Please print and use black ink only. Make sure all boxes are checked in the last 2 pages. If none apply please check the first box.

Sincerely, Staff of Curley Chiropractic LLC

Patient Intake Information

Date: _____

_____

(Legal) First Name (Legal) MI (Legal) Last Name DOB: Age

Street: _____ **Apt.** _____

City: _____ **State:** _____ **Zip**: _____

Social Security #: _____ **Marital status:** [ ] S [ ] M [ ] W [ ] D Spouse: _____

Language: [ ] English [ ] Spanish [ ] Indian [ ] Japanese [ ] Chinese [ ] Korean [ ] French [ ] German [ ] Russian Other: _____

Race/Ethnicity: [ ] White [ ] American Indian or Alaska Native [ ] Asian [ ] Native Hawaiian/ other pacific Islander [ ] Black or African American [ ] Hispanic or Latino [ ] Decline answer

Contact info: Home Ph: _____ Work Ph: _____ Cell Ph: _____

Cell Carrier: _____ Email Hm: _____

Email wk: _____

Contact Preference: [ ] Home Ph [ ] Work Ph [ ] Cell Ph [ ] Email Hm [ ] Email Wk [ ] Postal Mail

Occupation: _____ Employer: _____

Employer Address: _____
City Street State Zip

Emergency contact: _____ Phone: _____

Who referred you to our office? _____ Phone: _____

Insurance Information: *A copy of your insurance card(s) will be made, in addition, please complete the information requested below:*

Are you the policy holder? [ ] Y [ ] N If no, who is? [ ] Spouse [ ] Parent [ ] Employer Other: _____

_____

Policy Holders First Name MI Last name DOB

Policy Holders Social Security: _____

Policy Holders Employer: _____

Do you have secondary insurance? [ ] Y [ ] N If yes, please complete the following:

_____

Policy Holders First Name MI Last name DOB

Policy Holders Social Security: _____
Policy Holders Employer: _____

Patient Intake Information

Patient History

Please give a brief description of the problem[s] you are experiencing:

_____

_____

_____

Is/Are the problem[s] getting better? [ ] Y [ ] N or getting worse? [ ] Y [ ] N When did the problem[s] start? _____

_____

What appears to be the initial cause? _____

_____

Are you seeing any other providers for other health conditions? [ ] Y [ ] N

Please list problem[s], date problem[s] began and Provider[s] treating you for the condition[s]:

_____

_____

_____

Past History

Have you--- If yes, please list the date and treating provider.

Ever been diagnosed with Hypertension? [ ] Y [ ] N _____

Been hospitalized in the past 5 years? [ ] Y [ ] N _____

Been diagnosed with Diabetes? [ ] Y [ ] N _____
[ ] Type I [ ] Type II

Do you smoke? [ ] Never [ ] Former Smoker [ ] Current/Every Day Smoker [ ] Current someday[s] Smoker

Medications

What medications are you currently taking? Please include all non-prescriptions and over the counter vitamins, herbs, minerals, ect.
List date started, Brand Name, Strength, Dosage, Frequency, Duration, Quality, Refills Available, Prescribed by:
Please be specific as possible.

_____

_____

_____

_____

Do you have any allergies? [ ] Food [ ] Environmental [ ] Medication
List type of allergy and reaction[s]

_____

_____

Patient Intake Information

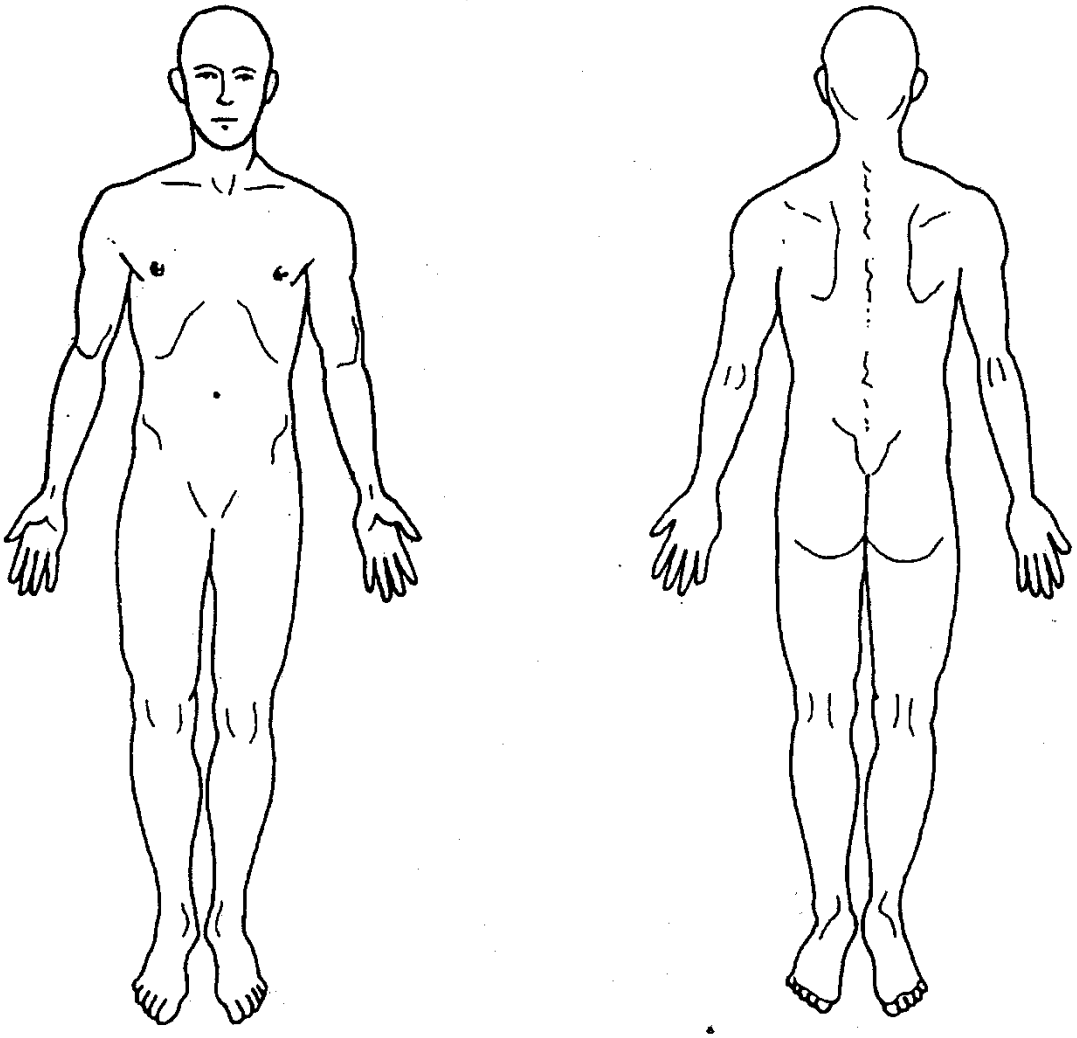
TELL US WHERE YOU HURT.

Pain Drawing

Please use the symbols below to indicate type of pain and location of symptom.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



Additional Symptoms/Complaints:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Intake Information

CONSENT TO X-RAY

Patient Name: _____ Date: _____

I hearby acknowledge that Dr. Tiffany Curley and/or her staff at Curley Chiropractic has informed me of the advisability of, risk inherent in, and the probable consequences of not receiving x-rays. She has also explained to me the reasons and need for such x-rays.

I do hearby authorize Dr. Tiffany Curley, a licensed Doctor of Chiropractic, to perform all such x-rays as she deems pertinent to the diagnosis and management of my case.

_____ _____ _____ _____
Patient/Guardian Signature Date Witness Signature Date

PREGNANCY WAIVER (to be completed by *ALL females)*

I hereby acknowledge that Dr. Tiffany Curley and/or her staff at Curley Chiropractic has informed me, prior to being x-rayed, of the advisability of risk and the probable consequences of receiving x-rays during pregnancy.
I have stated on my own volition that:

◯ I am NOT pregnant nor am I attempting to get pregnant as of this date and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

◯ I AM currently pregnant or am unsure if I am pregnant and therefore decline x-rays

_____ _____ _____ _____
Patient/Guardian Signature Date Witness Signature Date

Patient Intake Information

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of a chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following Procedures:

Spinal manipulative therapy	**palpation**	**vital signs**	
Range of motion testing	**orthopedic testing**	**basic neurological**	
Muscle strength testing	**postural analysis**	**testing**	
Ultrasound	**hot/cold therapy**	**EMS**	**Spinal Decompression**
Radiographic studies			

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, disclocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

***I have read* the** *above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.*

Dated: _____ **Dated: _____**

_____ **_____**

Patient's Name **Doctor's Name**

_____ **_____**

Signature (Parent of Guardian if pt. is a minor) **Signature**

Patient Intake Information

Oswestry LOW BACK Disability Index

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 is very painful.
- ❑ 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 my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, 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 (i.e. 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 only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ 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 sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

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 for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and causes 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, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

Patient Name: _____

Date: _____

Low Back

Neck Disability Index

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 to with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck
- ❑ I cannot 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 that come infrequently.
- ❑ I have moderate headaches which come infrequently
- ❑ I have moderate headaches which come frequently
- ❑ 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 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 at all
- ❑ I cannot do any work at all.

Section 8 – Driving

- ❑ I can 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 cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck
- ❑ I cannot drive my car at all.

Section 9 – Sleeping

- ❑ I have no trouble sleeping
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours 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 cannot do any recreation activities at all.

Patient Name: _____

Date: _____

Neck