# Duncan Chiropractic

16622 Pearl Rd., Strongsville, OH 44136
(440) 238-0106 (P) (440) 238-0173 (F)

Date:_____ Acct#_____

**Confidential Patient Information**

Patient Name:_____(If patient is a minor, see Minor Consent below)
Address:_____ City:_____ Zip:_____
SS:_____ E-mail_____
Home Phone:_____ Cell Phone:_____
Date of Birth:_____ Male:____ Female:___ Marital Status M S W D
Employer:_____ Occupation:_____
How did you hear about our office? _____
Referred by:_____
Reason for Visit:_____ Primary Physician:_____

Is your present condition related to, or the result of an auto collision, work-related injury or other personal injury? Y N

**Notice of Privacy (HIPPA) & Terms of Acceptance**

The goal of our office so to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you.
**Please read the statements below and if you have any questions please feel free to ask one of our staff members.**

Informed Consent:
A patient coming to the chiropractor doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractor doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health regiment. I understand that if I am accepted as a patient by Duncan Chiropractic, LLC, I authorize them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me up on my request.

**Consent to Evaluate and Treat a Minor:**
I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Missed Appointments:** There is a possible charge of $25.00 for all appointments not cancelled 24 hours prior to scheduled time. Be aware that you may be dismissed from the practice should you have in excess of 3 missed appointments without 24 hours cancellation notice.

**Communications:** In the event that we would need to communicate your healthcare information, to whom may we do so?
Spouse:_____ Other:_____
Child:_____ No One:_____

**Acknowledgement:** I have read and fully understand the above statements. I was offered and reviewed the Notice of Privacy Practices Vers. 2.0 (HIPPA) and have been provided and opportunity to discuss my right to privacy. A copy is available upon request.
Signature:_____ Date:_____

# Medical History Form

Date_____ Name_____ Date of Birth_____

Tobacco Use: Yes/No How Much?____/Day How Long? _____ Date Quit_____

Alcohol Use: How much per day _____

## Past Illnesses of Yourself and Family

| Illness | Self | Family | Illness | Self | Family | Illness | Self | Family |
|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | High Blood Pressure | | | Stroke | | |
| Anemia | | | Kidney Disease | | | Suicide Attempt | | |
| Asthma | | | Liver Disease | | | Thyroid Disease | | |
| Cancer/Tumor | | | Hepatitis | | | Tuberculosis, TB | | |
| Diabetes | | | Lung Disease | | | Ulcer in GI Tract | | |
| Drug Abuse | | | Mental Illness | | | Venereal Disease | | |
| Depression | | | Osteoarthritis | | | High cholesterol | | |
| Epilepsy/Seizures | | | Osteoporosis | | | HIV/Immune Dx | | |
| Glaucoma | | | Phlebitis | | | Other_____ | | |
| Heart Disease | | | Rheumatic Arthritis | | | | | |

## Review of Systems- Please check each item "Yes" or "No" as they relate to YOUR health:

| **Constitutional** | **Yes** | **No** | **Respiratory** | **Yes** | **No** | **Hematology/Lymph** | **Yes** | **No** |
|---|---|---|---|---|---|---|---|---|
| Weight Loss | | | Cough | | | Easy Bruising | | |
| Fatigue | | | Coughing blood | | | Gums Bleed Easily | | |
| Fever | | | Wheezing | | | Enlarged Glands | | |
| **Eyes** | **Yes** | **No** | Chills | | | **Musculoskeletal** | **Yes** | **No** |
| Glasses/Contacts | | | **Gastrointestinal** | **Yes** | **No** | Joint Pain/Swelling | | |
| Eye Pain | | | Heartburn/Reflux | | | Stiffness | | |
| Double Vision | | | Nausea/Vomiting | | | Muscle Pain | | |
| Cataracts | | | Constipation | | | Back Pain | | |
| **Ear/Nose/Throat** | **Yes** | **No** | Change in BMs | | | **Skin** | **Yes** | **No** |
| Difficulty Hearing | | | Diarrhea | | | Rash/Sores | | |
| Ringing in Ears | | | Jaundice | | | Lesions | | |
| Vertigo | | | Abdominal Pain | | | Itching/Burning | | |
| Sinus Trouble | | | Black or Bloody BM | | | **Neurological** | **Yes** | **No** |
| Nasal Stuffiness | | | **Genitourinary** | **Yes** | **No** | Loss of Strength | | |
| Frequent Sore Throat | | | Burning/Frequency | | | Numbness | | |
| **Cardiovascular** | **Yes** | **No** | Nighttime | | | Headaches | | |
| Murmur | | | Blood in Urine | | | Tremors | | |
| Chest Pain | | | Erectile Dysfunction | | | Memory Loss | | |
| Palpitations | | | Abnormal Discharge | | | **Females ONLY** | | |
| Dizziness | | | Bladder Leakage | | | Date Last mammogram _____ | | |
| Fainting Spells | | | **Allergic/Immunologic** | **Yes** | **No** | Normal _____ Abnormal_____ | | |
| Shortness of Breath | | | Hives/Eczema | | | Date Last PAP _____ | | |
| Difficulty Lying Flat | | | Hay Fever | | | Normal _____ Abnormal_____ | | |
| Swelling Ankles | | | **Psychiatric** | **Yes** | **No** | Age Onset Periods _____ | | |
| **Endocrine** | **Yes** | **No** | Anxiety/Depression | | | Age Onset Menopause _____ | | |
| Loss of Hair | | | Mood Swings | | | Periods Regular | Yes | No |
| Heat/Cold Intolerance | | | Difficult Sleeping | | | Number of Pregnancies _____ | | |

Signature/Reviewing Physician_____

Patient Name _____ Date: _____

## MEDICATIONS

| Name | Dose | Frequency | Purpose |
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## SURGERIES

Procedure _____ Date _____

Additional Information:

**Ryan Duncan D.C.**
P: 440.238.0106 F: 440.238.0173
16622 Pearl Rd. Strongsville, OH 44136

Name_____ DOB:_____ Sex_____

I understand that Duncan Chiropractic is submitting my x-rays to Dr. Edward Daily, D.C., D.A.C.B.R. for radiological evaluation and analysis by a specialist. I also understand that the fee for such services will be my responsibility.

_____ Insurance: $18 (in addition to your copay) one region. $23.00 two regions. $28 three regions. (this is for the radiology report; x-rays will be billed to your insurance company).

Patient Signature:_____

Date: _____/_____/_____

___Medicare and Time of Service (Cash Patients): $61.00 one region. Additional regions, $48 per region.

(Includes the cost of x-ray and radiology report)

Patient Signature:_____

Date: _____/_____/_____

____ Medicaid: $0.00

Patient Signature:_____

Date: _____/_____/_____

**Women Only: To the best of my knowledge, I am/am not Pregnant and give permission to x-ray me for diagnostic interpretation. (Initials) _____

## Low Back Disability Index Questionnaire

**Name:**_____ **Date:**_____

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** the most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, just circle the one choice which most closely describes your problem right now.**

**SECTION 1- PAIN INTENSITY**
A. The pain comes and goes and is very mild
B. The pain is mild and does not vary much
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much
E. The pain is severe and does not vary much

**SECTION 2- PERSONAL CARE**
A. I would not have to change my way of washing or dressing in order to avoid pain
B. I do not normally change my way of washing or dressing even though it causes some pain
C. Washing and dressing increases the pain, but I manage not to change my way of doing it
D. Washing and dressing increases the pain, and I find it necessary to change my way of doing it
E. Because of the pain, I am unable to do some washing or dressing without help
F. Because of the pain, I am unable to do any washing and dressing without help

**SECTION 3- LIFTING**
A. I can lift heavy weights without extra pain
B. I can lift heavy weights, but it causes extra pain
C. Pain prevents me from lifting heavy weights of the floor but I can if they are conveniently positioned, for example on a table
D. Pain prevents me from lifting heavy weights off the floor
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
F. I can only lift very lift weights at the most

**SECTION 4- WALKING**
A. I have no pain walking
B. I have some pain walking, but I can still walk my required normal distances
C. Pain prevents me from walking long distances
D. Pain prevents me from walking intermediate distances
E. Pain prevents me from walking even short distances
F. Pain prevents me from walking at all.

**SECTION 5- SITTING**
A. Sitting does not cause me any pain
B. I can sit as long as I need provided I have my choice of sitting surfaces
C. Pain prevents me from sitting more than one hour
D. Pain prevents me from sitting more than ½ hour
E. Pain prevents me from sitting more than 10 minutes
F. Pain prevents me from sitting at all

**SECTION 6- STANDING**
A. I can stand as long as I want without any pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for more than one hour without increasing pain
D. I cannot stand for more than ½ hour without increasing pain
E. I cannot stand for more than 10 minutes without increasing pain
F. I avoid standing because it increases my pain right away

**SECTION 7- SLEEPING**
A.I have no pain in bed
B. I have pain in bed but it does not prevent me from sleeping well
C. Because of pain I only sleep ¾ of normal time
D. Because of pain I only sleep ½ of normal time
E. Because of pain I only sleep ¼ of normal time
F. Pain prevents me from sleeping at all.

**SECTION 8- SOCIAL LIFE**
A. My social life is normal and gives me no pain
B. My social life is normal, but increases the degree of pain
C. Pain prevents me from participating in more energetic activities, eg. sports, dancing
D. Pain prevents me from going out very often.
E. Pain has restricted my social life to home
F. I hardly have any social life because of pain

**SECTION 9-TRAVELING**
A. I get no pain while traveling
B. I get some pain while traveling but none of my usual forms of travel make it an y worse
C. I get some pain while traveling, but it does not cause me to seek alternative forms of travel
D. I get extra pain from travel that causes me to seek alternative forms of travel
E. Pain restricts me from all forms of travel
F. Pain restricts me from all forms of travel, except that done lying down

**SECTION 10- EMPLOYMENT/HOMEMAKING**
A. My normal job/homemaking activities does not case me pain
B. My normal job/homemaking activities cause me extra pain, but I can still perform all that is required of me
C. I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities eg, lifting, vacuuming
D. Pain prevents me rom doing anything but light duties
E. Pain prevents me from doing even light duties
F. Pain prevents me from performing any job or homemaking chore

Source: Fairbank JC, Couper J, Davies JB, O'Brien JP. The Oswestry Low back pain disability questionnaire. Physiotherapy 1980;66(8):271-3.

**Disability Index Score:** _____%

## Neck Disability Index Questionnaire (NDI)

**Name:** **Date:**

*This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but* **Please just circle the one choice which closely describes your problem right now.**

**SECTION 1--Pain Intensity**

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

**SECTION 2--Personal Care (Washing, Dressing etc.)**

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

**SECTION 3--Lifting**

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

**SECTION 4 --Reading**

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

**SECTION 5--Headache**

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

**SECTION 6 -- Concentration**

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

**SECTION 7--Work**

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

**SECTION 8--Driving**

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

**SECTION 9--Sleeping**

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

**SECTION 10--Recreation**

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

**DISABILITY INDEX SCORE:** %_____

Source: Vernon H, Mior S. The Neck Disability Index: a study of reliability and validity. J Manipulative Physiol Ther 1991;14(7):409-15.

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