Patient Introduction Card

Pt. No. _____ Date: _____

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____ Sex: Male Female

Status: Married Single Divorced Other: _____ Social Security#: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Phone: _____

*Emergency Contact Name & Phone: _____

Privacy Practices Preferences:

I authorize being contacted for appointment & practice reminders by: Email Telephone Voicemail Text

I authorize being contacted for health related information or promotions about O'Donahue Chiropractic by:

Email Telephone Voicemail Text

I authorize the doctor to personally discuss with me products that may benefit my health or condition: Yes No

Major Complaint: _____

Have you had previous Chiropractic care? YES NO *If Yes, Doctor's Name? _____

Who (or what source) referred you? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged!

_____ _____

Patient/ Patient Representative Signature Date

REASON FOR VISIT

What is the date of your scheduled appointment? ____ / ____ / _____

How long have you had this complaint?

- ⌐ Less than 5 days (Acute)
- ⌐ Between 5-30 days (Sub Acute)
- ⌐ More than 30 days (Chronic)

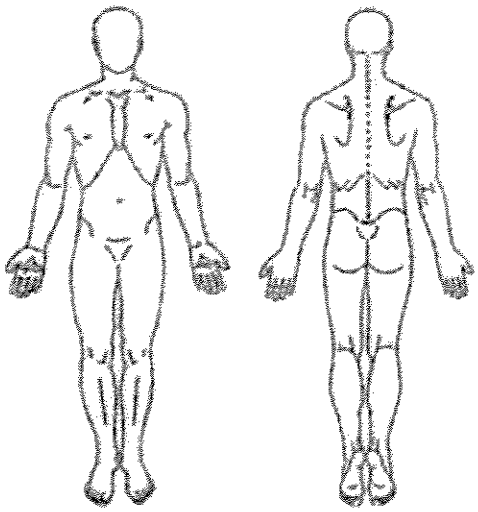
What caused this condition? _____

What is the date this condition began? (Skip if due to accident) ____ / ____ / _____

What terms describe your discomfort best? (aching, burning, tingling, etc.) _____

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P - pain
N - numbness
W - weakness
S - shooting
A - aching



On a scale of 1 to 10, with 10 being the most severe, how would you rate your current level of discomfort?

None *Unbearable*

0 1 2 3 4 5 6 7 8 9 10

How often do you feel this discomfort? ⌐ Constant ⌐ Frequent ⌐ Occasional ⌐ Intermittent

How has this complaint changed since the onset? ⌐ Worsened ⌐ Remained the same ⌐ Improved

What activity is most significantly affected by this discomfort? (Explain) _____

_____

What treatment have you received for this condition up to now? _____

_____

What aggravates this condition? _____

What improves this condition or gives you relief? _____

Have other health care provider(s) performed tests related to this condition? _____

_____

Have you ever had any previous episodes of this condition? _____

_____

CURRENT HEALTH

Other than the information already provided, do you have additional health concerns involving any of the following?

Muscles, Bones, or Joints ⌐ No ⌐ Yes Explain: _____

Nerves, Headaches, Dizziness, or Emotional ⌐ No ⌐ Yes Explain: _____

Head, Eyes, Ears, Nose or Throat ⌐ No ⌐ Yes Explain: _____

Heart, Blood Pressure, or Circulation ⌐ No ⌐ Yes Explain: _____

Shortness of Breath, Coughing, Asthma or Lung Condition ⌐ No ⌐ Yes Explain: _____

Stomach, Bowels or Digestive Conditions ⌐ No ⌐ Yes Explain: _____

Genital, Bladder, or Urinary Conditions ⌐ No ⌐ Yes Explain: _____

Diabetes, Thyroid or Glandular Conditions ⌐ No ⌐ Yes Explain: _____

Skin or Bleeding Conditions ⌐ No ⌐ Yes Explain: _____

Allergies or Sensitivities ⌐ No ⌐ Yes Explain: _____

PERSONAL AND FAMILY HISTORY

Have you had any surgical procedures?	⌐ No ⌐ Yes Explain: _____
Are there any past illnesses or conditions we should be aware of?	⌐ No ⌐ Yes Explain: _____
Do you have a past history of accidents or trauma?	⌐ No ⌐ Yes Explain: _____
Are there any past illnesses or conditions we should be aware of?	⌐ No ⌐ Yes Explain: _____
Are you presently taking any medication?	⌐ No ⌐ Yes Explain: _____
Do you have a past family illness history, such as diabetes, cancer, hypertension, and progressive neurological diseases that we should be aware of?	⌐ No ⌐ Yes Explain: _____

WORK AND SOCIAL HABITS

Current work habits: select all that apply	⌐ Permanently fully disabled ⌐ Permanently partially disabled ⌐ Cannot work due to current condition ⌐ Full-time (20-40+ hours/week) ⌐ Part-time (1-19 hours/week) ⌐ Retired ⌐ Student ⌐ Homemaker ⌐ Unemployed
Personal social habits: select all that apply	⌐ Smoke or use tobacco products ⌐ Drink alcohol ⌐ Drink caffeine ⌐ Use recreational drugs ⌐ Other, to be discussed with doctor
Present exercise habits: select all that apply	⌐ No current exercises ⌐ Exercise daily ⌐ Exercise 3+ times per week ⌐ Cannot return to exercise due to current condition
Diet and nutrition habits: select all that apply	⌐ Vegan or vegetarian ⌐ Daily supplements ⌐ Other

O'Donahue Chiropractic
915 E. Firetower Rd., Suite 104
Winterville, NC 28590

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:** _____

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:_____/_____

O'Donahue Chiropractic
INFORMED CONSENT FORM

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

The nature of the 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
___ range of motion testing
___ muscle strength testing
___ hot/cold therapy
___ radiographic studies
___ palpation
___ orthopedic testing
___ postural analysis
___ Electrical Stim
___ mechanical traction
___ vital signs
___ basic neurological testing
___ Other (please explain)_____
_____

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, dislocations, 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. The 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 or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. James O'Donahue and have had my questions answered to my satisfaction. 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.

_____	_____	_____
Patient Name (Please Print)	Patient/Representative Signature	Date
Dr. James O'Donahue	_____	_____
Doctor's Name (Please Print)	Doctor's Signature	Date

O'DONAHUE CHIROPRACTIC
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for seven years.

List below the names and relationship of people to whom you authorize the Practice to release your Protected Health Information (PHI):

_____	_____
_____	_____
_____	_____
_____	_____
Patient Name (please print)	*Representative Name*
_____	_____
Patient/Representative Signature	*Date*

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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 _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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

⓪ 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 _____