WELCOME TO MCBRIDE CHIROPRACTIC

Patient Name: _____ Birth Date: _____

Mailing Address: _____ Sex: M F

City _____ State _____ Zip_____ SSN: _____-____-_____

Preferred Phone # (_____)_____ Marital Status: M S W D

Alternate Phone # (_____)_____ Spouse Name: _____

Email: _____

Employer _____ Occupation_____

Would you like to receive appointment reminders? **YES NO** if YES **TEXT or EMAIL**

If there is someone you would like to authorize to access your records, appointment information (PHI) and information about your account balance on (FINANCIAL) enter their information below:

Name _____ DOB_____ ☐ PHI ☐ FINANCIAL

Emergency Contact: _____ Phone #: (_____)_____

Do you have an advanced care plan or a surrogate decision maker? **YES NO**

Who may we thank for referring you to this office: _____

Primary Care Physician: _____ Length of time in their care: _____
Address/Facility:_____

Is your current condition the result of an accident? **YES NO** If yes circle one (**HOME WORK AUTO**)

If it was a work accident, did you file a report with your employer? **YES NO**

Have you had similar injuries before? **YES NO** Date_____

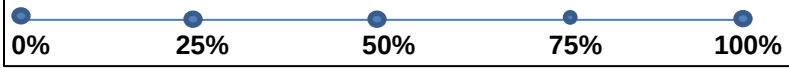
Have you lost time from work? **YES NO** Dates: _____

Current complaint (how you feel today):

_____

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable

Frequency of Pain



Date problem began: _____

How problem began: _____

_____

OTHERS SEEN FOR THIS CONDITION

Physician: _____ Length of time treated: _____

Treatment Provided: _____

Results:_____ Diagnosis: _____

Have you had any X-RAYS, MRI's or CT scans? YES NO When? _____ At what Facility: _____

Patient or Guardian Signature _____ **Date** _____

Pt Name _____

Account #

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN

What type of exercise do you perform on a daily basis? None ___ Light ___ Moderate ___ Heavy ___

What do your daily work habits include? (Ex. Sitting, standing, light labor, computer work) _____

_____

FAMILY HISTORY: please indicate family member ie: mother (**M**), father (**F**), sibling(**S**):

_____Cancer: Type _____ _____ Diabetes _____ High Blood Pressure

_____ Heart Problems _____Stroke _____Rheumatoid Arthritis

PATIENT HISTORY

Abnormal Weight	___Gain	___Loss		Falls within the past 12 months	**YES**	**NO**	Pain at Night	**YES**	**NO**
Taking Birth Control Pills	**YES**	**NO**		High Blood Pressure	**YES**	**NO**	Pain Unrelieved by		
Taking Blood Thinners	**YES**	**NO**		Marked Morning Pain/Stiffness	**YES**	**NO**	Position or Rest	**YES**	**NO**
Taking Corticosteroids	**YES**	**NO**		Menstrual Problems (Female only)	**YES**	**NO**	Prostate Problems (Male only)	**YES**	**NO**
Currently Pregnant	# weeks	_____		Numbness in Groin/Buttocks	**YES**	**NO**	Recent Fever or Chills	**YES**	**NO**
Diabetes	**YES**	**NO**		Osteoarthritis	**YES**	**NO**	Stroke (Date)_____	**YES**	**NO**
Dizziness/Fainting	**YES**	**NO**		Osteoporosis	**YES**	**NO**	Urinary Problems	**YES**	**NO**
Epilepsy/Seizures	**YES**	**NO**		Pacemaker	**YES**	**NO**	Visual Disturbances	**YES**	

MEDICATION: **DOSE:** **FREQUENCY:** **ROUTE:**

_____

_____

_____

SURGERIES, CANCERS, OR OTHER HEALTH CONCERNS:

_____

_____

_____

The following questions are for statistical purposes only and would never be used to discriminate against you. You may opt to not answer if you wish.

Do you currently smoke? YES NO Packs per day? ____ Have you smoked in the past? YES NO How long ago? _____

Preferred Language:
____ English
____ Other _____

Ethnicity:
____ Hispanic or Latino
____ Not Hispanic or Latino

Race:
_____ American Indian or Alaskan Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received (or been offered and declined) a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to; Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment, obtain payment from third-party payers, conduct normal health care operations such as quality assessments and accreditation.

_____

Printed Patient Name **Signature** **Date** **Relationship to patient**

I certify, to the best of my knowledge, the provided information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive health care benefits through this provider, I understand that I am liable for all the charges for services rendered and I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future. **I understand that I am liable for charges incurred in this office**. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed; therefore, I give authorization to my chiropractor to contact my physician and share information if necessary.

Patient Signature_____ **Date:** _____

I give Christopher P McBride DC permission to evaluate and treat my son/daughter/dependent _____, of whom I am their parent or legal guardian. I accept responsibility for payment of charges.

Guardian Signature _____ **Date:** _____

CONSENT TO TREATMENT

I authorized McBride Chiropractic, its health care practitioners, staff and other individuals involved in my healthcare to examine me, perform any tests, procedures and or treatments that may be helpful. I understand that the healthcare provider responsible for this care will explain any proposed procedures or treatments, including their usual and most common risks and hazards. I also understand that I have the right to refuse any proposed procedure of treatment.

Patient Signature_____ **Date:** _____

REVISED OSWESTRY NECK PAIN DISABILITY QUESTIONNAIRE

NAME (PLEASE PRINT):_____ DATE:_____

AGE: _____ DATE OF BIRTH:_____ OCCUPATION:_____

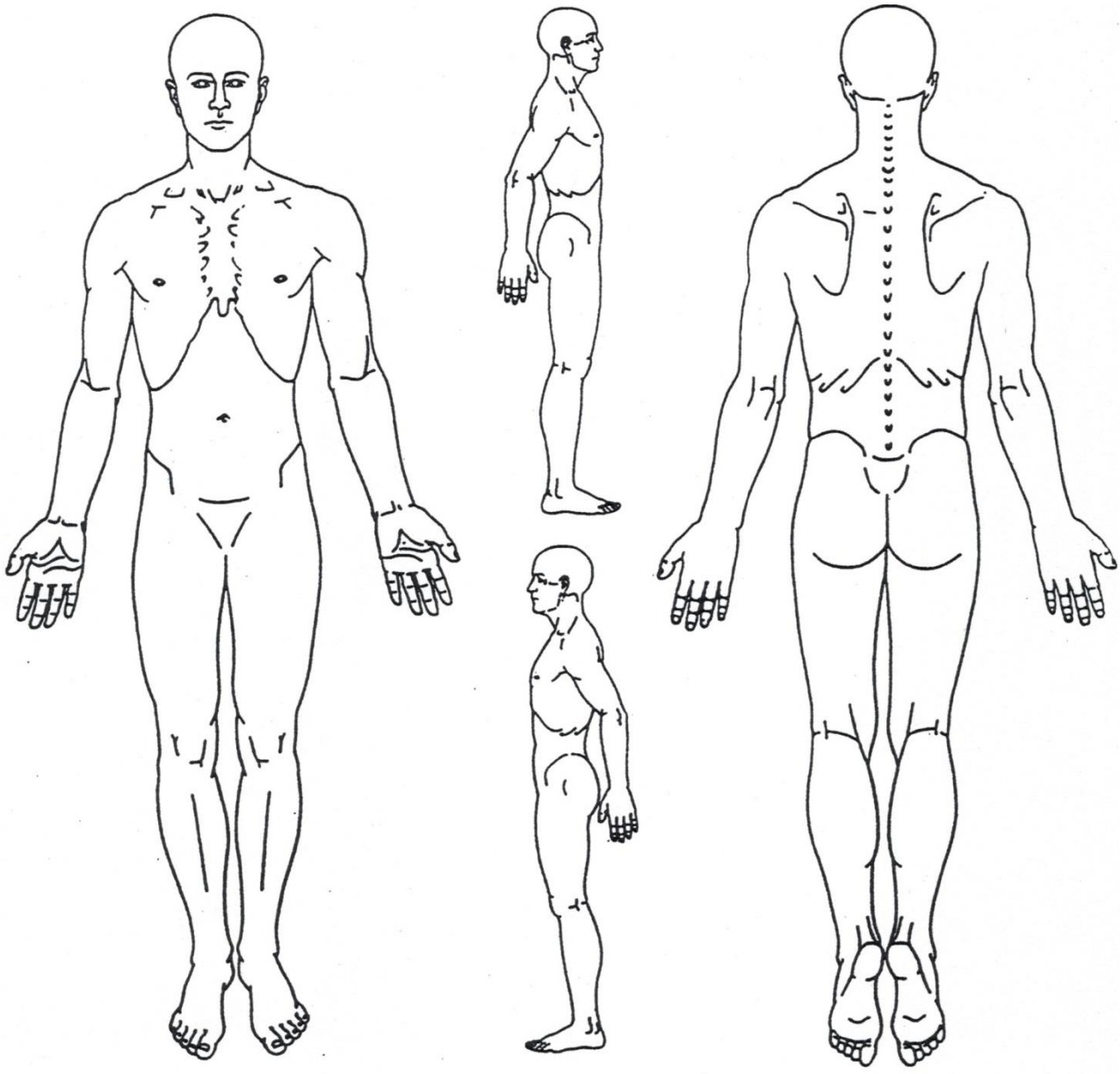
How long has this episode of Neck Pain lasted? ____ Years ___ Months ___ Weeks ___ Days

Is this your first episode of Neck Pain? _____ Yes _____ No

USE THE LETTERS BELOW TO INDICIATE THE TYPE AND LOCATION OF YOUR SENSATION RIGHT NOW

A=ACHE **B**=BURNING **N**=NUMBNESS **W**=WEAKNESS

P=PINS AND NEEDLES **S**=SHARP **T**=TIGHTNESS **O**=OTHER



OVER PLEASE

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

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

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

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 concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work / Daily Activities

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

Personal Care

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 I 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.

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 (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

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.
⑤ I have headaches almost all the time.

Office Use Only

Neck Index Score

Patient signature: _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (PLEASE PRINT):_____ DATE:_____

AGE: _____ DATE OF BIRTH:_____ OCCUPATION:_____

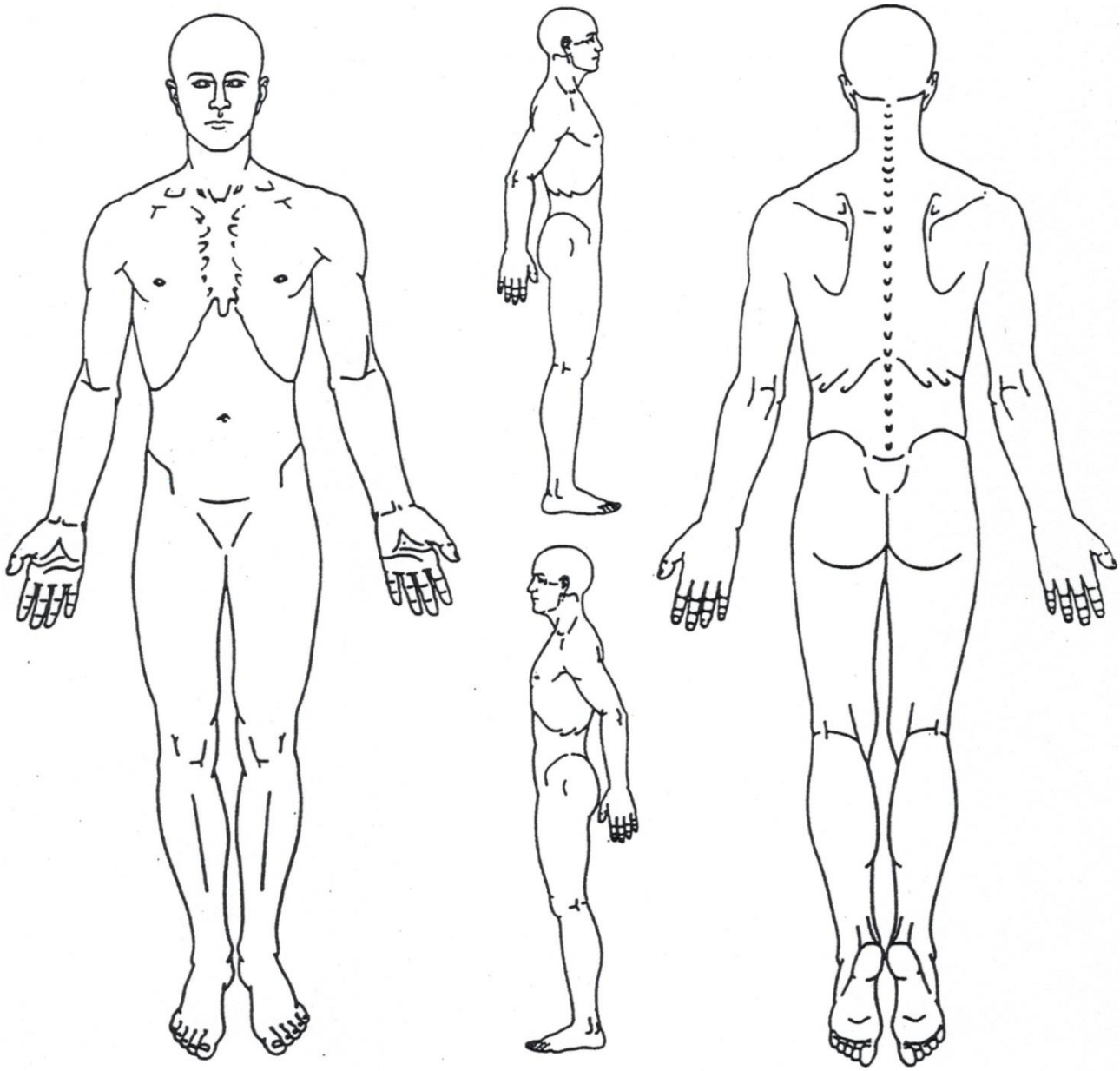
How long has this episode of Low Back Pain lasted? ____ Years ___ Months ___ Weeks ___ Days

Is this your first episode of Low Back Pain? _____ Yes _____ No

USE THE LETTERS BELOW TO INDICIATE THE TYPE AND LOCATION OF YOUR SENSATION RIGHT NOW

A=ACHE **B**=BURNING **N**=NUMBNESS **W**=WEAKNESS

P=PINS AND NEEDLES **S**=SHARP **T**=TIGHTNESS **O**=OTHER



OVER PLEASE

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling / Driving

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Office use only

Back Index Score

Patient Signature: _____