Dolecki Chiropractic Clinic

4110 Baldwin, Orion, MI 48359 Phone: 248.391.1040 Fax: 248.391.8927

Date_______________ Patient Number_______________

PATIENT INFORMATION

Name:____

Address:____

City:_______________ State:_______________ Zip Code:_______________

Phone: (cell)_______________ (home)_______________ Email:_______________

Best place to contact:_______________ Where can we send appointment reminders? Text or Email

Birthdate:_______________ Sex: (M) (F) Primary Care Physician_______________

Marital Status: (circle) Married Single Divorced Widowed Are you Pregnant?_______________

Emergency Contact Name and Number:_______________________________

Occupation:_______________ Referred by:_______________

Is your condition the result of a work injury or an accident?_________ If so, Auto Carrier_______________

HISTORY

What are your major complaints?	Date Started?	Have you had this before?	Is it constant, worsening, or comes & goes?
1.			
2.			
3.			

Have you received medical care for this condition?_____ Results:_______________

Have you received previous Chiropractic care?_________ Where?_______________ When?_______________

Do you smoke? ☐ Y ☐ N Do you Exercise? ☐ Y ☐ N Do you consume alcohol? ☐ Y ☐ N

	Date	Type of Accident	Describe Injury
Have you ever had any falls, accidents or injuries? YES please describe NO			
	Date	**Type of Surgery**	**Comments**
Have you ever had any Surgery? YES please describe NO			
	Name of Drug	**Doses per Day**	**Length of time taking**
Are you taking any medication/supplements? YES please describe NO			

(Please complete opposite side of this form also.)

Please check all that apply:

- ☐ Headaches
- ☐ Ringing in Ears
- ☐ Grinding in Neck
- ☐ Asthma
- ☐ Mid-back pain
- ☐ Menstrual Cramps/Pain
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Fatigue
- ☐ Sinus trouble/allergies
- ☐ Blurred Vision
- ☐ Pain in Shoulders
- ☐ Numbness in Arms/Hands
- ☐ Low Back Pain
- ☐ Constipation
- ☐ Numbness in Legs/Feet
- ☐ Diabetes
- ☐ Sleeping Problems
- ☐ Dizziness
- ☐ Neck Pain
- ☐ Pain in Arms/Hands
- ☐ Pins & Needles in Arms/Hands
- ☐ Stomach Trouble
- ☐ Pain in Legs/Feet
- ☐ Pins & Needles in Legs/Feet
- ☐ Cancer
- ☐ Osteoporosis

FAMILY HISTORY

Has any of your family experienced any of the following diseases? (Please use corresponding key)

	FATHER	MOTHER	SISTERS/BROTHERS	GRANDPARENTS
Cancer				
Depression				
Heart Disease				
Diabetes				
Epilepsy				
Arthritis				
Circulatory Problems				
Spinal Surgery				
Other				

WORK HISTORY

Circle the primary course of your day:

Sitting Standing Light Labor Heavy Labor Moving Around Leaning/Bending Over

Hours per Week? ____________ Years at Job ____________

GOALS

What are your goals by consulting with our office today? (Circle all that apply)

Get out of Pain/Discomfort Regain range of motion/joint function Improve overall health

Prevent future joint problems Learn valuable health information Keep my spine as healthy as possible

I herby authorize Dr. Christopher A. Dolecki to administer treatment to me or my dependents as they deem necessary based upon the information provided.

____________________ Patient Signature ____________ Date

____________________ Parent/Guardian Signature Authorizing Care ____________ Date

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Acknowledgement of Receipt of Notice of Privacy Policy

Effective: October 18, 2018

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Dolecki Chiropractic Clinic. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times.

Dolecki Chiropractic Clinic also uses protected health information for the following reasons: (you may opt out of this authorization at any time). By providing an email and/or mobile number, you agree to its use for appointment reminders, newsletters and other Clinic related information.

If you have any questions regarding this notice or our health information privacy policies, please contact: Dolecki Chiropractic Clinic (248) 391- 1040

______________________________ ______________

Signature of Patient or Personal Representative **Date of signature**

____

Print Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

Assignment of Benefits

In consideration of your undertaking to treat me, I agree to the following:

Assignment: I hereby instruct and direct my insurance company to pay by check made out and mailed directly or paid electronically to this clinic for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

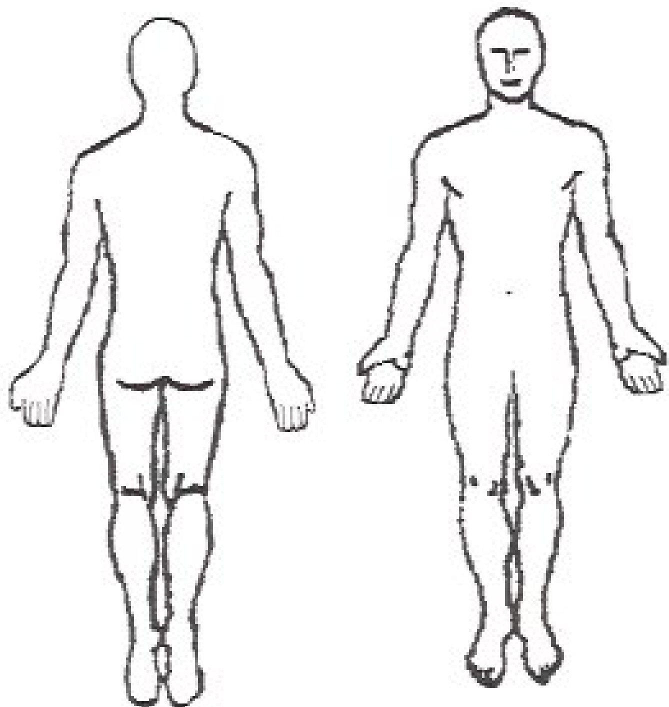
Release of Information: I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

Financial Responsibility: I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company.

______________________________ ______________

Signature of Patient or Personal Representative **Date**

Patient: ____________ Date: ____________



Mark pain areas on the figures above using the following symbols to describe the type of pain you are experiencing:

+ + +	Burning
0 0 0	Sharp/Stabbing
- - -	Throbbing
l l l	Dull Ache

Rate your pain on a scale of 0 (no pain) to 10 (worst pain imaginable). Circle your selection:

Neck Pain	0	1	2	3	4	5	6	7	8	9	10
Mid-back Pain	0	1	2	3	4	5	6	7	8	9	10
Low Back Pain	0	1	2	3	4	5	6	7	8	9	10

NECK INDEX

Patient Name: ________ Date: __________

This questionnaire will give the doctor information about how your neck condition affects your everyday life. Please answer every section and mark only the ***one box*** that applies to you. If two statements relate to you, please ***mark the box which most closely describes your problem.***

Section 1 - **Pain Intensity**
- ❑ 0-I have no pain at the moment.
- ❑ 1-The pain is very mild at the moment.
- ❑ 2-The pain is moderate at the moment.
- ❑ 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.

Section 2 - **Personal Care (Washing, Dressing, etc...)**
- ❑ 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.

Section 3 - **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, for example 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 lift only very light weights.
- ❑ 5-I cannot lift or carry anything at all.

Section 4 - **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.

Section 5 - **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.

Section 6 - **Concentration**
- ❑ 0-I can concentrate fully when I want to with no difficulty.
- ❑ 1-I can concentrate fully when I want to with slight difficulty.
- ❑ 2-I have a fair degree of difficulty concentrating when I want to.
- ❑ 3-I have a lot of difficulty concentrating when I want to.
- ❑ 4-I have a great deal of difficulty concentrating.
- ❑ 5-I cannot concentrate at all.

Section 7 - **Work**
- ❑ 0-I can do as much work as I want to.
- ❑ 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.

Section 8 - **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 my car at all because of severe neck pain.
- ❑ 5-I cannot drive my car at all.

Section 9 - **Sleeping**
- ❑ 0-I have no trouble sleeping.
- ❑ 1-My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❑ 2-My sleep is mildly disturbed (1-2 hrs. sleepless).
- ❑ 3-My sleep is moderately disturbed (2-3 hrs. sleepless).
- ❑ 4-My sleep is greatly disturbed (3-5 hrs. sleepless).
- ❑ 5-My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 - **Recreation**
- ❑ 0-I am able to engage in all my recreation activities with no neck pain at all.
- ❑ 1-I am able to engage in all my recreation activities with some neck pain.
- ❑ 2-I am able to engage in most but not all my 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.

Score__________

BACK INDEX

Patient Name: ______________ Date: ____________

This questionnaire will give the doctor information about how your back condition affects your everyday life. Please answer every section and mark only the ***one box*** that applies to you. If two statements relate to you, please ***mark the box which most closely describes your problem.***

Pain Intensity

- ❑ 0-I 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 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 ½ 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 ½ 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 ½ mile without increasing pain.
- ❑ 4-I cannot walk more than ¼ 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 in 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.

Score__________