

# FALK FAMILY CHIROPRACTIC CENTER, PC

1501 Ninth Avenue • Conway, SC 29526 • 843-248-0104

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail \_\_\_\_\_

Street Address and Number: \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Sex:** Male Female # of Children: \_\_\_\_\_ **Circle One:** Married • Single • Widowed • Divorced

Race (circle only 1) American Indian • Alaska Native • Asian • White • Black or African American  
Native Hawaiian • Other Pacific Islander • Declined to State

Ethnicity (circle only 1) Hispanic or Latino • Not Hispanic or Latino • Declined to State

Preferred Language \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

In case of emergency, please contact (include phone #): \_\_\_\_\_

Do you have health insurance you would like us to file? **Yes No**

Please describe your major complaint: \_\_\_\_\_  
\_\_\_\_\_

Name of person responsible for payment (if different from applicant): \_\_\_\_\_

I hereby authorize you to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. If Falk Family Chiropractic Center must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Falk Family Chiropractic Center for all costs of such collection efforts, including but not limited to all court cost and all attorney fees.

By signing your name below, you certify the accuracy of your medical and / or accident history and further certify that you present to Falk Family Chiropractic Center for evaluation and treatment of a health related condition and for no other purpose.

\_\_\_\_\_  
Signature of patient, or Guardian Authorizing care

\_\_\_\_\_  
Date



This is a personal and confidential case history. No information will be shared unless requested by you.

**About Your Health**

Throughout life, events occur which damage your health. This case history will uncover the layers of damage that resulted in poor health. Following your exam, we will outline a course of care to correct these layers of damage to recover your health potential.

**C History If Yes, Please Explain:**

Yes No explain here:

**Growth and Development**

- Have you ever received Chiropractic Care \_\_\_\_\_
- Were you dropped as a baby? \_\_\_\_\_
- Childhood Sicknesses? \_\_\_\_\_
- Broken bones? \_\_\_\_\_
- Stitches? \_\_\_\_\_
- Did you fall down stairs? \_\_\_\_\_
- Were you yanked by your arm? \_\_\_\_\_
- Did you have other traumas as a child? \_\_\_\_\_
- Have you been in **any** accidents? \_\_\_\_\_
  
- Have you had **any** surgeries? \_\_\_\_\_  
(Specify date) \_\_\_\_\_
- Do you have occupational stress? \_\_\_\_\_
- Physical stress? \_\_\_\_\_
- Mental stress? \_\_\_\_\_
- Hobbies/Sports injuries? \_\_\_\_\_
- Sleeping habits (nightmares)? \_\_\_\_\_

Sleeping posture  Side  stomach  back

**D Present State of Ill Health**

Other Symptoms

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Pins & Needles in Legs       | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Loss of Smell   |
| <input type="checkbox"/> Neck Pain        | <input type="checkbox"/> Pins & Needles in Arms       | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Loss of Taste   |
| <input type="checkbox"/> Mid-Back Pain    | <input type="checkbox"/> Numbness in Fingers          | <input type="checkbox"/> Chest Pains        | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Low Back Pain    | <input type="checkbox"/> Numbness in toes             | <input type="checkbox"/> Heartburn / reflex | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Shoulder Pain    | <input type="checkbox"/> Elbow Pain                   | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Wrist Pain       | <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Feet Cold          | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Knee Pain        | <input type="checkbox"/> Irritability                 | <input type="checkbox"/> Hands Cold         | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> Ankle Pain       | <input type="checkbox"/> Ringing in Ears              | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Painful Tailbone | <input type="checkbox"/> Spinal Curvature (Scoliosis) | <input type="checkbox"/> Swollen Joints     | <input type="checkbox"/> Tremors         |

Other \_\_\_\_\_

**PLEASE CHECK THE BOX FOR EACH CURRENT OR PAST SYMPTOM LISTED.**

<p><b>GENERAL SYMPTOMS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bronchitis</li> <li><input type="checkbox"/> Chills (Constant)</li> <li><input type="checkbox"/> Convulsions</li> <li><input type="checkbox"/> Loss of Weight</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Night Sweats</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Sleeping Problems</li> </ul> <p><b>CARDIO-VASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood Pressure—High / Low</li> <li><input type="checkbox"/> Heart Trouble</li> <li><input type="checkbox"/> Poor Circulation</li> <li><input type="checkbox"/> Heart rate—rapid / slow</li> <li><input type="checkbox"/> Strokes</li> </ul> <p><b>SKIN OR ALLERGIES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dryness</li> <li><input type="checkbox"/> Hives or Allergy</li> <li><input type="checkbox"/> Itching</li> </ul>	<p><b>GASTRO-INTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Belching or Gas</li> <li><input type="checkbox"/> Colon Trouble</li> <li><input type="checkbox"/> Gall Bladder Trouble</li> <li><input type="checkbox"/> Hemorrhoids (piles)</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Stomach Pain</li> <li><input type="checkbox"/> Jaundice</li> <li><input type="checkbox"/> Liver Trouble</li> <li><input type="checkbox"/> Hernia</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Vomiting Blood</li> <li><input type="checkbox"/> Bloody Stools</li> <li><input type="checkbox"/> Irritable Bowel</li> </ul>	<p><b>NOSE/THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Deafness</li> <li><input type="checkbox"/> Earache</li> <li><input type="checkbox"/> Ear Discharge</li> <li><input type="checkbox"/> Ear Noises</li> <li><input type="checkbox"/> Thyroid Problems</li> <li><input type="checkbox"/> Frequent Colds</li> <li><input type="checkbox"/> Sinusitis</li> <li><input type="checkbox"/> Sore Throats</li> <li><input type="checkbox"/> Hay Fever</li> <li><input type="checkbox"/> Nasal Obstruction</li> <li><input type="checkbox"/> Nose Bleeds</li> <li><input type="checkbox"/> Pain in Eyes</li> <li><input type="checkbox"/> Poor Vision</li> </ul> <p><b>FOR FEMALES ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cramps</li> <li><input type="checkbox"/> Painful Periods</li> <li><input type="checkbox"/> Vaginal Discharge</li> <li><input type="checkbox"/> Irregular Cycle</li> <li><input type="checkbox"/> Painful Periods</li> <li><input type="checkbox"/> Pregnant Now?</li> </ul> <p>_____ Last Pap Date _____ Last Menstrual Cycle</p>	<p><b>EYE/EAR</b></p> <p><b>RESPIRATORY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic Cough</li> <li><input type="checkbox"/> Difficulty Breathing</li> <li><input type="checkbox"/> Spitting Blood</li> <li><input type="checkbox"/> Spitting Phlegm</li> </ul> <p><b>GENITO-URINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bed Wetting</li> <li><input type="checkbox"/> Blood in Urine</li> <li><input type="checkbox"/> Kidney Infection</li> <li><input type="checkbox"/> Frequent Urination</li> <li><input type="checkbox"/> Incontinent</li> <li><input type="checkbox"/> Painful Urination</li> <li><input type="checkbox"/> Kidney Stones</li> <li><input type="checkbox"/> Swelling Ankles</li> <li><input type="checkbox"/> Varicose Veins</li> <li><input type="checkbox"/> Tonsillitis</li> <li><input type="checkbox"/> Prostate Trouble</li> </ul>
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**E HABITS**

- Current Every Day Smoker    Current Some Day Smoker    Former Smoker    Never Smoker
- Drinking   Alcohol: (Cups/day): \_\_\_\_\_    Coffee   Cups/Day: \_\_\_\_\_
- Soft Drink   Bottles or Cans/Day: \_\_\_\_\_    Water   Cups/Day: \_\_\_\_\_

**EXERCISE   DIET (Do you eat Healthy foods?)**

- None    Yes    No
- Moderate    Special diet \_\_\_\_\_
- Daily   \_\_\_\_\_
- Food Allergies \_\_\_\_\_

**F FAMILY HISTORY**

	Diabetes	Cancer	Back Pain	Heart Disease	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**G Are you taking any medication (prescription or over-the-counter)?**  Yes  No

If Yes, please indicate the following:

Medication: \_\_\_\_\_

Route:            Oral  
                      Intravenous  
                      Other: \_\_\_\_\_

Frequency: \_\_\_\_\_

Began Use: \_\_\_\_\_

Discontinued Use: \_\_\_\_\_

Medication: \_\_\_\_\_

Route:            Oral  
                      Intravenous  
                      Other: \_\_\_\_\_

Frequency: \_\_\_\_\_

Began Use: \_\_\_\_\_

Discontinued Use: \_\_\_\_\_

Medication: \_\_\_\_\_

Route:            Oral  
                      Intravenous  
                      Other: \_\_\_\_\_

Frequency: \_\_\_\_\_

Began Use: \_\_\_\_\_

Discontinued Use: \_\_\_\_\_

Medication: \_\_\_\_\_

Route:            Oral  
                      Intravenous  
                      Other: \_\_\_\_\_

Frequency: \_\_\_\_\_

Began Use: \_\_\_\_\_

Discontinued Use: \_\_\_\_\_

Have you taken any medications in the past?  Yes  No If yes, which ones?: \_\_\_\_\_

**Do you have allergies to medication?**  Yes  No

If Yes, please indicate the following:

Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Do you have other allergies (animal dander, dust, gluten, dairy...)?**  Yes  No

If Yes, please indicate the following:

Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_

Reaction: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**H DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?**

- |   |                                   |  |  |                                       |                                       |                                   |
|---|-----------------------------------|--|--|---------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Appendicitis   | <input type="checkbox"/> Anemia   | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Measles      | <input type="checkbox"/> Goiter   |
| <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Mumps    | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Polio        | <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer       | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Eczema   |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Gout     | <input type="checkbox"/> Lupes         | <input type="checkbox"/> Sarcoidosis     | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Psoriasis    |                                   |

AUTOMOBILE INJURY

Name \_\_\_\_\_ File # \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ Location \_\_\_\_\_

Did you report to the proper authorities?  Y  N Police? \_\_\_\_\_ Do you have an accident report?  Y  N

How did the accident occur? Were you the  Diver  Front Passenger  Rear Passenger Motorcycle  Operator /  Passenger  
ATV  Operator /  Passenger  Other: \_\_\_\_\_

Your Vehicle:  Subcompact  Compact  Mid-size  Full-size  Other \_\_\_\_\_  
 Car  SUV  Truck  Motorcycle

Travel Direction:  North  South  East  West  Other How fast were you going? \_\_\_\_\_ MPH

Road Conditions:  Dry  Damp  Wet  Snow  Icy  Other \_\_\_\_\_

Time of Day:  Daylight  Dawn  Dusk  Night  Other \_\_\_\_\_

Did you have on your Seat Belt? - Lap Belt  Y  N Shoulder Belt  Y  N

Was the Head Rest  Above your head  Below your head  No Head Rest Airbags:  Deployed  Did not deploy

Diver Braking Accident  Y  N Was the accident  Anticipated  Not Anticipated

Did your car  strike the other  struck by the other?  hit a stationary object  multiple impacts \_\_\_\_\_

Collision Location: :  Head On  Front  Behind  Passenger's side  Diver's Side  Other \_\_\_\_\_

Did you strike or hit anything in the car?  Steering wheel  Air Bag  Dashboard  Rear-view mirror  Windshield  
 Car interior  Other \_\_\_\_\_

What happened to your body in detail: \_\_\_\_\_

Moment of impact:  tensed body  Neck whipped  spine (back) twisted  Thrown over seat  
 Thrown side to side  Pinned by vehicle  \_\_\_\_\_

Exited Vehicle:  Under own power  Assited by EMS  Assisted by others  Was extricated  \_\_\_\_\_

Were you ejected from the vehicle?  Y  N Did you lose consciousness?  Y  N Disoriented?  Y  N

Medical attention:  Received on scene  Not received on site


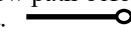


Patient went to:  This office  Hospital  Personal doctor  Home  Work  Resumed Activities  \_\_\_\_\_

Other Vehicle:  Subcompact  Compact  Mid-size  Full-size  Other \_\_\_\_\_  
 Car  SUV  Truck  Motorcycle


Other Vehicle Travel Direction:  North  South  East  West  Other Speed of other vehicle \_\_\_\_\_ MPH

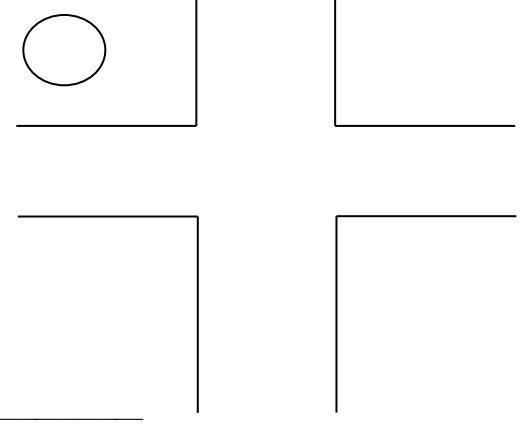
Other Collision Location: :  Head On  Front  Behind  Passenger's side  Diver's Side  Other \_\_\_\_\_

**Indicate On This Diagram What Happened**  
Sketch the scene of your accident. Writing in street or highway names or addresses.

1. Number each vehicle and show direction of travel by arrow 
2. Use solid line to show path before accident 
3. Show Pedestrian by: 
4. Show Railroad by: 
5. Show distance and direction to landmarks; identify landmarks by name or number.

Describe other details of the accident \_\_\_\_\_

**Indicate North By Arrow** 



For re-ordering information, contact:

**ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317**

**Phone: (602) 224-0220; Facsimile (602) 224-0230**

## NECK PAIN DISABILITY INDEX QUESTIONNAIRE

**Please Read:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your 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 MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

### Section 1 — Pain Intensity

- A I have no pain at the moment.
- B The pain is very mild at the moment.
- C The pain is moderate at the moment.
- D The pain is fairly severe at the moment.
- E The pain is very severe at the moment.
- F The pain is the worst imaginable at the moment.

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

- A I can look after myself normally 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 gives extra pain.
- C Pain prevents me from lifting heavy weights off the floor, but I can manage 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 to 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 — Headaches

- A I have no headaches at all.
- B I have slight headaches which come infrequently.
- C I have moderate headaches which come infrequently.
- 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 any 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 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 to engage in all of my recreational activities, with no neck pain at all.
- B I am able to engage in all of my recreational activities, with some pain in my neck.
- C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D I am able to 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 at all.

*After Vernon & Mior, 1991*

*Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics*

REVISED January 1, 1995

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

HOW LONG HAVE YOU HAD THIS PAIN? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS \_\_\_\_\_ WEEKS

IS THIS YOUR FIRST EPISODE OF THIS PAIN? \_\_\_\_\_ YES \_\_\_\_\_ NO

**USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW**

(Please remember to complete both sides of this form.)

KEY:

A=ACHE

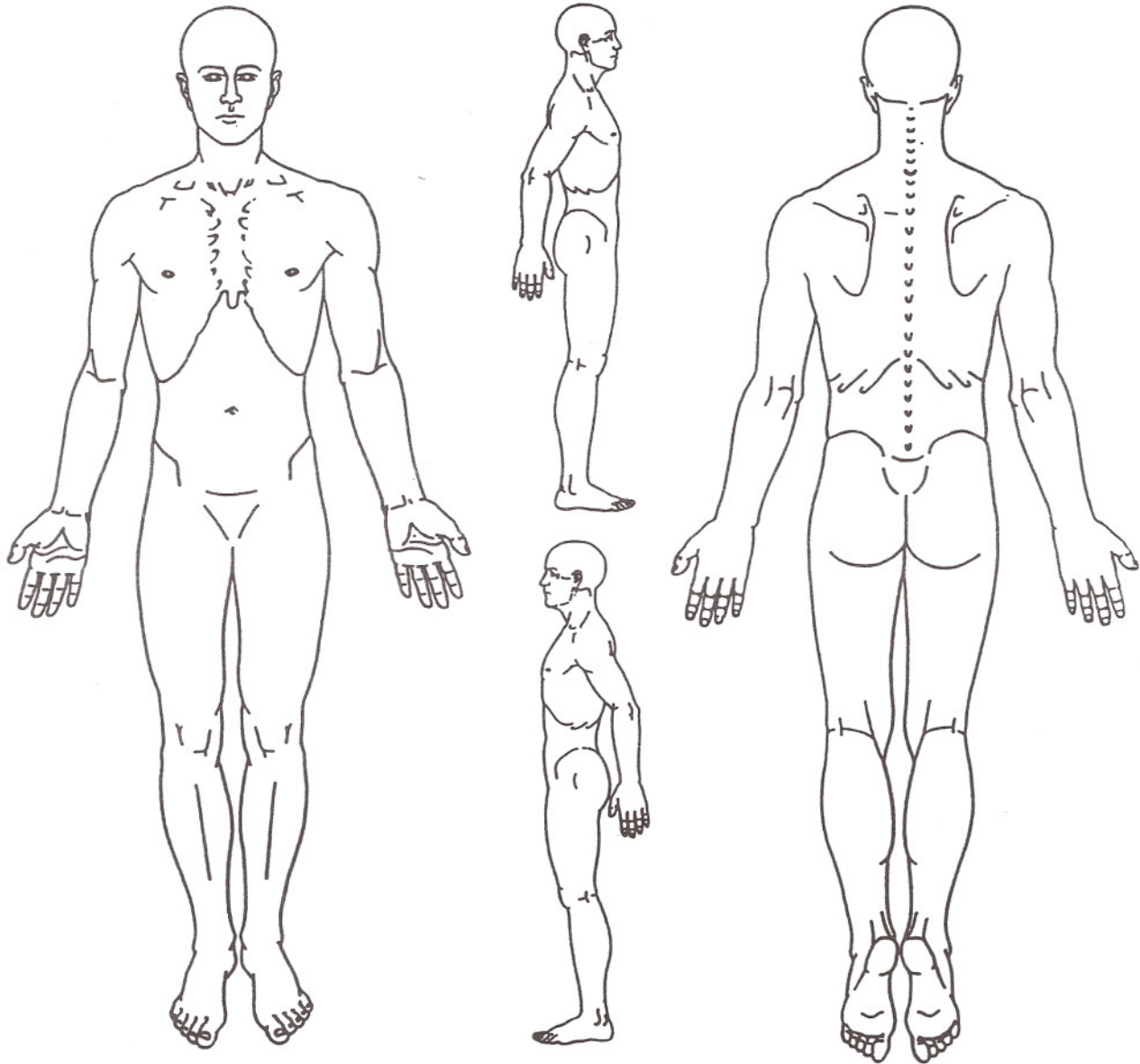
P=PINS & NEEDLES

B=BURNING

S=STABBING

N=NUMBNESS

O=OTHER



OVER PLEASE

For Doctor's Use:

Chief complaint (other than neck or low back pain): \_\_\_\_\_

(For neck conditions use the Neck Pain Disability Index Questionnaire; for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire.)

# REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

**Please Read:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your 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 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 comes and goes and is severe.
- F 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 and dressing without help.
- F Because of the pain, I am unable to do any washing or 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 off the floor.
- D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- 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 light weights, at the most.

## SECTION 4 -- Walking

- A Pain does not prevent me from walking any distance.
- B Pain prevents me from walking more than one mile.
- C Pain prevents me from walking more than 1/2 mile.
- D Pain prevents me from walking more than 1/4 mile.
- E I can only walk while using a cane or on crutches.
- F I am in bed most of the time and have to crawl to the toilet.

## SECTION 5 -- Sitting

- A I can sit in any chair as long as I like without pain.
- B I can only sit in my favorite chair as long as I like.
- C Pain prevents me from sitting more than one hour.
- D Pain prevents me from sitting more than 1/2 hour.
- E Pain prevents me from sitting more than ten minutes.
- F Pain prevents me from sitting at all.

*From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989*

## SECTION 6 -- Standing

- A I can stand as long as I want without pain.
- B I have some pain while standing, but it does not increase with time.
- C I cannot stand for longer than one hour without increasing pain.
- D I cannot stand for longer than 1/2 hour without increasing pain.
- E I cannot stand for longer than ten minutes without increasing pain.
- F I avoid standing, because it increases the pain straight away.

## SECTION 7 -- Sleeping

- A I get no pain in bed.
- B I get pain in bed, but it does not prevent me from sleeping well.
- C Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D Because of pain, my normal night's sleep is reduced by less than one-half.
- E Because of pain, my normal night's sleep is reduced by less than three-quarters.
- 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 my pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D Pain has restricted my social life and I do not go out very often.
- E Pain has restricted my social life to my home.
- F I have hardly any social life because of the 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 any worse.
- C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D I get extra pain while traveling which compels me to seek alternative forms of travel.
- E Pain restricts all forms of travel.
- F Pain prevents all forms of travel except that done lying down.

## SECTION 10 -- Changing Degree of Pain

- A My pain is rapidly getting better.
- B My pain fluctuates, but overall is definitely getting better.
- C My pain seems to be getting better, but improvement is slow at present.
- D My pain is neither getting better nor worse.
- E My pain is gradually worsening.
- F My pain is rapidly worsening.

REVISED 9/11/92

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Consent for Use or Disclosure of Health Information

### Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital by your request or if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to disclose your name, address, phone number, billing information and your clinical records to the South Carolina Chiropractic Association (SCCA). This disclosure will be made if we need the SCCA's assistance to receive reimbursement for your services or, we need the SCCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to use your name, address, phone number, e-mail, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you do not answer, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

### Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

### Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

\_\_\_\_\_  
Printed Name (or Patient Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature (or Patient Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.