Tankersley Chiropractic

165 Indian Lake Blvd., Suite 102 • Hendersonville, TN 37075
Phone: (615) 826-7889

CONFIDENTIAL PATIENT HEALTH HISTORY

(please fill out in legible writing)

Today's Date: _____

Name: _____ Nickname: _____
Last First Middle

Address: _____

City _____ State _____ Zip_____

Home Phone: _____ Cell Phone: _____

Cell Phone Carrier (AT&T, Verizon, T-Mobile) : _____

Spouse Name: _____ Phone: _____

Social Security #: _____ Gender: Male Female

Marital Status: _____ Race/Ethnicity: _____

Date of Birth: _____ Email Address: _____

Occupation: _____

Employers Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How would you like to receive appointment reminders? Email Text message

Have you ever seen a Chiropractor before? Yes No

Last visit date? _____ Chief Complaint: _____

Whom may we thank for referring you to our office? _____

List any medications you are taking or please provide a list on your next visit: _____

_____

Smoking Status: daily / occasionally / former / never

Authorization to treat:
I understand that no guarantees have been made concerning my recovery as every individual responds to Chiropractic differently. I hereby authorize Tankersley Chiropractic and whomever they may designate as an assistant to administer therapies and take x-rays if needed. I have read and understand the office policy stated above and agree to accept responsibility as described.

Patient/Guardian Signature: _____ **Date:** _____

Guardian Name (printed) **:** _____

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Authorization to release insurance and treatment information

I hereby instruct and authorize my insurance company to release information concerning my coverage and benefits for both health/auto insurance and pay by check made out and mailed directly to: Tankersley Chiropractic, 165 Indian Lake Blvd., Suite 102 Hendersonville, TN 37075.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize Tankersley Chiropractic to release and gather any or all my medical records as deemed necessary to/from other health care providers. I also authorize release of records to my insurance company as requested to facilitate payment to Tankersley Chiropractic. I understand this office will take all necessary precautions to insure my privacy. I have been given a copy of the HIPAA regulations for my review.

I understand that my account is considered delinquent if over 90 days old and may be sent to an outside source for collection. I agree that if Tankersley Chiropractic initiates collection efforts to recover amounts owed on my account, then, in addition to amounts owed for the services rendered, I will pay any and all costs incurred by Tankersley Chiropractic in pursuing collection, including, but not limited to, reasonable attorney fees, and any court costs or other costs of litigation incurred in collecting my delinquent account.

I have read and understand the office policy stated above and agree to accept responsibility as described.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. By signing below, I acknowledge that I have been made aware of its availability.

Patient/Guardian Signature: _____ **Date:** _____

Guardian Name (printed) **:** _____

Tankersley Chiropractic

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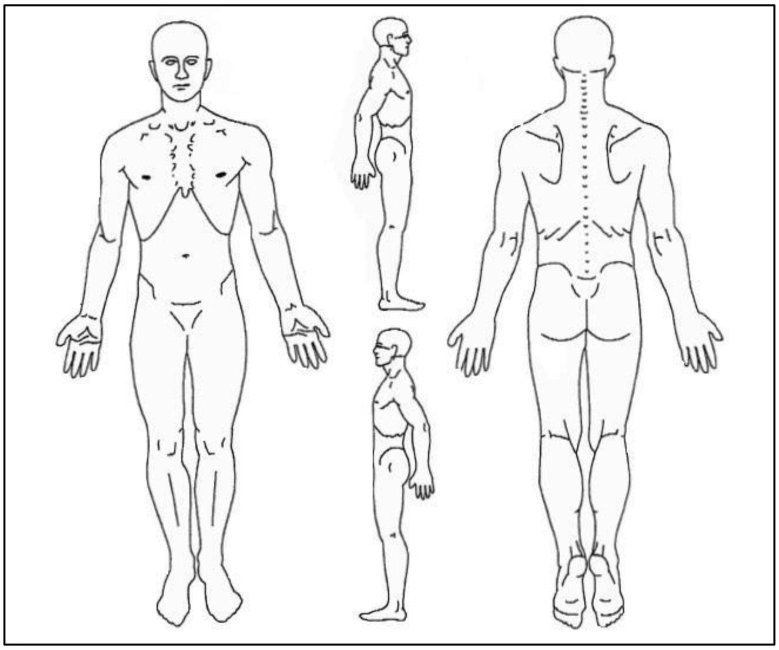
Subjective Pain Questionnaire

Name: ____ Date:________________



Mark each area of pain or complaint and use the boxes below to describe you condition.

On a scale of 1-10 with 10 being severe, rate your pain, stiffness, or numbness below.

Area of pain:

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Constant Off/On (if off / on answer next question)
If off & on, I feel it ________ (1, 2, 5 x's) per Day, Week, Month
Radiate: Y / N Where does it radiate? ______________________________
Better: Ice Heat Rest Movement Stretching Medication Other
Worse: Sit Stand Walk Lying Sleeping Bending Working Overuse AM PM All

Pain At Its **Best**: 0 1 2 3 4 5 6 7 8 9 10 Pain At Its **Worse**: 0 1 2 3 4 5 6 7 8 9 10

Area of pain:

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Constant Off/On (if off / on answer next question)
If off & on, I feel it ________ (1, 2, 5 x's) per Day, Week, Month
Radiate: Y / N Where does it radiate? ______________________________
Better: Ice Heat Rest Movement Stretching Medication Other
Worse: Sit Stand Walk Lying Sleeping Bending Working Overuse AM PM All

Pain At Its **Best**: 0 1 2 3 4 5 6 7 8 9 10 Pain At Its **Worse**: 0 1 2 3 4 5 6 7 8 9 10

Area of pain:

Type of Pain: Sharp Stabbing Burning Achy Dull Stiff & Sore
Frequency: Constant Off/On (if off / on answer next question)
If off & on, I feel it ________ (1, 2, 5 x's) per Day, Week, Month
Radiate: Y / N Where does it radiate? ______________________________
Better: Ice Heat Rest Movement Stretching Medication Other
Worse: Sit Stand Walk Lying Sleeping Bending Working Overuse AM PM All

Pain At Its **Best**: 0 1 2 3 4 5 6 7 8 9 10 Pain At Its **Worse**: 0 1 2 3 4 5 6 7 8 9 10

Other areas of concern: ____

____

Name: _____ Date: _____

Many of the following conditions respond to Chiropractic and Acupuncture treatment
please check all that apply

General: (constitutional)
- ❑ Recent Weight Change
- ❑ Fever
- ❑ Fatigue
- ❑ ***None in this Category***

Musculoskeletal:
- ❑ Low Back Pain
- ❑ Mid Back Pain
- ❑ Neck Pain
- ❑ Arm Problems _____
- ❑ Leg Problems _____
- ❑ Painful Joints _____
- ❑ Stiff/Swollen Joints
- ❑ Sore/Weak Muscles or Joints
- ❑ Muscle Spasms/Cramps
- ❑ Broken Bones _____

_____
- ❑ Other: _____
- ❑ ***None in this Category***

Neurological:
- ❑ Numbness or tingling sensations
- ❑ Loss of Feeling
- ❑ Dizziness or light headed
- ❑ Frequent or Recurrent Headaches
- ❑ Convulsions or seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Have you ever had a head injury?
- ❑ **Ever** been in an auto accident?
- ❑ Date of last accident?

_____
- ❑ Other: _____
- ❑ ***None in this Category***

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory Loss or Confusion
- ❑ Other: _____
- ❑ ***None in this Category***

Genitourinary:
- ❑ Sexual Difficulty
- ❑ Frequent Urination

Genitourinary Cont. :
- ❑ Incontinence or Bed Wetting
- ❑ Other: _____
- ❑ ***None in this Category***

Gastrointestinal:
- ❑ Loss of Appetite
- ❑ Change in Bowel Movements
- ❑ Painful Bowel Movements
- ❑ Nausea or Vomiting
- ❑ Abdominal Pain
- ❑ Frequent Diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ ***None in this Category***

Cardiovascular & Heart:
- ❑ Chest Pains
- ❑ Rapid or Heartbeat changes
- ❑ Blood Pressure Problems
- ❑ Swelling of Hands, Ankles, or Feet
- ❑ Heart Problems
- ❑ Other: _____
- ❑ ***None in this Category***

Respiratory:
- ❑ Difficulty Breathing
- ❑ Persistent Cough
- ❑ Coughing Blood
- ❑ Asthma or Wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ ***None in this Category***

Eyes and Vision:
- ❑ Blurred or double vision
- ❑ History of Ocular Migraines
- ❑ Eye disease or injury
- ❑ Other: _____
- ❑ ***None in this Category***

Ears, Nose and Throat:
- ❑ Swollen throat or voice change
- ❑ Swollen glands in neck
- ❑ Ringing in the ears

Ears, Nose and Throat Cont. :
- ❑ Ear – Ache / Ringing
- ❑ Ear Drainage
- ❑ Sinus / Allergy problems
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ ***None in this Category***

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive Thirst or urination
- ❑ Cold Extremities
- ❑ Heat or Cold intolerance
- ❑ Change in hat or glove size
- ❑ Dry skin
- ❑ Glandular or hormone problem
- ❑ Swollen Glands
- ❑ Anemia
- ❑ Easily Bruise or Bleed
- ❑ Phlebitis
- ❑ Immune system disorder
- ❑ Other:
- ❑ **None *in this Category***

Skin and Breasts:
- ❑ Rash or Itching
- ❑ Change in Skin Color
- ❑ Change in hair or nails
- ❑ Non-healing sores
- ❑ ***None in this Category***

Women Only:

Are you pregnant?
- ❑ Yes Due Date: _____
- ❑ No

Last Menstrual Period: _____
- ❑ Infertility
- ❑ Painful or Irregular periods
- ❑ Other: _____
- ❑ ***None in this Category***

Number of Children _____

Neck Index

ACN Group, Inc. Form NI-100

In the last 1-2 weeks, how has your condition affected the following?

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

In the last 1-2 weeks, how has your condition affected the following?

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