CASE HISTORY INFORMATION

FIRST NAME: _____ M:I_____ LAST:_____ DOB: ___/___/_____ AGE: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

DAYTIME PHONE #:_____ EVENING PHONE #: _____

EMAIL: _____ PRIMARY DOCTOR: _____

PRESENT COMPLAINTS: _____

_____

MARITAL STATUS: M S W D REFERRED BY: _____

CURRENTLY MY PAIN IS: ☐ MINIMAL ☐ SLIGHT ☐ MODERATE ☐ SEVERE

PLEASE ANSWER THE FOLLOWING QUESTIONS

	YES	NO		YES	NO
1. Do you have a tendency to faint?	☐	☐	10. Do you have headaches?	☐	☐
2. Do you bleed easily?	☐	☐	11. Do you have excessive thirst?	☐	☐
3. Do you have high blood pressure?	☐	☐	12. Are you doing any therapies now?	☐	☐
4. Do you have respiratory problems?	☐	☐	13. Are you taking medications/drugs/herbs?	☐	☐
5. Do you sweat a lot?	☐	☐	14. Are you hungry at present time?	☐	☐
6. Do you bruise or discolor easily?	☐	☐	15. Are you feeling exhausted at present time?	☐	☐
7. Do you have/ever had hepatitis?	☐	☐	16. Do you have bowel problems?	☐	☐
8. Do you sleep well?	☐	☐	17. Are you allergic to anything?	☐	☐
9. Kidney/bladder/liver/gallbladder trouble?	☐	☐	18. (FEMALES) Are you currently pregnant?	☐	☐

PLEASE EXPLAIN: _____

_____

_____

PLEASE MARK IF YOU HAVE EXPERIENCED PROBLEMS WITH THE FOLLOWING:

☐ Allergies
☐ Ears
☐ Nose, Mouth, Throat
☐ Heart
☐ Lungs/Respiratory
☐ _____

☐ Intestines/Colon
☐ Gynecology
☐ Urinary
☐ Fibromyalgia
☐ Asthma
☐ _____

☐ Heart
☐ Muscles
☐ Blood
☐ Psychological
☐ AIDS/HIV
☐ _____

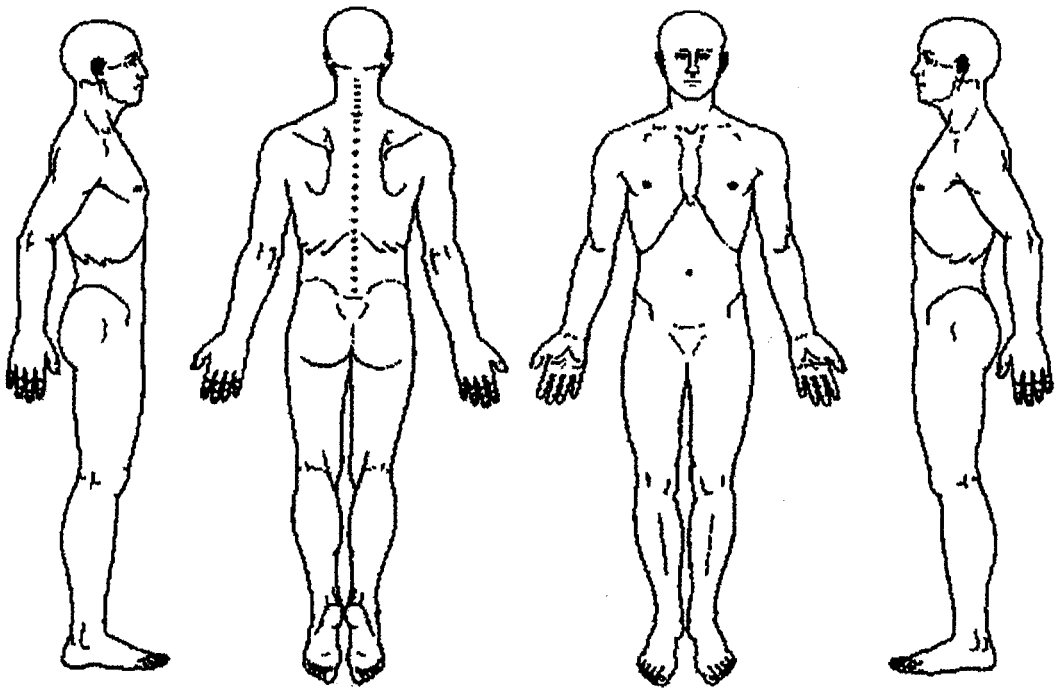
FAMILY HEALTH HISTORY:

Health status of family members (please explain if deceased): _____

_____

_____

Please mark in the diagram any areas where you have or discomfort.



CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I, the undersigned, do hereby request and consent to the performance of acupuncture treatment and other Oriental medicine procedures. The methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, Gua Sha, electrical stimulation, infrasonic AGM, Japanese shiatsu, Chinese or Western herbal medicine, and nutritional counseling. I have been informed that acupuncture is a safe method of treatment, but occasionally, there may be bruising or tingling near the needling sites that last a few days. There may be some bruising after cupping and Gua Sha. The herbs and nutritional supplements which may be recommended are traditionally considered safe in the practice of Chinese medicine. I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock and convulsions.

I have been advised that only sterilized needles will be used. All acupuncture needles are made in Japan, and properly disposed of after each and every treatment.

I do not expect the doctor to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her in my best interests.

By signing below, I agree to the above procedures, I intend this consent to cover the entire course of treatment for my present conditions.

Patient's Signature: _____ Date: _____/_____/_____

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Patient: _____

Please review the below-listed diseases and conditions and indicate those that are recurrent health problems of a family member. Leave blank those that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar environments.

CONDITION	FATHER Age( )	MOTHER Age( )	SPOUSE Age( )	BROTHER(S) Age( ) Age( )		SISTER(S) Age( ) Age( )		CHILDREN Age( ) Age( ) Age( )		
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problem										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____

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

① 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

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 _____

WAGNER CHIROPRACTIC CENTER

3778 UNION STREET

LAFAYETTE, INDIANA 47905

ACUPUNCTURE CANCELLATION POLICY

In order to provide the best care to all of our patients, Wagner Chiropractic Center requires 24-hour notice of cancellation of all acupuncture services. **Without notice, the possible fees are as follows:**

30 Minute Acupuncture: $25.00	Pediatric Acupuncture: $17.50
60 Minute Acupuncture: $45.00	Cupping: $25.00

Signature: _____ Date: _____