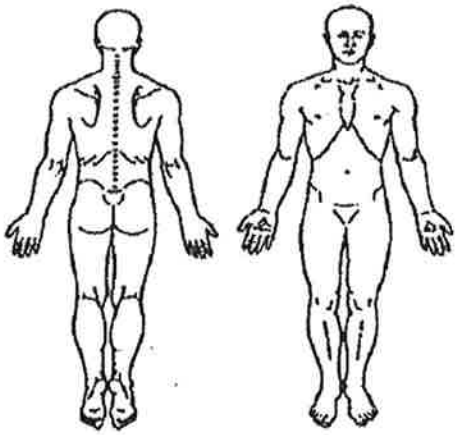
Reason For Your Visit

Symptoms	No Pain										Unbearable	76-100%	51-75%	26-50%	0-25%
Neck	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent
Upper/Mid-Back	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent
Low-Back	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent
Hips — L or R	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent
Arms – L or R	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent
Legs — L or R	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent
Headaches	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent
Other:_____	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent
Other:_____	0	1	2	3	4	5	6	7	8	9	10	Constant	Frequent	Occasional	Intermittent

Describe Your Symptoms

Neck	Sharp	Dull Ache	Burning	Tingling	Numbness
Mid-Back	Sharp	Dull Ache	Burning	Tingling	Numbness
Low-Back	Sharp	Dull Ache	Burning	Tingling	Numbness
Hips — L or R	Sharp	Dull Ache	Burning	Tingling	Numbness
Arms – L or R	Sharp	Dull Ache	Burning	Tingling	Numbness
Legs — L or R	Sharp	Dull Ache	Burning	Tingling	Numbness
Headaches	Sharp	Dull Ache	Burning	Tingling	Numbness
Other:_____	Sharp	Dull Ache	Burning	Tingling	Numbness
Other:_____	Sharp	Dull Ache	Burning	Tingling	Numbness

Please indicate your areas of pain:



Are your symptoms: ☐ Getting Better ☐ Getting Worse ☐ Staying about the same

What activities make your symptoms worse? _____

What activities make your symptoms better? _____

Causation

What was the cause of your symptoms? ☐ Auto Accident ☐ Work Injury ☐ Trauma ☐ Illness ☐ Unknown ☐ Other _____

Please explain: _____

WHEN did your symptoms begin? _____

Have you had this complaint before? ☐ Yes ☐ No How many times? _____

Medical History

Have you seen another doctor for this condition? ☐ Yes ☐ No Who and When? _____

What was the diagnosis and treatment? _____

What diagnostic studies were done for this condition? ☐ X-rays ☐ MRI ☐ CAT/Scan ☐ Other_____ When?_____

Family Physician _____ What medication are you currently taking? _____

Please list past surgeries_____

Please list past hospitalizations _____

Please list pregnancies and any complications _____

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General Patient Information

Confidential Health Questionnaire

For each condition listed below, check the Past column if you have had the condition in the past, or in the Present column if you currently have the condition.

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			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking / Tobacco Use
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Drug / Alcohol Dependence
☐	☐	Elbow / Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Drug / Alcohol Use
☐	☐	Wrist Pain	☐	☐	Bladder Infection			
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Allergies
☐	☐	Jaw Pain	☐	☐	Loss of Bladder Control	☐	☐	Depression
			☐	☐	Prostate Problems	☐	☐	Systemic Lupus
☐	☐	Hip / Upper Leg Pain				☐	☐	Epilepsy
☐	☐	Knee / Lower Leg Pain	☐	☐	Abnormal Weight Gain / Loss	☐	☐	Dermatitis / Eczema / Rash
☐	☐	Ankle / Foot Pain	☐	☐	Loss of Appetite	☐	☐	HIV / AIDS
			☐	☐	Abdominal Pain			
☐	☐	Joint Swelling / Stiffness	☐	☐	Ulcer	**Females Only**		
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Birth Control Pills
☐	☐	Rheumatoid Arthritis	☐	☐	Liver / Gall Bladder Disorder	☐	☐	Hormonal Replacement
☐	☐	General Fatigue	☐	☐	Cancer	☐	☐	Pregnancy
☐	☐	Muscular Incoordination	☐	☐	Tumor	**Other Health Problems / Issues**		
☐	☐	Visual Disturbances	☐	☐	Asthma	☐	☐	_____
☐	☐	Dizziness	☐	☐	Chronic Sinusitis	☐	☐	_____

Please indicate if an immediate family member has had any of the following:

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

Lifestyle

Hand Dominance: ☐ Left ☐ Right Do you consider yourself to eat a balanced diet? ☐ Often ☐ Occasionally ☐ Never

How many hours do you sleep per night? Do you participate in sports activities? ☐ Often ☐ Occasionally ☐ Never

What hobbies do you participate in? _____

Do you participate in physical labor / work? ☐ No ☐ Light ☐ Moderate ☐ Heavy Do you smoke? ☐ Yes ☐ No How much?

What vitamins/supplements are you currently taking? _____

Do you consume alcohol? ☐ Often ☐ Occasionally ☐ Never Do you consume caffeinated beverages? ☐ Regularly ☐ Occasionally ☐ Never

Do you exercise? ☐ Regularly ☐ Occasionally ☐ Never What type of exercise?

Other Lifestyle Comments? _____

What do you hope to get from your visit / treatment? (select all that apply)

☐ Wellness: *Improving overall health in the absence of true symptoms or disease.*

☐ Corrective: *Restoring underlying mechanical dysfunction while improving symptoms.*

☐ Pain Management: *Managing pain symptoms without improving overall health.*

☐ Maintenance: *Maintaining the current status of your health.*

Patient Signature _____ **Date** _____

Physician Notes: _____

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SHP Spinal Health Professionals

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage 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 anyone section relate to you, but please just mark the box which most closely describes your problem.

Section #1 – Pain Intensity

0 ☐ There is no pain at the moment.
1 ☐ The pain is very mild at the moment.
2 ☐ The pain is moderate at the moment.
3 ☐ The pain is fairly severe at the moment.
4 ☐ The pain is very severe at the moment.
5 ☐ The pain is most imaginable at the moment.

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

0 ☐ I can look after myself normally without causing extra pain.
1 ☐ I can look after myself normally but it causes extra pain.
2 ☐ It is painful to look after myself and I am slow and careful.
3 ☐ I need some help but manage most of my personal care.
4 ☐ I need help every day in most aspects of self care.
5 ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section #3 – Lifting

0 ☐ I can lift heavy weights without extra pain.
1 ☐ I can lift heavy weights but it causes extra pain.
2 ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
3 ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4 ☐ I can lift very light weights.
5 ☐ I cannot lift or carry anything at all.

Section #4 – Reading

0 ☐ I can read as much as I want with no pain in my neck.
1 ☐ I can read as much as I want with slight pain in my neck.
2 ☐ I can read as much as I want with moderate pain in my neck.
3 ☐ I cannot read as much as I want because of moderate pain in my neck.
4 ☐ I can hardly read at all because of severe pain in my neck.

Section #5 – Headaches

0 ☐ I have no headaches at all.
1 ☐ I have slight headaches which come infrequently.
2 ☐ I have moderate headaches which come infrequently.
3 ☐ I have moderate headaches which come frequently.
4 ☐ I have severe headaches which come frequently.

Section #6 – Concentration

0 ☐ I can concentrate fully when I want with no difficulty.
1 ☐ I can concentrate fully when I want with slight difficulty.
2 ☐ I have a fair degree of difficulty in concentrating when I want.
3 ☐ I have a lot of difficulty in concentrating when I want.
4 ☐ I have a great deal of difficulty in concentrating when I want.
5 ☐ I cannot concentrate at all.

Section #7 – Work

0 ☐ I can do as much work as I want.
1 ☐ I can only do my usual work, but no more.
2 ☐ I can do most of my usual work, but no more.
3 ☐ I cannot do my usual work.
4 ☐ I can hardly work at all.
5 ☐ I cannot do any work at all.

Section #8 – Driving

0 ☐ I can drive my car without any neck pain.
1 ☐ I can drive my car as long as I want with slight pain in my neck.
2 ☐ I can drive my car as long as I want with moderate pain in my neck.
3 ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
4 ☐ I can hardly drive at all because of severe pain in my neck.
5 ☐ I cannot drive my car at all.

Section #9 – Sleeping

0 ☐ I have no trouble sleeping.
1 ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
2 ☐ My sleep is mildly disturbed (1- 2 hrs. sleepless).
3 ☐ My sleep is moderately disturbed (2 - 3 hrs. sleepless).
4 ☐ My sleep is greatly disturbed (3 - 5 hrs. sleepless).
5 ☐ My sleep is completely disturbed (5 - 7 hrs. sleepless).

Section #10 – Recreation

0 ☐ I'm able to engage in all my recreation activities with no neck pain at all.
1 ☐ I'm able to engage in all my recreation activities with some neck pain.
2 ☐ I'm able to engage in most but not all of my usual recreation activities because of pain in my neck.
3 ☐ I'm able to engage in a few of my usual recreation activities because of pain in my neck.
4 ☐ I can hardly do any recreation activities because of pain in my neck.
5 ☐ I cannot do any recreation activities at all

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Oswestry Back Disability Index

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage 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 anyone section relate to you, but please just mark the box which most closely describes your problem.

Section #1 – Pain Intensity

0 ☐ Pain comes and goes and is mild
1 ☐ Pain is mild and does not vary
2 ☐ Pain comes and goes and is moderate
3 ☐ Pain is moderate and does not vary much
4 ☐ Pain comes and goes and is severe
5 ☐ Pain is severe and does not vary much

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

0 ☐ Does not change habits to avoid pain
1 ☐ Does not change habits / some pain
2 ☐ Does not change habits / increases pain
3 ☐ Changes habits / increases pain
4 ☐ Unable to do some personal care without help
5 ☐ Unable to wash or dress without help

Section #3 – Lifting

0 ☐ Lifts heavy weights with no pain
1 ☐ Lifts heavy weights with pain
2 ☐ Cannot lift heavy weights off the floor
3 ☐ Can lift heavy weights from a table
4 ☐ Can lift only light weights from a table
5 ☐ Can left only very light weights

Section #4 – Walking

0 ☐ Pain does not prevent me from walking any distance
1 ☐ Pain prevents me walking for more than 1 mile (1.6 km)
2 ☐ Pain prevents me walking for more than 1/2 mile (0.8 km)
3 ☐ Pain prevents me walking for more than 1/4 mile (0.4 km)
4 ☐ I can only walk using a stick or crutches
5 ☐ Bedridden and must crawl to the toilet

Section #5 – Sitting

0 ☐ I can sit in a chair as long as desired
1 ☐ I can only sit in my favorite chair as long as I desire
2 ☐ Can sit no more than 1 hour
3 ☐ Can sit no more than 30 minutes
4 ☐ Can sit no more than 10 minutes
5 ☐ Cannot sit at all due to pain

Section #6 – Standing

0 ☐ Can stand for an unlimited time without pain
1 ☐ Some pain standing / doesn't increase with time
2 ☐ Cannot stand more than one hour
3 ☐ Cannot stand more than 30 minutes
4 ☐ Cannot stand more than 10 minutes
5 ☐ Cannot stand at all

Section #7 – Sleeping

0 ☐ No pain in bed
1 ☐ Gets pain in bed, but sleeps well
2 ☐ Normal sleep reduced by 1/4
3 ☐ Normal sleep reduced by 1/2
4 ☐ Normal sleep reduced by 3/4
5 ☐ Cannot sleep at all due to pain

Section #8 – Traveling

0 ☐ Travel without pain
1 ☐ Travel causes some pain, but not made worse
2 ☐ Causes extra pain / no change in form
3 ☐ Cause pain / uses alternate travel
4 ☐ Pain restricts all forms of travel
5 ☐ Pain restricts travel except lying down

Section #9 – Social Life

0 ☐ Normal and causes no pain
1 ☐ Normal but causes extra pain
2 ☐ Limits energetic interest
3 ☐ Pain limits / doesn't go out as often
4 ☐ Pain restricted social life to home
5 ☐ Pain restricts all social life

Section #10 – Changing Degree of Pain

0 ☐ Pain is rapidly improving
1 ☐ Pain fluctuates but is improving
2 ☐ Improvement is slow
3 ☐ Pain level is unchanged
4 ☐ Pain is gradually worsening
5 ☐ Pain is rapidly worsening

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