WELCOME TO OUR OFFICE

COVE FREEDOM
CHIROPRACTIC

MEDHUB
PERSONAL INJURY

SYMPTOMS QUESTIONAIRE

Patient Name: ______________________ ☐ **Initial Visit** ☐ **Subsequent visit**

Please tell us about your symptoms: ____

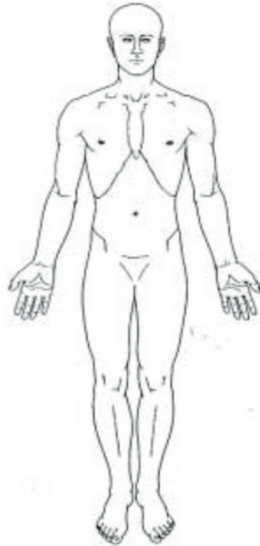
____

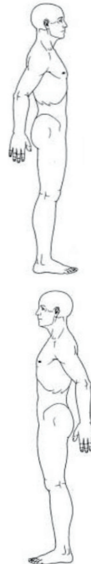
My pain/symptom($) are getting: **Better.** **Worse.** **About the same.** **Other**

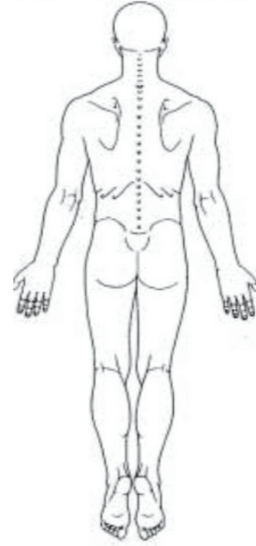
PLEASE USE THE KEY TO MARK THE DIAGRAM

Pain/Discomfort Scale: (Please Circle) **Least 0 1 2 3 4 5 6 7 8 9 10+. Worst**

A = Ache **B =Burning** **N = Numbness** **S = Stiff** **SR = Sore**
T = Tingle **P = Pain** **W = Weak** **P&N = Pins & Needles**







PLEASE TELL US HOW YOUR SYMPTOMS ARE AFFECTING YOUR ACTIVITIES

Home

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sleeping	☐	☐	☐	☐
Self Care	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

Work/School

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Concentration	☐	☐	☐	☐
Duties, Activities	☐	☐	☐	☐
Mood	☐	☐	☐	☐
Travel	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

Other Activities

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sit,Stand,Walk	☐	☐	☐	☐
Raising from Chair	☐	☐	☐	☐
Bend,Lift, Twist	☐	☐	☐	☐
Turn Head	☐	☐	☐	☐
Hobbies, Exercise, Sports	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
	☐	☐	☐	☐

Patient Signature: ______________________ Date: ____/____/______

Doctor's Signature: ______________________ Date: ____/____/______

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

To the patient:

You have a right to be informed about your condition, the recommended chiropractic treatment and the potential risk involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or their licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risk and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risk and benefits of alternative treatment, including no treatment at all.

I understand. That there are some risks to chiropractic treatment including but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ Increase symptoms and pain
- ☐ No improvement of symptoms of pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other______________________

In rare cases there have been reported complications of vertebral artery dissection(Stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

____
Print name

____
Signature of patient

____
Date signed

To be completed by the patient's representative:

____
Print name of patient

____
Print name of patient's representative

____
Signature of patients representative

as: ______________________________
Relationship/authority of patients representative

____
Date signed

To Be completed by doctor or staff

____
Witness to patient's signature

____
Date

____
Translated by

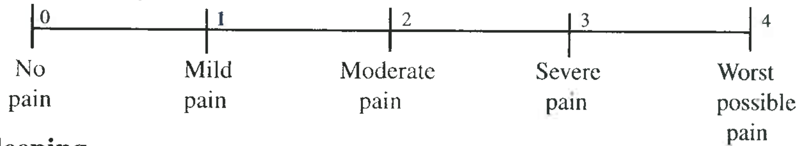
____
Date

Functional Rating Index

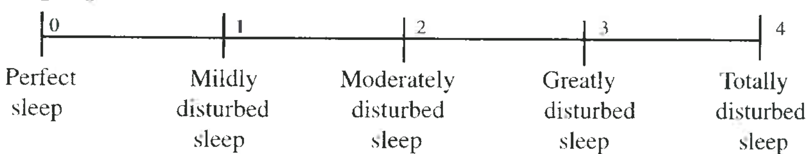
For use with **<u>Neck and/or Back Problems</u>** only.

In order to properly assess your condition, we must understand how much your **<u>neck and/or back problems</u>** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

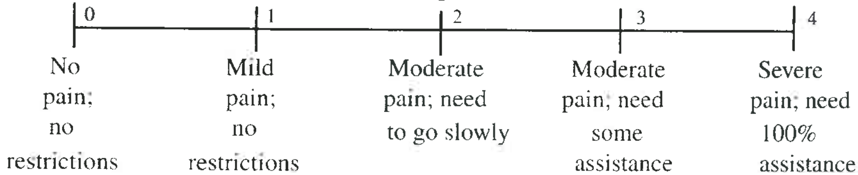
1. Pain Intensity



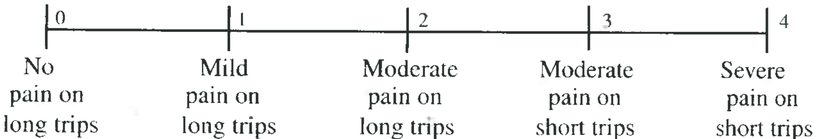
2. Sleeping



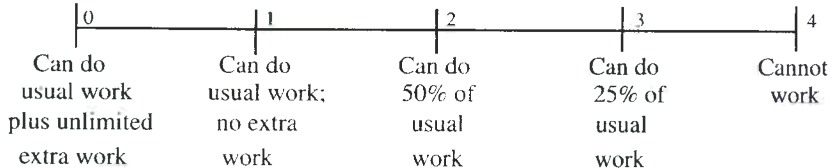
3. Personal Care (washing, dressing, etc.)



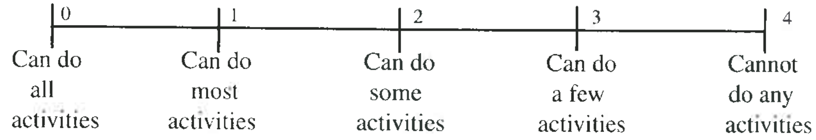
4. Travel (driving, etc.)



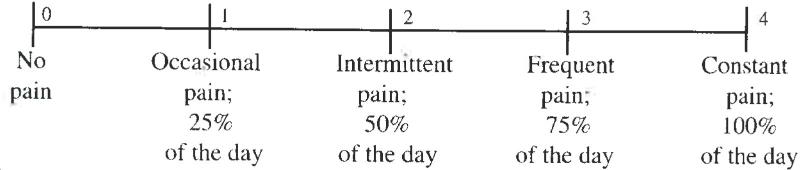
5. Work



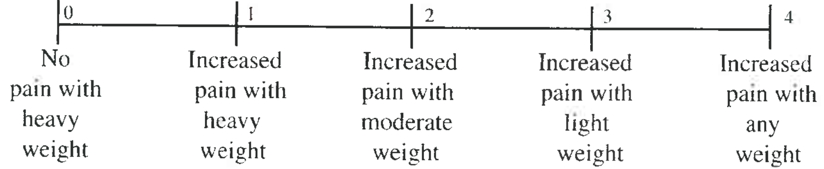
6. Recreation



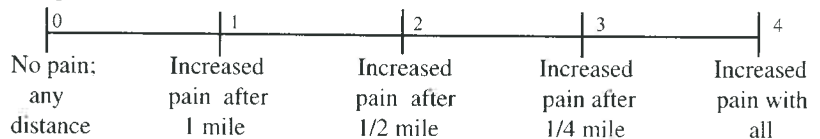
7. Frequency of pain



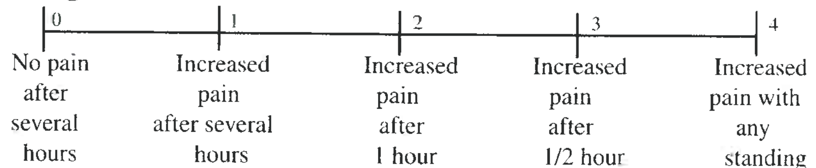
8. Lifting



9. Walking



10. Standing



Name ____________________
PRINTED

____
Signature

____
Date

Total Score __________

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Suite 111
Copperas Cove, TX 76522

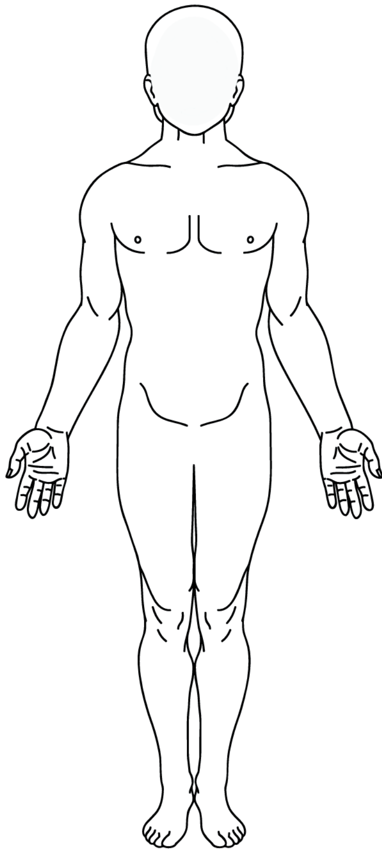
Name:______________________________ **Date:**______________________________

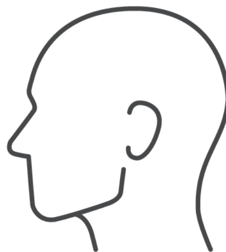
Borg Pain Scale

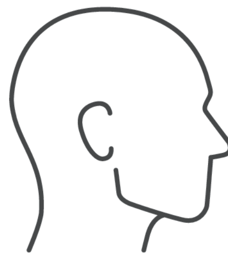
On a scale of 1 - 10, please rate your pain level

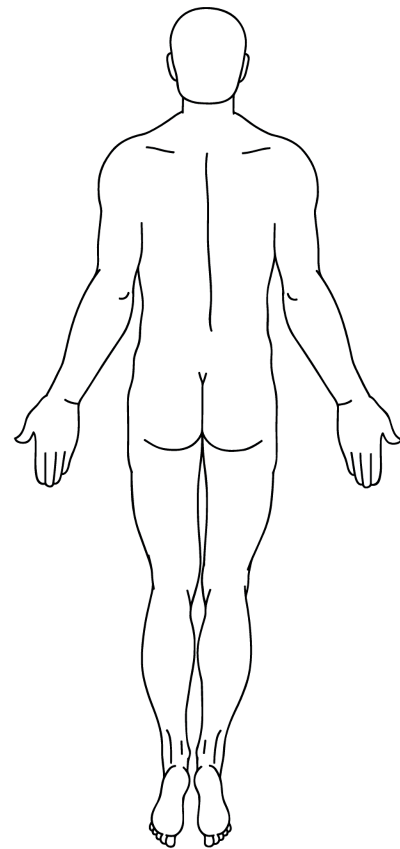
Normal	Low Pain	Moderate Pain	Intense Pain	Emergency
__0	__1	__4	__7	__10
	__2	__5	__8	
	__3	__6	__9	

Please place an "X" where you feel your pain.









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Copperas Cove, TX 76522

Name:___________________________ Date:_______________________________

Neck Disability Index

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

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, for example 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 lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4- Reading

☐ I can read as much as I want to 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.
☐ 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.

Section 5- Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which 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.
☐ I can't do any work at all.

Section 8- Driving

☐ I 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 my car 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 moderately disturbed (1 - 2 hrs. sleepless).
☐ My sleep is moderately disturbed (2 - 3 hrs. sleepless).
☐ My sleep is greatly disturbed (3 - 4 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 pain in my neck.
☐ 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.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score:_____x2) / (____Sections x 10) =_____________% ADL______

Comments____

Reference: Vernon, Milor. JMPT 1991: 14(7): 409-15

211 Liberty Bell Ln., Suite111
Copperas Cove, TX 76522

Name:___________________________ Date:______________________________

Low Back Disability Questionaire (Revised OSWESTRY)

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

Section 1- Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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, for example 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 lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4- Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than on-quarter mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

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 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Section 6- Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8- 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 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 out as often.
- Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9- Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10- 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 at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score:_____x2) / (____Sections x 10) =_____________% ADL______

Comments_______________________________________

Reference: Fairbank, Physiotherapy 1981;66(8): 271-3, Hudson-Cook. In Rland, Jenner (eds.), Back Pain New Approoaches To Rehabilitation & Education. manchester Univ Pres, manchester 1989: 187-204

Cove Freedom
Chiropractic

211 Liberty Bell Ln., Suite 111
Copperas Cove, TX 76522

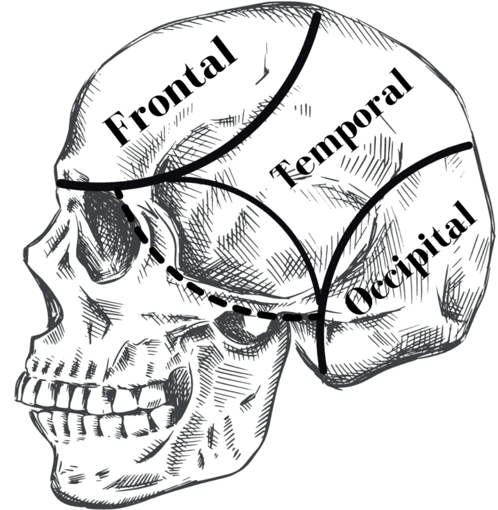
Name:____________________________ Date:_______________________________

Headache Pain and Its Effect on Daily Living

Using the grading scale below, locate and describe your headache pain completely. Place your grades in the boxes on the bottom of the page.(If your headaches are in more than one area grade each separately.)

Site

Indicate where the pain is: If your pain is in the front, is it on the right side, left side or both sides? If your pain is on the side, is it on the right, left or both sides. Grade each headache separately. If it occurs in more than one area (i.e. Front and Back)



Grade your headaches effect due to pain and discomfort.

1. Minimal - The pain is annoying, but it is forgotten during activities of daily living
2. Slight - The pain is tollerated, but it does interfere with some daily activities
3. Moderate - The pain extensively interferes with activities, including sleep. Recreation and socialization are also severely limited.
4. Marked - The pain prevents most activities, including sleep. Recreation and socialization are impossible

Frequency

1. Have Intermittent symptoms occurring up to 25% of my awake time.
2. I experience occasional symptoms between 25% and 50% of the time.
3. Pain is frequent and occurs between 50% and 75% of the time.
4. I have constant pain occurring between 75% and 100% of my awake time.

☐ **Site:** Front of head(Frontal) _____Right _____Left _____Both
Grade: ____1 ____2 ____3 ____4
Frequency: ____1 _____2 ____3 ____4

☐ **Site:** Side of Head(Temporal) _____Right _____Left _____Both
Grade: ____1 ____2 ____3 ____4
Frequency: ____1 _____2 ____3 ____4

☐ **Site:** Back of Head(Occipital) _____Right _____Left _____Both
Grade: ____1 ____2 ____3 ____4
Frequency: ____1 _____2 ____3 ____4

COVE FREEDOM
CHIROPRACTIC

CLINIC POLICIES

The following is an explanation of our clinic policies. We believe that a clear definition will allow us all to concentrate on the most important issue. Regaining and maintaining your health.

No Charge Consultation
Cove Freedom Chiropractic Clinic will do a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problems. There is no charge or obligation in connection with this appointment.

New Patient Care Services
We require the payment in full on the first visit unless prior arrangements are made. Then the balance of these charges may be made in payments over the course of your treatment schedule. Properly documented auto accident claims are not required to pay at this time if appropriate forms and liens are signed.

Established Patient Care
Patients under care are required to make regular payments on all unpaid balances except for properly documented auto injury claims. Payments need to be made according to prior arrangements. We reserve the right to charge finance charges and late fees to any account that is not paid in a timely manner.

Appointments
In order to better serve our patients, we ask that you call if you need to reschedule your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could have been used to help someone else. Please help us help others.

Questions and Answers
Your questions about any aspect of your care and account are invited. Please feel free to ask your doctors or staff members. We will make every effort to answer your inquiries.

Payments
Payments for office visits are due the same day as your office visits unless other documented arrangements have been made, such as our Cove Freedom Finance plan, Special Consideration payment Plan, or our Cove Freedom Membership plan.

I have read the Cove Freedom Chiropractic Clinic Policies and will honor them.

Patient's Signature ______________________ Date ____/____/____