

History of Slip & Fall

Patient's Name: _____ Today's Date: _____
St. Address: _____ City: _____ State/Zip: _____
Phone Home#: _____ Cell#: _____ Work#: _____
Age: _____ Date of Birth: _____ SS#: _____
Date of Accident: _____ Time Occurred: _____ AM/PM Place: _____

Please briefly describe, in your own words, how the accident occurred.

Were there witnesses to your slip and fall? Y / N

Was there a spill or problem with the ground/floor? Y / N Explain: _____

Was the area that the accident occurred occupied by other people? Y / N

Was the area roped/marked off or were signs posted warning people of the hazard? Y / N

If not, were you aware of the hazard prior to the accident? Y / N

Please describe the condition of the ground where you were walking?

What was your pace? (Circle one) Standing Casual walk Fast walk Jogging Running

Other (please explain): _____

What injuries did you sustain? _____

Was an accident report filed after the injury? Y / N

Was an ambulance called to the scene? Y / N

If so, were you transported to the hospital? Y / N Hospital Name: _____

Have you seen any other doctors or healthcare professionals for your injuries? Y / N

If so, who? _____

Have you received any imaging for your injuries after the accident? Y / N

If so, where did you have imaging, and what was imaging performed on? _____

Did you hit your head as a result of the accident? Y / N

Did you lose consciousness? Y / N

As a result of the accident, you felt your symptoms when? (Circle one):

Immediately Within 1 Hour Within 6 Hours
During the Night Next Morning Next Day

Other: _____

As a result of the accident, you have had problems with the following symptoms?

(Circle all that apply):

Headaches Upper Back Pain Mid Back Pain
Low Back Pain Neck Pain Shoulder Pain
Chest Pain/Soreness Stomach Pain/Soreness Numbness/Tingling Extremities
Wrist/Elbow Pain/Soreness Hip/Knee/Ankle Pain/Soreness Loss of Bowel/Bladder Control
Blurred Vision Other: _____

Are you working now? Y / N With restrictions? Y / N List restrictions: _____

Since the accident, how do you feel as of today? (Circle one): Worse No Improvement Better

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Patient History

Name _____ Sex M F Date _____
Address _____ City _____ State _____ Zip _____
H. Phone _____ C. Phone _____ W. Phone _____
Age _____ Date of Birth _____ SS# _____ Referred By _____
Occupation _____ Employer _____

Have you ever received chiropractic care? Yes No If yes, when? _____

1. Chief Complaint(s): _____

Location of Complaint(s): _____

Complaint(s) began when and how? _____

Please circle the quality of the pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does the pain radiate or travel (shoot) to any areas of your body? Y N Where? _____

Do you have any numbness/tingling in your body? Y N Where? _____

On a scale from 1-10, rate the severity of your pain (1-little/no pain) 1 2 3 4 5 6 7 8 9 10 (10-worst pain ever)

How often is the complaint present and how long does it last? _____

Does anything make the complaint worse? _____

Does anything make the complaint better? _____

3. Please list any previous treatments, medications, surgery, interventions, or care you have sought for your complaint:

4. Health History

Previous illnesses you have had throughout your life: _____

Previous history of injuries or traumas (Including falls, broken bones, sprains/strains, automobile accidents, concussions, etc.):

Patient History (Continued)

Patient Name: _____ Date: _____

Please list any medications that you are currently taking:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS - Do you currently have problems in any of the following areas?			
System	Yes No	Date Diagnosed	Condition/Current Treatment/Surgery
Eye disease, eye injury, eye surgery	Yes No		
Constitutional (fever, weight loss, other)	Yes No		
Ears (reduced hearing or hearing loss)	Yes No		
Nose/Mouth/Throat (sinus problems, sore throat)	Yes No		
Cardiovascular (heart disease, hypertension)	Yes No		
Pacemaker/Defibrillator Yes No	Yes No		
Respiratory (breathing problems, lungs, cough)	Yes No		
Gastrointestinal (heartburn, diarrhea, vomiting, GERD, acid reflux)	Yes No		
Neurological (numbness, weakness, stroke, headaches, paralysis,)	Yes No		
Females – Pregnant? / Nursing?	Yes No		
Genitourinary (male or female organ problems, urinary problems, kidneys)	Yes No		
Dialysis	Yes No		
Dermatologic (skin rashes, excessive dryness)	Yes No		
Musculoskeletal (muscle or joint problems)	Yes No		
Arthritis	Yes No		
Diabetes/Thyroid	Yes No		
Allergic/Immunologic	Yes No		
Psychiatric (depression, OCD)	Yes No		
Hematologic (bleeding tendency, anemia)	Yes No		
Cancer (Type):	Yes No		

Please list any major surgeries:

Date	Type of Surgery	Complications? Successful?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Family Health History

Associated health problems of relatives:

Condition	Family Member (i.e. mother, father, sibling, grandparent)
Heart Disease	
Stroke	
Cancer	
Arthritis	
Stroke	
Diabetes	
Other	

6. Social and Occupational History

Marital Status: _____ Children: (How many? Are they healthy?) _____

Education Completed: High School GED Some College College Graduate Post Graduate Studies

Recreational Activities: _____

Diet: Poor Fair Balanced Excessive Restricted. Explain _____

Exercise: 0-1 days per week 2-4 days per week 5+ days per week. What type? _____

Do you use any of the following? Alcohol Tobacco Drug use. If so, How much/often? _____

Stress Level? Low Medium High _____

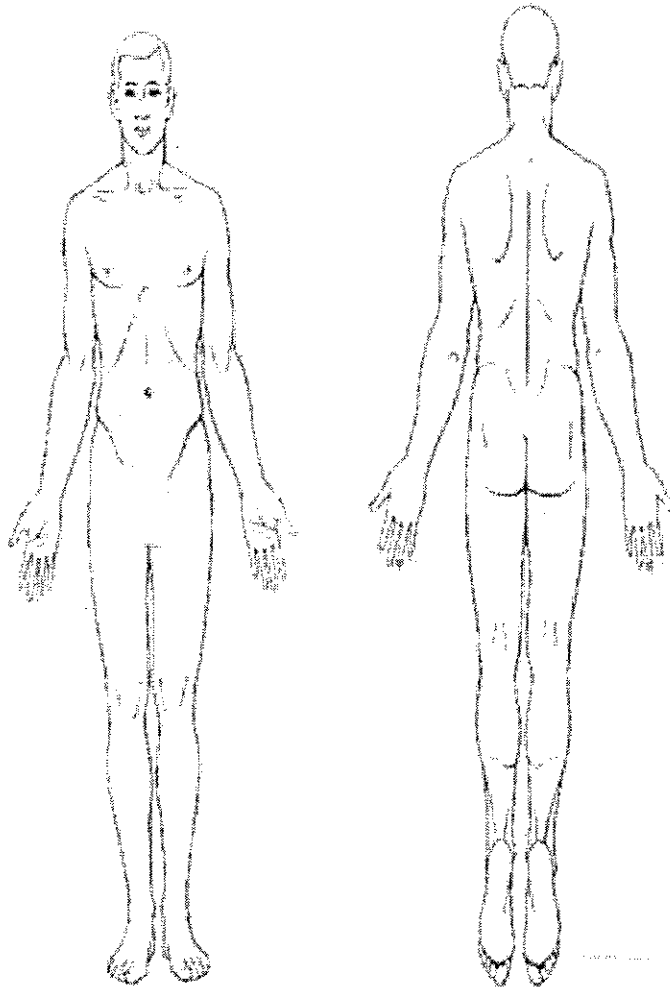
Physical Demands Mild Moderate Heavy Sedentary _____

I have completed and understand the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Port Orange Chiropractic, Inc. to provide me with chiropractic care, in accordance with this state's statutes.

Patient/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Complete the diagram below.
Please shade the area(s) of pain or discomfort.



Patient Name: _____ **Today's Date:** _____

NECK DISABILITY INDEX

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

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

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

SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 - Reading

- I can read as much as I want with no pain in my neck.
- I can read as much as I want with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all due to pain.

SECTION 5 - Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

SECTION 6 - Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7 - Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can not do any work at all.

SECTION 8 - Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

REVISED OSWESTRY INDEX

Name: _____ Date: _____ File #: _____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 - Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderately increasing
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

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

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 - Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- I can stand as long as I want without pain.
- I have some pain standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼.
- Because of pain, my normal night's sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- Pain has restricted my social life and I do not go much.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

SECTION 9 - Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain prevents all forms of travel except done lying down.
- Pain restricts all forms of travel.

SECTION 10 - Changing Degrees of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but slowly improves.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Patient Name: _____ Date: _____

Instructions: These questions ask for your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Unable to work at all*

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Need help with all my personal care*

3. Does your pain interfere with your traveling?
Travel anywhere I like 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Only travel to see doctors*

4. Does your pain affect your ability to sit or stand?
No problems 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Cannot sit / stand at all*

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Cannot do at all*

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Cannot do at all*

7. Does your pain affect your ability to walk or run?
No problems 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Cannot walk / run at all*

8. Has your income declined since your pain began?
No decline 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Lost all income*

9. Do you have to take pain medication every day to control your pain?
No medication needed 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *On pain medication throughout the day*

10. Does your pain force you to see doctors much more often than before your pain began?
Never see doctors 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *See doctors weekly*

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Never see them*

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Total interference*

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Need help all the time*

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression / tension 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Severe depression / tension*

15. Are there emotional problems caused by your pain that interfere with your family, social, and / or work activities?
No problems 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 *Severe problems*

Examiner

- A patient is responsible for reporting to the health care provider whether he/she comprehends a contemplated course of action and what is expected of him/her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he/she is unable to do so for any reason, for notifying the health care facility.
- A patient is responsible for his/her actions if he/she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Florida Patient's Bill of Rights and Responsibilities, Florida Statutes Chapter 391 (026)

*Port
Orange
Chiropractic, Inc.*

*3729 S. Nova Road
Port Orange, FL 32129
James M. Young, D.C.*

*386-761-0520
386-761-0553 (fax)*

Notice of Privacy Practices

****Each health care facility or provider shall observe the following standards:*

Individual Dignity

- The individual dignity of a patient must be respected at all times and during all occasions.
- Every patient who is provided health care services retains certain rights to privacy, which must be respected without regard to the patient's economic status or source of payment for his/her care.
- A patient has the rights to a prompt and reasonable response to a request or question.
- A patient has the right to retain and use personal clothing or possessions as space permits, unless for him/her to do so would infringe upon the right of another patient or is medically or programmatically contraindicated for documented medical, safety, or programmatic reasons.

Information

- A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to that patient.
- A patient has the right to know what patient support services are available within the facility.
- A patient has the right to be given by his/her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or not possible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information as well.
- A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.
- The patient has the right to know what facility rules and regulations apply to patient conduct.
- A patient has the right to express grievances regarding alleged violations of patient's rights. A patient has the right to know the health care provider's or health care facilities procedures for expressing a grievance.
- A patient who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

Financial Information & Disclosure

- A patient has the right to be given, upon request, by the responsible provider, his/her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.
- A health care provider or health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving care accepts assignment under Medicare reimbursement as payment in full for the medical services and treatments received in the health care provider's office or health care facility.
- A health care provider or health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for services.
- A patient has the right to receive a copy of an itemized bill upon request. The patient has the right to be given an explanation of charges upon request.

Access to Health Care

- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, religion, national origin, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide such treatment.
- A patient has the right to access any mode of treatment that is, in his/her own judgment and the judgment of his/her health care practitioner, in the best interests of the patient, including complementary or alternative health care treatments, in accordance with provisions of s. 456.41.

Experimental Research

In addition to the provisions of s. 766.103, a patient has the right to know if medical treatment is for purposes of experimental research and to consent prior to participation in such experimental research. For any patient, regardless of ability to pay or source of payment for his/her care, participation must be a voluntary matter. A patient does have the right to refuse to participate. The patient's consent or refusal must be documented in the patient's care record.

Patient's Knowledge of Rights & Responsibilities

In receiving health care, patients have the right to know and understand what their rights and responsibilities are.

Responsibilities of Patients

- A patient has the right to be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his/her need for privacy.
- A patient has the right to prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his/her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- A patient has the right to know what rules and regulations apply to his/her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, religion, national origin, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his/her rights, as stated in Florida law, through the grievance procedure of the health care provider or facility which served him/her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his/her knowledge, accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, allergies, and other matters relating to his/her health.
- A patient is responsible for reporting unexpected changes in his/her condition to the health care provider.