

#

REGISTRATION FORM

Date: _____

Name _____ SS: _____

Home Phone _____ Mobile (Cell) Phone _____

Address _____ City/State _____ Zip _____

Age _____ Birth Date _____ Marital Status M S W D

Email _____ How Many Children? _____

Occupation _____ Employer _____

Address _____ City/State _____ Zip _____ Phone _____

Name of Spouse _____ Occupation _____

Patient's Nearest Relative _____ Address _____

City/State _____ Zip _____ Phone _____

Referred by: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this healthcare office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this healthcare office will be credited to my account upon receipt. However, I clearly understand and agree that any services rendered me and charged directly to me and that I am personally responsible for payment. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

_____ Initials

Please Hand the Front Desk Personnel a Copy of Your Insurance Card

Patient's Signature _____ Date ___/___/___/

Name _____ Date _____ Chart _____

ACCIDENT INFORMATION (Fill out completely, if does not apply put N/A)

Please describe the collision in your own words? _____

Where did the collision occur? **City/Town:** _____ **State:** _____

Date of collision: ___/___/___/ **Time:** _____ AM / PM

Were you the: **Driver** **Passenger** **Pedestrian**

What type of vehicle were you in? _____ What type was the other vehicle? _____

Was there a second impact? If so Explain _____

Was the impact from: **Front** **Rear** **Left Side** **Right Side**

What was the approximate speed at the time of impact? **Your Vehicle** _____ mph **Other Vehicle** _____ mph

How much damage was there to the outside of the vehicle? **None** **Some** **Major**

Were you wearing a seat belt? **Yes** **No**

Does your vehicle have an airbag? **Yes** **No** Did it deploy? **Yes** **No**

Immediately after the accident, where did you experience pain? **Be specific:** _____

Immediately after the accident were you: **conscious** **dazed** **unconscious**, if so how long? _____

Were you surprised by the impact? **Yes** **No**

Did you go to the hospital? **yes** **no** **If yes, how did you get there?** _____

If you went to the hospital or saw another doctor, please answer the following?

Hospital Name _____ **Doctor Name** _____

Diagnosis _____ **Treatment Received** _____

Tests _____

Have you retained an attorney? **Yes** **No** **Litigation?** **Yes** **No** **Maybe**

If yes, please give name and address: _____

Patients Signature _____ **Date** ___/___/___/

Name _____ Date _____ ID# _____

Describe your symptoms:

How did your symptoms begin? _____

Are your symptoms : Improving Getting Worse Same

RELEVANT MEDICAL HISTORY (Check if you have had in the past or present)

<input type="checkbox"/> Arthritis/Osteoporosis	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Psychological problems
<input type="checkbox"/> Asthma/Sinus trouble	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Neck pain or spasms
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hand or wrist pain	<input type="checkbox"/> Neuritis/Numbness/Neuro disorders
<input type="checkbox"/> Back pain/Sciatica	<input type="checkbox"/> Headaches	<input type="checkbox"/> Thyroid or menstrual problems
<input type="checkbox"/> Concussion/Dizziness	<input type="checkbox"/> Hepatitis/Measles/T.B.	<input type="checkbox"/> M.S./Muscular dystrophy
<input type="checkbox"/> Digestion problems	<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/Aids/Blood infections	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Heart	<input type="checkbox"/> Cancer	<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Gout	<input type="checkbox"/> Healing	<input type="checkbox"/> Frequent infections
<input type="checkbox"/> Kidneys	<input type="checkbox"/> Skin	<input type="checkbox"/> Liver
<input type="checkbox"/> Lungs	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bladder
<input type="checkbox"/> Hormones	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Deep vein thrombosis

Do you have any artificial joints? Hip Yes ___ No ___ Knee Yes ___ No ___ Other? _____

Do you have a Heart Valve Implant? Yes _____ No _____

FAMILY HISTORY:

	Diabetes	Cancer	Heart	Lung	Thyroid	Living	Deceased	Cause
Mother								
Father								
Brother								
Sister								

Is there a family (blood relative) history of:

- Flatfeet
- Arthritis
- Stroke
- Bunions
- Diabetes
- Heart Disease
- Bleeding disorder
- Neurological disorder
- Hammertoes
- Circulation problems

SOCIAL HISTORY:

- Smoking history:**
- never smoked
 - quit (how long ago _____)
 - Smoke _____ pks/day for _____ yrs
- Alcohol History:**
- Never used
 - Have _____ drinks/week
 - have drank alcohol for _____ yrs

ADDITIONAL HISTORY:

Previous surgeries or hospital stays; Any recent exposures to communicable diseases or other concerns:

Instructed to see PCP

Allergies to Medications: _____

Have you been treated for any health conditions in the past year?

Have you ever seen a chiropractor? Yes No If yes, who? _____

For Podiatry patients; Shoe Size? _____

Additional Information:

Patients Signature _____

Date ____ / ____ / ____

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

- Ⓐ 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 moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

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 sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit 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 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while 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 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do 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 increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases 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.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes 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 off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

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 cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

Changing degree 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 improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓟ 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

- 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

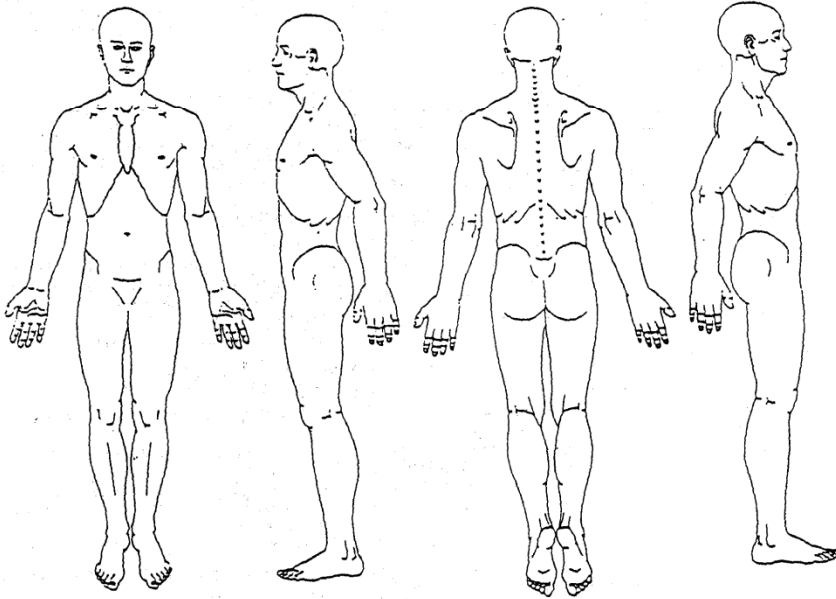
PAIN DRAWING

DATE _____

NAME _____

Using the following descriptive symbols, draw the location of your pain on body outlines below.
In addition, mark the level of your pain on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
///	====	0000	/////	XXXX
\\	===	00	/////	XXX



No Pain

Worst Possible Pain

Please make a slash through this line as to the level of your pain.

Patient Signature

(Over)