Hornstein Family Chiropractic

715 Dakota Ave. Suite 2
Wahpeton, ND 58075

Phone: 701-672-1300
Fax: 701-672-1301

hfcfamilywellness@gmail.com

www.hornsteinfamilychiropractic.com

Find us on Facebook

# Confidential Patient Information

Date: _____

First Name: _____ Last Name: _____ MI: ____

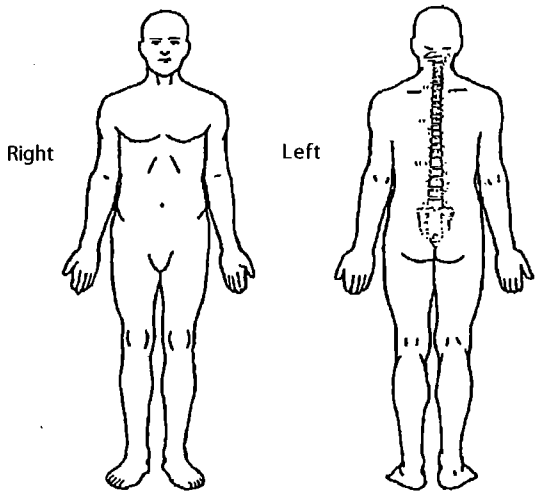
## Major Complaint Information

What is your major complaint(s)? _____

When did this symptom(s) begin? _____

How did this symptom(s) begin? _____

## On the illustrations below, mark the area where you are experiencing pain




Describe the pain:

- ○ Sharp
- ○ Dull
- ○ Numbness
- ○ Tingling
- ○ Achy
- ○ Burning
- ○ Stabbing
- ○ Cramping
- ○ Stiffness
- ○ Swelling
- ○ Other _____

If this is an injury, describe what happened:

_____

_____

_____

_____

On a scale from 1 - 10, how do you feel now? (1 being best, 10 being worst)

1 2 3 4 5 6 7 8 9 10

Have you experienced this before? ○ Yes ○ No When? _____

Did it develop from? ○ Auto Accident ○ Work Related ○ Other: _____

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Does Tylenol, Ibuprofen, or Aspirin help? ○ Yes ○ No If so, how? _____

Does heat affect this? ○ Yes ○ No If so, how? _____

Does cold affect this? ○ Yes ○ No If so, how? _____

Have you seen a doctor for this condition? ○ Yes ○ No Doctor's Name: _____

Date Consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? ○ Yes ○ No If so, how many times do you wake up per night? _____

In what position do you sleep? ○ Back ○ Side ○ Stomach

Do you sleep with a pillow? ○ Yes ○ No If so, how many? _____

Do you wear a heel lift? ○ Yes ○ No If so, which side? ○ Right ○ Left

Does it cause pain to cough, grunt, or sneeze? ○ Yes ○ No If so, where? _____

## Check those injuries below during which you experience difficulty or pain:

___ Lying on back or side
___ Turning over in bed
___ Lying flat on stomach
___ Getting in/out of a car
___ Gripping
___ Dressing self
___ Sexual activity
___ Sleeping
___ Pushing/Pulling
___ Reaching
___ Kneeling
___ Sitting
___ Lifting
___ Crossing legs
___ Walking
___ Standing for long periods
___ Bending forward /backward
Other: _____

## Headaches

Do you get headaches? ○ Yes ○ No How often? _____ Do you have a family history of headaches? ○ Yes ○ No
Do you experience the following along with your headaches: Pain or cracking in your jaw? ○ Yes ○ No
Abnormal blood pressure? ○ Yes ○ No ○ High ○ Low Nausea, Vomiting or Visual disturbance? ○ Yes ○ No
When was your last eye exam by a doctor? ○ 1-6 months ○ 6-12 months ○ 1-2 years ○ over 2 years Results: _____

## Neck Pain

If you have neck pain, does it affect: (check all that apply) ○ hearing ○ vision ○ balance ○ cause ringing in your ears
Do you hear grating or popping sounds? ○ Yes ○ No Do you feel pressure or pain behind your eyes? ○ Yes ○ No
Do you have difficulty lifting or turning your head? ○ Yes ○ No If so, in which direction? ○ Right ○ Left ○ Up ○ Down

## Lower Back Pain

If you have lower back pain, does the pain radiate to your abdomen? ○ Yes ○ No
Do you ever have unexplained loss of bowel or urinary function? ○ Yes ○ No

Have you ever been to a chiropractor before? ○ Yes ○ No Please list:

| Name of chiropractor: | Last Visit Date: | Name of chiropractor: | Last Visit Date: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

List all medications you are taking now, including over the counter medication, and supplement/vitamins:

_____

_____

Are you allergic to any medications: ○ Yes ○ No ○ Not sure Please list: _____
Do you smoke or chew tobacco? ○ Yes ○ No Do you drink any alcohol? ○ Yes ○ No
Any injuries or car accidents? ○ Yes ○ No Please list: _____
Have you ever had any surgeries or hospitalization? ○ Yes ○ No Please list below:

| Type of Hospitalization/Surgery: | Date: | Type of Hospitalization/Surgery: | Date: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Have you been x-rayed in the past? ○ Yes ○ No What Region? _____
If female, are you pregnant? ○ Yes ○ No ○ Not sure If yes, what is your due date? _____
Do you have a family physician? ○ Yes ○ No Name of physician: _____ Date of last physical: _____
Practice physician is located: _____
Have you been treated for any health conditions in the last year? ○ Yes ○ No If yes, explain: _____

_____

## Additional Complaints

Please check all additional complaints that you have at this time:

| | | | | |
|---|---|---|---|---|
| ○ Headache | ○ Neck pain | ○ Sinus trouble | ○ Menstrual difficulties | ○ Diabetes |
| ○ Loss of concentration | ○ Neck stiffness | ○ Nervousness | ○ Nausea | ○ Allergies |
| ○ Eyes sensitive to light | ○ Neck motion restriction | ○ Chest pain | ○ Diarrhea | ○ Hepatitis |
| ○ Memory loss | ○ Upper back pain/stiffness | ○ Shortness of breath | ○ Constipation | ○ Convulsions |
| ○ Heavy feeling of head | ○ Mid back pain/stiffness | ○ Loss of consciousness | ○ Cold hands | ○ Anemia |
| ○ Dizziness | ○ Lower back pain/stiffness | ○ Irritable | ○ Cold feet | ○ Heart disease |
| ○ Ringing in ears | ○ Right/left shoulder pain | ○ Anxiety | ○ Jaw pain | ○ Arthritis |
| ○ Loss of balance | ○ Right/left arm pain | ○ Depression | ○ Cuts | ○ HIV (Aids) |
| ○ Loss of smell | ○ Right/left leg pain | ○ Insomnia | ○ Bleeding | ○ Other (please list) |
| ○ Loss of taste | ○ Pins & needles arms/legs | ○ Fatigue | ○ Broken bones | _____ |
| ○ Pain behind eyes | ○ Numbness | ○ Flushed face | ○ Bruising | _____ |
| ○ Fainting | ○ Swelling | ○ Excessive perspiration | ○ Cancer | _____ |
| ○ Palpitations | ○ Vision problems | ○ Digestive trouble | ○ High blood pressure | _____ |

Do you have, or have you ever had, any diseases or medical problems not listed? ○ Yes ○ No

If so, please list: _____

Do you have a family history of disease or medical problems? ○ Yes ○ No

If so, please list: _____

Any additional information you would like the doctor to know about before beginning care at Hornstein Family Chiropractic?

_____

## Personal Information

Name: _____

Address: _____ City/Sate/Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Birth Date: _____ Age: _____ Gender: ○ Male ○ Female Social Security Number: _____

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

May we call you at work? ○ Yes ○ No Home? ○ Yes ○ No Cell? ○ Yes ○ No

Marital Status: ○ S ○ M ○ D ○ W Spouse's Name: _____

Spouse's Occupation: _____ Spouse's Employer: _____ # of Children: _____

Children's Names: _____

How did you hear about our office? _____

## Emergency Information

Name of Contact: _____ Phone Number: _____

Place of Employment: _____ Phone Number: _____

# Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Hornstein Family Chiropractic to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Hornstein Family Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

**Specific Risk Possibilities Associated with Chiropractic Care.**

**Soreness-** Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort after your treatment.

**Soft Tissue Injury-** Occasionally, chiropractic treatment may aggravate a disc injury or cause other minor joint, ligament, tendon or other soft tissue injury.

**Rib Injury-** Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

**Physical Therapy Burns-** Heat generated by physical therapy may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor or a staff member at Hornstein Family Chiropractic.

**Stroke-** is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Col. 37 No.2, Jun 1993) estimates that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments

**Other Problems-** There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature: Date:

I, as parent/legal guardian, give my informed consent for my child/minor to have chiropractic treatment administered.

Parent/Legal Guardian signature: Date:

Hornstein Family Chiropractic
715 Dakota Avenue, Suite 2 – Wahpeton, ND 58075 – 701-672-1300

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient _____ Date _____

**IF THE PATIENT IS A MINOR THE PARENT MUST SIGN ABOVE!**

# Hornstein Family Chiropractic

Dr. Andrea L. Hornstein 715 Dakota Avenue, Suite 2 – Wahpeton, ND 58075 Ph: 701-672-1300

## X-RAY CONSENT FORM

Patient: _____ Date: _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required prior to the administration of treatment.

*In order to perform x-rays on any patient, our office requires that patient's consent for such tests.*

**Please Choose One:**

The doctor has explained that the purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic 'unusual finding' when reviewing this x-ray, I will be informed. Then I must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

_____ I understand that my doctor may need x-rays in order to diagnose my condition and **I give permission** for the administration of these diagnostic tests.

_____ I understand that my condition may require my doctor to take x-rays to further diagnose my symptoms. I choose **NOT** to have any x-rays at this time and release my doctor of all liabilities as a result of this choice.

**Signature:** _____ **Date:** _____

**FEMALES ONLY:**

I understand that if I am pregnant and have x-rays taken which may expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exams.

With those factors in mind, I am advising my doctor that:

| | | | |
|---|---|---|---|
| I am pregnant | _____ Yes | _____ No | _____ Do not know |
| I could be pregnant | _____ Yes | _____ No | _____ Do not know |
| I have an IUD | _____ Yes | _____ No | |
| I have had a tubal legation | _____ Yes | _____ No | |
| I have had a hysterectomy | _____ Yes | _____ No | |
| I have irregular menstrual periods | _____ Yes | _____ No | |
| My last menstrual period began on _____ | | | |
| I have begun menopause | _____ Yes | _____ No | |

_____ This is to certify that to the best of my knowledge I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

**Signature:** _____ **Date:** _____

# 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

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.

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

*Neck Index Score* _____

# 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

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.

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

*Back Index Score*