E'town Chiropractic Center

Confidential Patient Information

In order for us to understand your health problem properly, please complete this form neatly, accurately, and completely. Thank you.

Date_____________________ Email______________________ cell#_______________________

Name_____________________________ SS#__________________ Home#________________

Street____________________________ City__________________________ Zip______________

Age_______ Birth date_________________ Marital status S M W D # Children______________

Occupation______________________________ Employer __________________________________

Address ________________________________ Office phone _______________________________

Name of spouse__________________________ Occupation__________________________________

Employer_______________________________ Contact # __________________________________

Other Nearest Relative ____________________ Contact #__________________________________

Heard about our office through? ____

Is this injury do to a work injury? Y N Is this injury do to auto accident? Y N

List present complaints:

1 ______________________________________

2 ______________________________________

3 ______________________________________

4 ______________________________________

5 ______________________________________

Details of any accident/injury and when began:

____

____

____

____

____

List other doctors consulted for present complaints and injuries:

Name: ____ When consulted ____________________

Diagnosis_____________________________________ Treatment _________________________

How long was treatment _________________________Results ____________________________

Name: ____ When consulted ____________________

Diagnosis_____________________________________ Treatment _________________________

How long was treatment _________________________Results ____________________________

Family Doctor ___________________________________ Date last seen ______________________

Please circle any of following conditions:

Pacemaker Cancer Skin Eruptions Heart Condition Epilepsy Pregnant Nerve Damage

Metal Implants: location_________________ Recent surgery: location ______________________

What surgeries have you had

Type/When/Doctor/Remarks ______________________________

____

____

List former serious accidents and falls: (auto, work, home, leisure, sports, other - circle one)

What/When/Symptoms/Treatment/Results ______________________________

____

____

List broken bones:

What/When/Remarks ______________________________

____

____

List medications and/or diet supplements you take:

What/Frequency/Doctors/Side Effects/Remarks ______________________________

____

____

Environment

Work - (Please circle appropriate answer)

Seated/Standing - Work Bench/Desk/Counter/Other ______________________________

Job involves - Lifting/Bending/Stooping/Twisting/Turning/Carrying/Walking/Standing/Other ______________

Chair - Executive/Steno/Bench/Stool/Folding/Other ______________ Shoes - High heels/Boots/Other ______________

Leisure

Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe) ______________

____

Strenuous activities? Exercise - Type/Frequency/Length of time? ______________________________

____

Sports - Type/Frequency/Length of time? ______________________________

If you have discontinued sports or strenuous activities, why the change? ______________________________

Exert Yourself - Frequently/Occasionally/Rarely/Never? Describe how? ______________________________

____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes ☐ No ☐

Patient Health Questionnaire - PHQ

ACN Group

ACN Use Only rev 9/11/2002

Patient Name ______________________ *Date* ______________________

1. Describe your symptoms ______________________

____

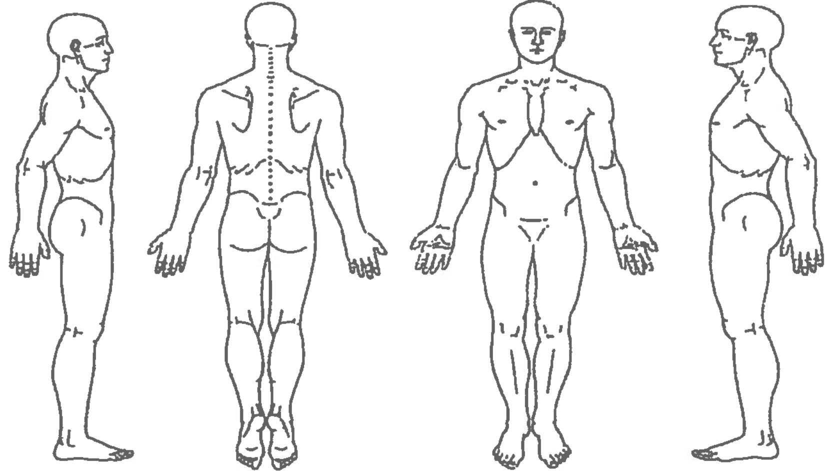
a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? *(like visiting with friends, relatives, etc)*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* __________ ③ CT Scan *date:* __________
② MRI *date:* __________ ④ Other *date:* __________

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature ______________________ *Date* ______________________

All the information that I have provided is true and factual to the best of my knowledge.

Signature ______________________________ Date ______________________________

FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, 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, against the Doctor's recommendation, my account balance will be immediately due and payable. I also agree to pay any and all expenses the Doctor may incur for the collection of my account.

Patient's Signature ______________________ S.S. # ______________________ Date ______________________

Other Responsible Party ___ ______________________ S.S. # ______________________ Information taken by ______________

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

______________________________ , hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a post card mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and necessary for the Practice to conduct specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________ ______________________________
Name of Individual (Printed) Signature of Individual

______________________________ ______________________________
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

______________________________ ______________________________
Date Signed Witness

E'town Chiropractic Center, 620A Westport Rd., Elizabethtown, KY. 42701
270-769-9844

Kentucky State Law requires healthcare providers to obtain your **INFORMED CONSENT** prior to examination and treatment. The purpose of this form is to inform you, not alarm you. What you are being asked to sign is confirmation that you have been informed of the following:

Examination & X-rays: this office uses highly sensitive x-ray film, intensifying screens, and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only noteworthy risk with taking x-rays deals with pregnancy. If there is any possibility that you are pregnant, inform us prior to any x-ray examination. If there is no possibility of this condition, the inherent risks are so rare that we have no available statistics to quantify their probability.

PLEASE CIRCLE ONE AND INITIAL: I AM / I AM NOT pregnant at this time / Does Not Apply Initial: _____

****

Chiropractic Adjustment/ Chiropractic Manipulative Therapy (CMT): The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, which is not cause for alarm. **There are some material risks involved in doing these procedures as they are as follows:**

-Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

-Rib Fractures: Fractures caused by chiropractic care are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate, gentle treatments are used, minimizing the possibility of fractures to the ribs.

-Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatment may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury *about 1 serious complication per 100 million low back manipulations* (2).

- Vertebral Artery Dissection (VAD)/Stroke: The overall incidence of vertebral artery dissection leading to stroke in the general population is about *2 per 1000 people* (3). Although chiropractic adjustments/manipulation has been implicated as a possible cause of stroke, this possibility is very rare. The best available data suggests that a stroke is secondary to chiropractic adjustment/manipulation may occur 1 per 500,000 patients (4)-a rate well below the overall risk in the general population. In comparison, the overall risk of death from taking non-steroidal anti-inflammatory drugs (i.e. Aspirin, Ibuprofen, Naproxen Sodium, etc.) is 4 per 10,000 patients (5). The risk of serious complications or death from spine surgeries of the neck is 11.25 per 1,000 patients (5). As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and tests that will likely reduce the potential for stroke even more.

-This list is of side-effects is not exhaustive and there could be other negative side-effects of various treatments rendered in this office.

Initial: _______

I understand the risks and possible negative side effects of Chiropractic Care, Massage Therapy, and other therapeutic modalities and treatments at E'town Chiropractic Center that are involved in my treatment, and I have had the chance to ask questions of the doctor and staff regarding these procedures and make an informed decision in the treatment of my condition(s). By initialing these sections and signing this statement I authorize Dr. Tindall and any or all members of E'town Chiropractic Center staff to treat me using the method designed by Dr. Tindall.

Chiropractic is a second largest system of health delivery. As with any health care delivery system, we cannot promise a cure for any system, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

DATE: ____/_____/______

PATIENT SIGNATURE: ___________________________________ SS# _____/____/______

WORKER'S COMPENSATION INJURY QUESTIONNAIRE

Please Print:

Name:______________________________________ Date:_______________

Employer's Business Name at time of Accident:________________________________

Employer's Phone:_______________ Employer's Address___________________________

Occupation:____
❑Yes ❑No Previous Worker's Compensation Injury? Impairment Rating:_______________

Length of time at this job prior to injury:_____________________________________
Date of Injury:_______________ Time of injury:__________ Last Date Worked:__________

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying standing, etc.)_______________________________________
____
____

When did the pain begin?(please be specific)_____________________________________

Where did you first feel it?(please be specific)___________________________________

Was the pain intense at first or did it gradually worsen?___________________________

REPORT ACCIDENT/ACCIDENT OBSERVER

What date did you report this injury on?_______________________________________

Who did you report this injury to?____________________ Position?_______________

Did anyone else observe accident/injury? ❑Yes ❑No If yes, Name:___________________
Position:___________________

SYMPTOMS FROM ACCIDENT

Did you experience bleeding cuts or bruises? ❑Yes ❑No
If bleeding cuts where?____________________ If bruises, where?_____________________

Please describe how you felt. PLEASE BE SPECIFIC.
Immediately after the accident:____
Later that ❑Day ❑Night:____
The next day(s):____
____

Check symptoms that have become apparent since the accident/injury:

❑Nervousness
❑Neck Pain/Stiffness
❑Midback Pain
❑Low Back Pain
❑Eyes sensitive to light
❑Pain behind eyes
❑Dizziness
❑Cold sweats
❑Face flushed
❑Ringing/Buzzing Ears
❑Loss of balance
❑Loss of smell
❑Loss of taste
❑Loss of memory
❑Pins & Needles - Arms
❑Pins & Needles - Legs
❑Shortness of breath
❑Head seems too heavy
❑Irritability
❑Depression
❑Sleeping trouble
❑Toe Numbness
❑Finger Numbness
❑Cold Hands
❑Cold Feet
❑Chest Pain
❑Constipation
❑Diarrhea
❑Fatigue
❑Tension
❑Fever
❑Headache
❑Fainting
❑Anxiety
❑Seizures
❑Visual disturbance
❑Forgetfulness
❑Blurred Vision
❑Double Vision
❑Confused
❑Disoriented
❑Other__________

WORK STATUS HISTORY:

❑Yes ❑No Have you lost time from work as a result of this new injury? If yes, please give dates:____

____

❑Yes ❑No Have you gone back to work? When:_______________________________

If yes, status or work: ❑Modified ❑Regular

List restrictions you have been placed on:_______________________________

If you have gone back to work, list activities that are:

PAINFUL:_______________________________

DIFFICULT:_______________________________

❑Yes ❑No If you are currently on disability (time loss), do you want to go back to work doing your regular job? If no, why not?_______________________________

❑Yes ❑No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain:_______________________________

____

FIRST DOCTOR/HOSPITAL/CLINIC:

❑Yes ❑No Were you hospitalized as a result of this accident? If yes, where:___________________

Doctor 1 Name:_______________________________ Date of First Visit:___________________

❑Yes ❑No Were you examined? ❑Yes ❑No Were X-rays taken?

What diagnosis did the doctor give you?_______________________________

❑Yes ❑No Were you given treatment? If yes, what type?_______________________________

What benefits did you receive from this treatment?_______________________________

____

Date of last treatment?_______________________________

❑Yes ❑No Did the doctor refer you to another health professional? If yes, to whom and for what?___

____

❑Yes ❑No Did you follow the doctor's recommendation? If no, why not?___________________

____

SECOND DOCTOR/CLINIC:

Doctor 2 Name:_______________________________ Date of First Visit:___________________

❑Yes ❑No Were you examined? ❑Yes ❑No Were X-rays taken?

What diagnosis did the doctor give you?_______________________________

❑Yes ❑No Were you given treatment? If yes, what type?_______________________________

What benefits did you receive from this treatment?_______________________________

____

Date of last treatment?_______________________________

PRIOR SIMILAR SYMPTOMS:

❑Yes ❑No Did you have any physical complaints just before the accident? If yes, please describe in detail:_______________________________

____

❑Yes ❑No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? If yes, what part was previously injured?___________________

___________________________ Date previously injured?___________________

Describe previous injury:_______________________________

❑Yes ❑No Were you treated? By whom?_______________________________

Date treatment began:___________________ Date treatment ended:___________________

The last date you felt pain or problems from that previous injury:___________________

CURRENT SYMPTOMS:

Neck: ❑ N/A ❑constant ❑ intermittent mild moderate severe
❑sharp ❑dull ❑ache ❑burning ❑stiff ❑catch ❑ sore ❑ throbbing
❑other_______________
headches ❑Y ❑N how often?__________ where__________
left arm ❑ constant ❑ intermittent
❑ tingling ❑numbness ❑pain ❑ throbbing ❑ shooting ❑ weakness
right arm :❑ constant ❑ intermittent
❑ tingling ❑numbness ❑pain ❑ throbbing ❑ shooting ❑ weakness
left hand: ❑ constant ❑ intermittent
❑ tingling ❑numbness ❑pain ❑ throbbing ❑ shooting ❑ weakness
right hand: ❑ constant ❑ intermittent
❑ tingling ❑numbness ❑pain ❑ throbbing ❑ shooting ❑ weakness
worse when : ❑ *flexing* ❑*extending* ❑*rotation* ❑left ❑right ❑reading ❑ lifting
❑other_______________
better when : ❑heat ❑ice ❑rest ❑massage ❑stretching ❑exercise
❑other_______________

notes:_______________

____

Mid back : ❑ N/A ❑constant ❑ intermittent mild moderate severe
❑sharp ❑dull ❑ache ❑burning ❑stiff ❑catch ❑ sore ❑ throbbing
❑other_______________
worse when : ❑ flexing ❑extending ❑rotation ❑left ❑right ❑reading ❑ lifting
❑other_______________
better when : ❑heat ❑ice ❑rest ❑massage ❑stretching ❑exercise
❑other_______________
notes:_______________

____

Low Back: ❑ N/A ❑constant ❑ intermittent mild moderate severe
❑sharp ❑dull ❑ache ❑burning ❑stiff ❑catch ❑ sore ❑ throbbing
❑other_______________
worse when : ❑ flexing ❑extending ❑rotation ❑left ❑right ❑reading ❑ lifting
❑other_______________
better when : ❑heat ❑ice ❑rest ❑massage ❑stretching ❑exercise
❑other_______________
notes:_______________

____
left leg: ❑ constant ❑ intermittent
❑ tingling ❑numbness ❑pain ❑ throbbing ❑ shooting ❑ weakness
right leg: ❑ constant ❑ intermittent
❑ tingling ❑numbness ❑pain ❑ throbbing ❑ shooting ❑ weakness
left foot: ❑ constant ❑ intermittent
❑ tingling ❑numbness ❑pain ❑ throbbing ❑ shooting ❑ weakness
right foot: ❑ constant ❑ intermittent
❑ tingling ❑numbness ❑pain ❑ throbbing ❑ shooting ❑ weakness

E’town Chiropractic Center
620 A Westport Road
Elizabethtown, KY 42701

Dean Tindall, DC, DCP, DABCO

WORKMEN'S COMPENSATION PATIENT GUIDELINE

I, ____________________________ agree to hereby be treated by E’town Chiropractic Center for injuries sustained on __________________ while under the employement of ___________________________for a workmen's compensation injury.

I hereby further agree to maintain and cooperate with Dr. Dean W. Tindall’s recommendations for the care of this injury.

In the event of any excessive missed appointments without notification to E’town Chiropractic Center, Dr. Tindall should assume that I have reached a point of stabilization and symptomatic relief and therefore, can notify my company, insurance agent, insurance carriers, and lawyers that he is no longer treating me and I can return to work immediately, without restrictions.

I hereby further agree upon such notifications by Dr. Tindall's office to my employer and/or attorney and/or insurance carriers, I agree to pay upon demand, all bills incurred, for my treatment to date, at E’town Chiropractic Center, in full.

I clearly understand that all past , present and future bills incurred at E’town Chiropractic Center are my responsibility for payment and I agree to pay all bills upon demand.

_______________________________ _____________________
PATIENT DATE

_______________________________ _____________________
WITNESS DATE wcg.doc

The Disability Index (for low back pain/ dysfunction)

Patient Name: ____________________________ File: __________ Date: __________

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ I 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 severe and does not vary much.

SECTION 2-PERSONAL CARE

- ☐ 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 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.

SECTION 3-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, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are positioned on the floor.
- ☐ 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 that one 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.

SECTION 5-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 one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ pain prevents me sitting more than 10 minuets.
- ☐ I avoid sitting because it increases pain right away.

The Disability Index (for low back pain/ dysfunction) (cont.)

SECTION 6-STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on 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 minuets without increasing pain.
- ❑ I avoid standing because it increases the pain right away.

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 1/4.
- ❑ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ❑ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ❑ 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 my more energetic interests, e.g., dancing, etc.
- ❑ Pain has restricted my social life and do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of pain.

SECTION 9-TRAVELLING

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling, but none of my usual forms of travel make it any 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 restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

SECTION 10-CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates, but is definitively getting better.
- ❑ My pain seems to be getting better, but improvements is slow at present.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

Pain Scale:
Rate the Severity of your pain by marking one box on the following scale

No Pain	0	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

SCORE:______________________

Name________________________________ Date ________________ Age ________

Sex: M / F

Job Demands Questionnaire

Job Title____________________________ Number of Years Employed______________

1. How many hours per week do you usually work on this job?_____

2. Work postures: For <u>this</u> job, fill in the hours per day that you usually work in the following postures.

	Max. at 1 Time	Total Hours
-Sitting down (office, car, truck, etc.)	_______	_______
-Standing (at a counter, at a machine, etc.)	_______	_______
-Walking while carrying less than 20 pounds	_______	_______
-Walking while carrying more than 20 pounds	_______	_______

3 How often do you have to kneel or crawl in your work?

( )	( )	( )	( )	( )
NOT AT ALL (never)	RARELY (less than 1/10 of the time)	OCCASIONALLY (less than 1/3 of the time)	FREQUENTLY (1/3 to 2/3 of the time)	CONSTANTLY (more than 2/3 of the time)

4. How often do you have to lie down (for example, as an auto mechanic) in your work?

( )	( )	( )	( )	( )
NOT AT ALL (never)	RARELY (less than 1/10 of the time)	OCCASIONALLY (less than 1/3 of the time)	FREQUENTLY (1/3 to 2/3 of the time)	CONSTANTLY (more than 2/3 of the time)

5. How often do you have to squat or remain bent or twisted at the hips in your work?

( )	( )	( )	( )	( )
NOT AT ALL (never)	RARELY (less than 1/10 of the time)	OCCASIONALLY (less than 1/3 of the time)	FREQUENTLY (1/3 to 2/3 of the time)	CONSTANTLY (more than 2/3 of the time)

6. How often do you do work which caused vibrations to your whole body?

( )	( )	( )	( )	( )
NOT AT ALL (never)	RARELY (less than 1/10 of the time)	OCCASIONALLY (less than 1/3 of the time)	FREQUENTLY (1/3 to 2/3 of the time)	CONSTANTLY (more than 2/3 of the time)

7. Do you have to operate a foot pedal?

( )	( )	( )	( )	( )
NOT AT ALL (never)	RARELY (less than 1/10 of the time)	OCCASIONALLY (less than 1/3 of the time)	FREQUENTLY (1/3 to 2/3 of the time)	CONSTANTLY (more than 2/3 of the time)

8. On this job, how often do you lift:

	not at all (never)	rarely (less than 1/10 of the time)	occasionally (less than 1/3 of the time)	frequently (1/3 to 2/3 of the time)	constantly (more than 2/3 of the time)
10 to 20 lbs.	( )	( )	( )	( )	( )
20 to 50 lbs.	( )	( )	( )	( )	( )
50 to 100 lbs.	( )	( )	( )	( )	( )
More than 100 lbs.	( )	( )	( )	( )	( )

9. On this job, how often do you carry:

	not at all (never)	rarely (less than 1/10 of the time)	occasionally (less than 1/3 of the time)	frequently (1/3 to 2/3 of the time)	constantly (more than 2/3 of the time)
10 to 20 lbs.	( )	( )	( )	( )	( )
20 to 50 lbs.	( )	( )	( )	( )	( )
50 to 100 lbs.	( )	( )	( )	( )	( )
More than 100 lbs.	( )	( )	( )	( )	( )

10. How often do you jump from one level to another? (For example, jumping down from a truck cab or from a loading dock.)

( )	( )	( )	( )	( )
NOT AT ALL (never)	RARELY (less than 1/10 of the time)	OCCASIONALLY (less than 1/3 of the time)	FREQUENTLY (1/3 to 2/3 of the time)	CONSTANTLY (more than 2/3 of the time)

11. About how often per day do you climb a flight of steps on this job?

( )	( )	( )	( )	( )
NOT AT ALL (never)	RARELY (less than 1/10 of the time)	OCCASIONALLY (less than 1/3 of the time)	FREQUENTLY (1/3 to 2/3 of the time)	CONSTANTLY (more than 2/3 of the time)

12. Five ratings of physical demands are described below. Please mark the one which best describes your job.

Sedentary	Sometimes I stand or walk, but I sit down most of the time. Occasionally, I lift up to a 10 pound load.
Light	Any of the following may apply: -I walk or stand more than one third of the time -I often lift up to 10 pounds, sometimes up to 20 -I sit down, but often work foot pedal
Medium	I often lift up to 20 pounds, or sometimes up to 50 pounds.
Heavy	I often lift up to 50 pounds, or sometimes up to 100 pounds.
Very Heavy	I often lift over 50 pounds, or sometimes over 100 pounds.

Functional Assessment

This is a functional assessment questionnaire that is important to determine how your current health condition is affecting your daily life. Please fill out this form as accurately as you can.

Pain level: 0-10, 0-no pain—10 unbearable pain: **Rating: ________**

In the space by each activity, write the number that corresponds with the level of restriction.

(0) No difficulty, (1) Mild difficulty, (2) Moderate difficulty, (3) Severe difficulty, (4) Can Not Do, (5) N/A

Sleep: _____
Drive a car: _____
Recreation: _____
Lifting 10-25 lbs.:_____
Lifting 50+ lbs.:_____
Static standing:_____
Overhead reaching: _____
Pet care: _____
Computer use: _____
Climb stairs: _____
Carry groceries:_____
Household chores: _____
Yard work: _____
Caring for family: _____
Going down stairs: _____

Self-Care- Dress, bath, shave, etc.:_____
Job Performance: _____
Lifting 0-10 lbs.: _____
Lifting 25+ lbs.: _____
Walking: _____
Kneeling (e.g. weed garden): _____
Changing positions from sit to stand: _____
Reading: _____
Feeding/eating: _____
Sexual activities: _____
Static sitting: _____
Lifting children: _____
Bending to tie/put on shoes: _____
Getting into/out of car: _____

______________________________ Patient Signature

______________________________ Date

E'town Chiropractic & Naturopatic Center

Dean W. Tindall, DC, ND, DABCO
620A Westport Road
Elizabethtown, Ky. 42701
270-769-9844

Assignment of Payment

Patient ____

Address ____

Attorney ____

Insurance Carrier ______________________________________

Policy Number ____

My attorney and/or insurance company are hereby requested and authorized to pay directly to: Dean W. Tindall, DC, DCP, DABCO any monies due to him on account, paid first by the paying insurance carrier, with any remaining balance to be paid for out of settlement made on my behalf.

Further, I agree to pay Dean W. Tindall, DC, DCP, DABCO the difference, if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay Dean W. Tindall, DC, DCP, DABCO the full amount of his charges, should my condition be such that it is not covered by my policy, or for any reason the insurance carrier refuses to cover the claim.

Dated at: E'town Chiropractic Center-Elizabethtown, Kentucky

This______________day of _____________________________,20___

Witness____

____

Signature of Patient

E'town Chiropractic & Naturopatic Center

Dean W. Tindall, DC, ND, DABCO
620A Westport Road
Elizabethtown, Ky. 42701
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Dated at: E'town Chiropractic Center-Elizabethtown, Kentucky

This______________day of ____________________________,20___

Witness____

____

Signature of Patient