Acct #: _____

Notto Chiropractic Health Center
Patient Information

Name: _____

Preferred Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: (____) _____-_____

Work Phone: (____) _____-_____

Who Referred You? _____

In Case of Emergency: _____

Phone Number: _____

Sex: _____

Date of Birth: _____/_____/_____

SS#: _____

Employer: _____

Marital Status: ☐ Single ☐ Married

☐ Divorced ☐ Separated ☐ Widowed

Spouse's Information

Name: _____

Date of Birth: _____/_____/_____

Employer: _____

Reason For Visit: _____

_____

Previous Treatments For This Condition: _____

Other Doctors Seen For This Condition: _____

Are you pregnant? ☐ Yes ☐ No

When Did Your Symptoms Begin? _____/_____/_____ ☐ Came On Gradually

Were You In An Accident? ☐ Yes ☐ No Date of Accident: _____/_____/_____

If Yes, Auto _____ Home _____ W/C _____

Describe the Accident: _____

_____

Do You Have An Attorney? Yes _____ No _____ Name: _____

Authorized Consent For Treatment of Minor

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____

Mother, Father, Other

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE DOCTOR, OR GROUP INDICATED ON THE CLAIM.**

A copy of this signature is as valid as the original.

I attest that the above information is accurate to the best of my ability.

_____

Patient Signature

Complaints

Name _____ Date _____

A	NECK OR CERVICAL SPINE	NONE	MILD	MODERATE	SEVERE
A	Neck Pain and Soreness	A	B	C	D
B	Loss or Pain upon Movement	A	B	C	D
C	Shoulder Pain	A	B	C	D
D	Pain/Numbness/Tingling into arm or hand	A	B	C	D
E	Weakness in arm or hand	A	B	C	D
B	**MID-BACK OR THORACIC SPINE**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Mid-back Pain	A	B	C	D
B	Rib or Chest Pain	A	B	C	D
C	**LOWER BACK OR LUMBAR SPINE**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Lower Back Pain or Soreness	A	B	C	D
B	Loss or Pain with Movement	A	B	C	D
C	Pain into Hips or Buttocks	A	B	C	D
D	Pain into Legs, Knees, or Feet	A	B	C	D
E	Numbness/Burning in Legs or Feet	A	B	C	D
D	**OTHER COMPLAINTS:**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Headaches	A	B	C	D
B	Visual Disturbances/ Blurry Vision	A	B	C	D
C	Ringing or Buzzing in Ears	A	B	C	D
D	Nausea or Vomiting	A	B	C	D
E	Difficulty Breathing	A	B	C	D
F	Dizziness	A	B	C	D
G	Recent Weight Loss	A	B	C	D
H	Bowel or Bladder Dysfunction	A	B	C	D
E	**AGGRAVATED BY:**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Coughing	A	B	C	D
B	Sneezing	A	B	C	D
C	Prolonged Sitting	A	B	C	D
D	Prolonged Standing	A	B	C	D
E	Prolonged Riding in a Car	A	B	C	D
F	Lying on Stomach	A	B	C	D

Activities of Daily Living

Oswestry Back Disability Index

Name: _____ Date: _____

		No Pain	Slight Pain	Mild Pain	Moderate	Severe Pain	Very Severe
A	Pain Intensity	A	B	C	D	E	F
B	Personal Care	A	B	C	D	E	F
C	Lifting	A	B	C	D	E	F
D	Walking	A	B	C	D	E	F
E	Sitting	A	B	C	D	E	F
F	Standing	A	B	C	D	E	F
G	Sex Life	A	B	C	D	E	F
H	Social Life	A	B	C	D	E	F
I	Sleeping	A	B	C	D	E	F
J	Traveling	A	B	C	D	E	F

Name: _____ Date: _____

Please CIRCLE any of the following diseases you may have had:

Group 1	Group 2	Group 3	Group 4
A) Anemia	A) Diphtheria	A) Polio	A) Whooping Cough
B) Measles	B) Hypertension	B) Ulcer	B) Migraine Headache
C) Arthritis	C) Emphysema	C) Eczema	C) Gallbladder Disease
D) Smallpox	D) Chickenpox	D) Asthma	D) Tumor or Cancer
E) Pleurisy	E) Malaria	E) Colitis	E) Heart Disease
F) Stroke	F) Diabetes	F) Gout	F) Diverticulitis
G) Bursitis	G) Tuberculosis	G) Mumps	G) Rheumatic Fever
H) Pneumonia	H) Rheumatism	H) Hernia	H) Venereal Disease
I) Epilepsy	I) Osteoporosis	I) Typhoid Fever	I) Kidney Disease
J) Neuritis	J) Hypoglycemia	J) Scarlet Fever	J) Bowel Obstruction
K) Hay Fever	K) Encephalitis	K) Thyroid Disease	K) Alcoholism
L) Hepatitis	L) Meningitis	L) Shingles	L) Chemical Dependency

None: _____

Surgical History: Indicate the Year

A) Stomach/Colon _____ H) Hernia _____

B) Rectum _____ I) Uterus _____

C) Tonsils _____ J) Breast(s) _____

D) Ovaries _____ K) Prostate _____

E) Gallbladder _____ L) Spinal _____

F) Appendix _____ M) Other _____

G) Thyroid _____ None: _____

Please specify other: _____

Family Health History:

Father		**Mother**
Age: _____		Age: _____
Y N	Deceased	Y N
( )	Good Health	( )
( )	Heart Disease	( )
( )	Diabetes	( )
( )	Stroke	( )
( )	Cancer	( )
( )	Gout	( )

Additional Information:

_____

Non-Accident Patient History

Name: _____ **Date: _____**

History of the Occurrence

Did your symptoms: A) Come on suddenly (example awoke with pain)

B) Came on gradually over the last (circle one from each column below

few	days
several	weeks
	months
	years

Are your symptoms: ( ) getting worse ( ) staying about the same ( ) slowly improving

Work Status History

Occupation or Job Title _____

Have you missed time from work? Y or N

If yes: Full Time off work _____ to _____

Returned to Modified Work _____ to _____

( ) Been unable to work since the illness began.

Name: _____ **Date: _____**

OSWESTRY Disability Index

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 circle in each section only the ONE number that applies to you.

Section 1: Pain Intensity

0. My pain comes and goes and is very mild.
1. My pain is mild and does not vary much.
2. My pain comes and goes and is moderate.
3. My pain is moderate and does not vary much.
4. My pain comes and goes and is very severe.
5. My pain is severe and does not vary much.

Section 2: Personal Care

0. I can wash and dress like normal.
1. I have to change my way of washing and dressing due to 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.

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 manage if they are conveniently positioned (e.g., on a table).
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at the most.

Section 4: Walking

0. I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than one mile without pain.
3. I cannot walk more than ½ mile without pain.
4. I cannot walk more than ¼ mile without pain.
5. I cannot walk at all without pain.

Section 5: 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. I cannot sit more than one hour without pain.
3. I cannot sit more than ½ hour without pain.
4. I cannot sit more than ¼ hour without pain.
5. I cannot sit at all without pain.

Section 6: Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand longer than 1 hour without pain.
3. I cannot stand longer than ½ hour without pain
4. I cannot stand for longer than 10 minutes without pain.
5. I avoid standing because it increases the pain right away.

Section 7: Sleeping

0. I do not have pain while in bed.
1. I get pain in bed, but it does not prevent me from sleeping.
2. My sleep is reduced by less than ¼ because of pain.
3. My sleep is reduced by less than ½ because of pain.
4. My sleep is reduced by less than ¾ because of pain.
5. I cannot sleep at all without pain.

Section 8: Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal, but gives me pain.
2. Pain has no significant effect on my life apart from limiting more energetic activities.
3. Pain restricts my social life and I do not go out often.
4. Pain has restricted my social life to my home.
5. I do not have a social life due to pain.

Section 9: Traveling

0. I have no pain when traveling.
1. I get some pain while traveling, but none of my usual forms of travel makes it any worse.
2. I get extra pain while traveling, but I do not seek alternate forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

Section 10: Changing Degree of Pain

0. My pain is getting better.
1. My pain fluctuates, but is getting better
2 . My pain seems to be getting better, but it is slow.
3. My pain is not getting better or worse.
4. My pain is gradually getting worse.
5. My pain is worsening.

For Office Use Only: Score: ____	0-10 None 11-20 Minimal 21-30 Mild 31-40 Moderate 41-50 Severe

Notice of Privacy Practices Acknowledgement
Notto Chiropractic Health Center

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of the Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I authorize Notto Chiropractic Health to release my medical information to the following person(s):

Spouse: _____

Children: _____

Other: _____

None of the above: _____

_____
Patient Name or Legal Guardian (print)

_____
Date

_____
Signature

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date _____ Attempt _____

Staff Name _____

NOTTO CHIROPRACTIC HEALTH CENTER
619 East Parkway Drive
Russellville, AR 72801

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

DOB: ___/___/_____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Preferred method of communication: Email/Phone/Mail

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____