

# Chiropractic Case History

## Welcome to Our Office!

Name \_\_\_\_\_ Today's date \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Cell phone: \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Marital: M S W D Employer & phone: \_\_\_\_\_ (In case we need to contact you)  
 Name of spouse \_\_\_\_\_ Emergency Contact Name and phone # \_\_\_\_\_

Your E-mail: \_\_\_\_\_ Who is your family medical doctor? \_\_\_\_\_

What medications are you taking now? \_\_\_\_\_

If you are a new patient to our office, whom may we thank for referring you? \_\_\_\_\_

1. **What** symptoms or complaint brought you to our office? \_\_\_\_\_
2. **When** did your symptoms begin? \_\_\_\_\_
3. **FREQUENCY** of your Complaint, percent of the time: **Rare** = less than 10% of the time; **Occasional** = 10 - 25%;  
**Intermittent** = 25-50%; **Frequently** = 50-75%; **Constant** = 75-100%
4. **SEVERITY**: **Minor** = only a nuisance; **Mild** = difficult to live with; **Moderate** = very difficult to live with;  
**Severe** = extremely difficult to live with
5. **QUALITY**: How would you describe your symptoms? pain, dull ache, sharp, stabbing, burning, throbbing, tingling, numbness,  
 other : \_\_\_\_\_
6. Do your symptoms **radiate** down your arm or leg? NO / YES
7. What activities **aggravate** your symptoms? drive, work, etc... \_\_\_\_\_
8. What gives **relief**? rest, ice, heat, sleep, medication? \_\_\_\_\_ exercise, chiropractic, physical therapy, other \_\_\_\_\_
9. Circle the # that corresponds to your symptoms: no symptom or pain = 0 1 2 3 4 5 6 7 8 9 10 = severe symptoms/pain
10. **Place a check next to the activity that hurts or are difficult to perform because of the condition that brought you here:**

### Personal Grooming:

\_\_\_\_\_ combing hair  
 \_\_\_\_\_ shaving  
 \_\_\_\_\_ in / out to bath tub  
 \_\_\_\_\_ brushing teeth

### Travel: \_\_\_\_\_ minutes per day

\_\_\_\_\_ driving, auto, train, truck, airplane  
 \_\_\_\_\_ as passenger  
 \_\_\_\_\_ getting in and out of vehicle

### General:

\_\_\_\_\_ walking  
 \_\_\_\_\_ standing  
 \_\_\_\_\_ running  
 \_\_\_\_\_ sitting

### General:

\_\_\_\_\_ lifting children  
 \_\_\_\_\_ bending  
 \_\_\_\_\_ climbing stairs  
 \_\_\_\_\_ reading  
 \_\_\_\_\_ sleeping or lying in bed  
 \_\_\_\_\_ rolling over in bed  
 \_\_\_\_\_ swimming  
 \_\_\_\_\_ sports / hobby:  
 \_\_\_\_\_ using typewriter or computer  
 \_\_\_\_\_ kneeling  
 \_\_\_\_\_ using telephone  
 \_\_\_\_\_ exercising  
 \_\_\_\_\_ OTHER \_\_\_\_\_

### Housework:

\_\_\_\_\_ doing laundry  
 \_\_\_\_\_ making beds  
 \_\_\_\_\_ vacuuming  
 \_\_\_\_\_ washing dishes  
 \_\_\_\_\_ ironing  
 \_\_\_\_\_ carrying groceries  
 \_\_\_\_\_ caring for pets  
 \_\_\_\_\_ cooking

### Yard Work:

\_\_\_\_\_ mowing lawn  
 \_\_\_\_\_ shoveling (snow, dirt, mulch, sand)  
 \_\_\_\_\_ raking leaves  
 \_\_\_\_\_ gardening

\_\_\_\_\_ / 35 (36 w/other): This patient has pain or difficulty performing \_\_\_\_\_ % of 35 (36) common ADL's.

# Biopsychosocial

## Social :

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

1. What is your occupation?
2. Have you lost work because of this condition? \_\_\_\_ If yes, how many days or what dates? \_\_\_\_\_
3. Is this condition due to injury or sickness arising out of employment? \_\_\_\_\_ auto accident? \_\_\_\_ other? \_\_\_\_
4. Do you exercise? If so, where and what type: \_\_\_\_\_
5. Do you smoke? no / yes packs / day? \_\_\_\_\_ No. of years? \_\_\_\_\_
6. Do you drink alcohol? no / yes = heavy moderate light times per week \_\_\_\_\_
7. Do you have small children: no / yes how many? \_\_\_\_\_
8. Have you ever been in an auto accident? No / yes = When? \_\_\_\_\_
9. Have you ever seriously injured yourself from a fall or other trauma? \_\_\_\_\_
10. What operations have you had and when? \_\_\_\_\_
11. Serious illness and when? \_\_\_\_\_

Circle your sleeping position(s): stomach, half stomach half side with one knee up, back, side

Do you sit at a desk frequently? Yes / No

Does your back hurt when you vacuum? Yes / No

Do you drive more than 20 minutes per day on the high way? Yes / No

Do you have to lift or reach for items (any items) on a daily basis? Yes / No

## **REVIEW OF SYSTEMS:** Please explain any "YES" answers

### ***Do you have or have you had significant problems with (your):***

1. Eyes, ears, nose or mouth? no / yes \_\_\_\_\_
2. Heart or lungs? no / yes \_\_\_\_\_
3. Stomach, digestion (heart burn, indigestion, bloating), bowels, bowel movement or gastrointestinal tract? no / yes \_\_\_\_\_
4. Genitourinary system: please circle symptoms or conditions you now have or have in the past:  
**Female:** fibroids, breast pain, cancer, PMS, pain associated with period, frequent yeast infections, Heavy flow  
**Male:** urinary difficulties, difficulty stopping or starting urination, prostate enlargement, cancer etc? \_\_\_\_\_
5. Muscles, ligaments, bones, arthritis, .....? no / yes \_\_\_\_\_
6. Nerves, i.e. MS, pinched nerve, shaking, tripping, unsteady walk....? no / yes \_\_\_\_\_
7. Skin , sores, wound care, .....? no / yes \_\_\_\_\_
8. Psychiatric, i.e. bipolar, frequent depression,.....? no / yes \_\_\_\_\_
9. Do you seek professional counseling? no / yes \_\_\_\_\_
- 10 Is stress a factor in your life? \_\_\_\_\_
- 11 Hormone issues, lupus, autoimmune conditions, diabetes? \_\_\_\_\_
- 12 Blood or lymphatic problems? no / yes \_\_\_\_\_
- 13 Are you currently losing weight for unknown reasons? no / yes \_\_\_\_\_
14. Do you have allergies or sensitivities to anything? no / yes \_\_\_\_\_
- 15 Other? \_\_\_\_\_

## **Family History:**

1. Are there health related conditions that run or may run in your family, i.e. back problems, heart disease, cancer, alcohol, etc.. ? no / yes - explain:
2. Does or did your mother, father or siblings have allergies or sensitivities?



**Dr. Robert Poane**  
One Barrington Pl., Suite 108 Bel Air, Maryland 21014  
410 - 420 - 7676

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**ACKNOWLEDGMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

*You may refuse to sign this Acknowledgment.*

I, X \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.  
(please print your name)

X \_\_\_\_\_  
(please sign your name acknowledging receipt)

X \_\_\_\_\_  
(today's date)

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We attempted to obtain the patient's acknowledgment of receipt of our Notice of Privacy Practices, but the Acknowledgment could not be obtained for the following reason: \_\_\_\_\_ Individual refused to sign \_\_\_\_\_ An emergency situation prevented us from obtaining the signature, \_\_\_\_\_ Other: \_\_\_\_\_

Dr. Poane's representative signature and date verifying that the patient did not sign the Acknowledgment: \_\_\_\_\_

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**Financial Policy**

**AUTHORIZATION TO PAY PHYSICIAN:** I hereby authorize and direct the \_\_\_\_\_ insurance company to pay by check made payable to R. T. Poane LLC at One Barrington Place, Suite 108, Bel Air, Maryland 21014, the medical and surgical expense benefits allowable, and otherwise payable to me under my insurance policy, as payment towards the total charges for professional services rendered. To assist in collections, I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney in this case. I agree to pay, in a current manner, any balance of said professional service charge over and above this insurance payment (except where prohibited by contract). This is a direct assignment of my rights and benefits under this policy, of which a photo copy shall be considered as effective and valid as the original.

Any balance owed after 30 days shall accrue interest at a rate of 2% per month. Should collection efforts be required, I shall be responsible for reasonable attorney fees, court costs, and any out of pocket expense.

I understand that I am ultimately responsible for payment in full to this office. I also understand that because of insurance delay's I may receive a bill months after my care has ended, but if I suspend or terminate my schedule of care, as determined by my treating doctor, fees for professional services will be immediately due and payable.

Please print your name: X \_\_\_\_\_

I (patient, guardian or parent Signature Authorizing care) X \_\_\_\_\_

understand and agree to the Financial policy above. Today's date: X \_\_\_\_\_

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**1. It is my responsibility to know if my medical insurance (or other responsible party), will pay for chiropractic and other services or products I receive in this office.**

**2. I will not rely or depend on Dr. Poane's Chiropractic Office to handle my insurance or financial affairs.**

The two sentences above are written in common language. I admit and confess I understand them to mean I am responsible for payment if my insurance or other responsible party does not pay for the care I choose to receive in this office.

X \_\_\_\_\_  
(Patient or guardian signature)

Today's date: X \_\_\_\_\_

## Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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

- ☐ ① The pain comes and goes and is very mild.
- ☐ ② The pain is mild and does not vary much.
- ☐ ③ The pain comes and goes and is moderate.
- ☐ ④ The pain is moderate and does not vary much.
- ☐ ⑤ The pain comes and goes and is very severe.
- ☐ ⑥ The pain is very severe and does not vary much.

### Sleeping

- ☐ ① I get no pain in bed.
- ☐ ② I get pain in bed but it does not prevent me from sleeping well.
- ☐ ③ Because of pain my normal sleep is reduced by less than 25%.
- ☐ ④ Because of pain my normal sleep is reduced by less than 50%.
- ☐ ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ☐ ⑥ Pain prevents me from sleeping at all.

### Sitting

- ☐ ① I can sit in any chair as long as I like.
- ☐ ② I can only sit in my favorite chair as long as I like.
- ☐ ③ Pain prevents me from sitting more than 1 hour.
- ☐ ④ Pain prevents me from sitting more than 1/2 hour.
- ☐ ⑤ Pain prevents me from sitting more than 10 minutes.
- ☐ ⑥ I avoid sitting because it increases pain immediately.

### Standing

- ☐ ① I can stand as long as I want without pain.
- ☐ ② I have some pain while standing but it does not increase with time.
- ☐ ③ I cannot stand for longer than 1 hour without increasing pain.
- ☐ ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ ⑥ I avoid standing because it increases pain immediately.

### Walking

- ☐ ① I have no pain while walking.
- ☐ ② I have some pain while walking but it doesn't increase with distance.
- ☐ ③ I cannot walk more than 1 mile without increasing pain.
- ☐ ④ I cannot walk more than 1/2 mile without increasing pain.
- ☐ ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ☐ ⑥ I cannot walk at all without increasing pain.

### Personal Care

- ☐ ① I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ ② I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ☐ ⑥ Because of the pain I am unable to do any washing and dressing without help.

### Lifting

- ☐ ① I can lift heavy weights without extra pain.
- ☐ ② I can lift heavy weights but it causes extra pain.
- ☐ ③ Pain prevents me from lifting heavy weights off the floor.
- ☐ ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ ⑥ I can only lift very light weights.

### Traveling

- ☐ ① I get no pain while traveling.
- ☐ ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ☐ ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ☐ ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ☐ ⑤ Pain restricts all forms of travel except that done while lying down.
- ☐ ⑥ Pain restricts all forms of travel.

### Social Life

- ☐ ① My social life is normal and gives me no extra pain.
- ☐ ② My social life is normal but increases the degree of pain.
- ☐ ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ☐ ④ Pain has restricted my social life and I do not go out very often.
- ☐ ⑤ Pain has restricted my social life to my home.
- ☐ ⑥ I have hardly any social life because of the pain.

### Changing degree of pain

- ☐ ① My pain is rapidly getting better.
- ☐ ② My pain fluctuates but overall is definitely getting better.
- ☐ ③ My pain seems to be getting better but improvement is slow.
- ☐ ④ My pain is neither getting better or worse.
- ☐ ⑤ My pain is gradually worsening.
- ☐ ⑥ My pain is rapidly worsening.

**Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100**

**Back  
Index  
Score**



## Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

### Sleeping

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

### Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

### Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

### Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

### Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

### Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- 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.
- ⑥ I cannot lift or carry anything at all.

### Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

### Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

### Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score