RICHLAND CHIROPRACTIC CENTER
YOUR HEALTH IS OUR MISSION

Chad Espeland, DC

Name_____ Sex: M F
Address _____Apt. _____
City _____ State_____Zip_____
Home Phone #_____ D.O.B._____ Age_____
Cell Phone # _____ Cell Carrier _____
SS# _____ D. L. #_____
Marital Status: M S D W Sep. Height ____'____" Weight _____ lbs.
E-mail _____Occupation_____
Employer_____WorkPhone #_____Ext._____

IN CASE OF EMERGENCY, CONTACT_____
Phone#(H)_____(W)_____Relationship_____
Address_____
City_____ State_____ Zip_____
Referred to this office by _____
Nearest relative(not living with you) Name mother_____
Address _____
City, State, Zip_____

Electronic Communication Policy
We would like to contact you via emails and/or text messages for certain office communication, such as appointment reminders, office closings, etc. In accordance with HIPAA protocols, this provides us with the permission to contact you by the method(s) of your choice.

Please mark only one (1) answer:
_____ I give my permission to receive text messages **and** email communications.
_____ I give my permission to receive text messages, **but** not email communications.
_____ I give my permission to receive email communications, **but** not text messages.
_____ I do not want to receive text messages or emails.

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

File #_____

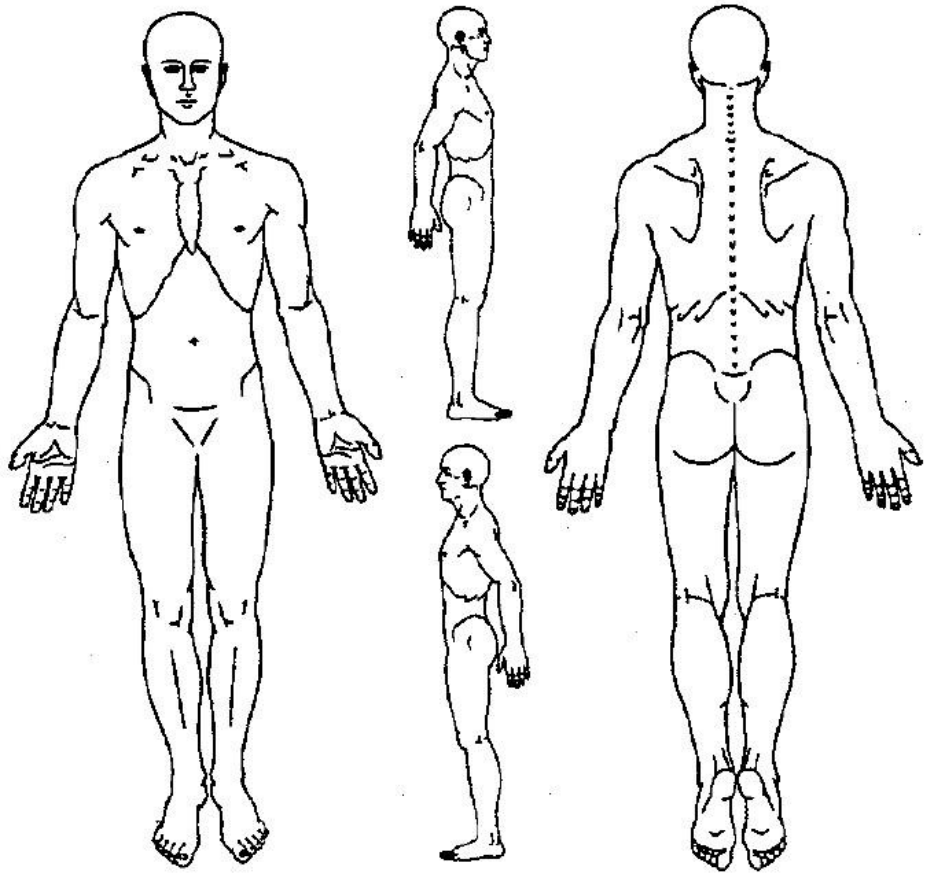
Revised 10/28/17

Name _____ Date _____

Is the condition due to an accident? Y N If yes, date_____
Type of accident: Auto Work Home Other_____
Describe your problem or condition_____
_____
_____
_____
When did your problem/condition start? Please provide your best estimate. Date_____
How did your problem/condition start? Gradual (over time) Sudden Unknown
Is your problem/condition getting worse over time? Yes No Unknown
Type of pain: Sharp Throbbing Stabbing Achy Shooting Annoying
Burning Tingling Dull Pounding Pulsating Pinching
How often do you have this pain? 25% (intermittent) 50% (occasional) 75% (frequent) 100% (constant) of the time.
What time of day is the pain the worst: Morning Afternoon Evening Night
What time of day is the pain the least: Morning Afternoon Evening Night
How intense is the pain on a scale of 1(no pain) to 10(severe pain)?_____
Does the problem/condition interfere with: Work Sleep Activities around house Exercise Social Activities Hobby
Is there anything that makes your pain better? _____
Is there anything that makes your pain worse? _____
Have you ever had a similar problem to the one you are currently experiencing? Y N
If yes, how many times has the problem/condition bothered you in the past? _____
What treatment have you tried for this problem/condition? OTC medications Rx medications Chiropractic
Physical therapy Injections Surgery None Other_____
Please circle and give date if you have had any of the following for the problem you are experiencing?: MRI_____
Myelogram_____ X-rays_____ CT Scan _____ Bone scan_____
Name of doctors that have treated you for this problem/condition:_____
Have you ever had chiropractic care? Y N If yes, how long ago_____

Please use the letters below to mark the area(s) on the body outlines to the right, in which you are experiencing symptoms.

A = Ache
B = Burning
D = Dull
N = Numbness
P = Pins/Needles
S = Sharp/Shooting



(Continues on the back of sheet)

Name_____ Date_____

(Please check any symptoms you have from the list below)

HEAD

_____ Headaches
- _____ entire head
- _____ back of head
- _____ forehead
- _____ temples
- _____ mild _____ occasional
- _____ moderate _____ frequent
- _____ severe _____ constant

NECK

_____ Neck pain
_____ Neck stiffness
_____ Neck pain & stiffness
_____ Mild _____ Occasional
_____ Moderate _____ Frequent
_____ Severe _____ Constant
_____ Neck pain with movement
- _____ forward
- _____ backward
- _____ turning to the left
- _____ turning to the right
- _____ bending to the left
- _____ bending to the right

_____ Pinched nerve
_____ Neck feels out of place
_____ Muscle spasms in the neck
_____ Grinding sounds in the neck
_____ Arthritis in the neck

UPPER BACK

_____ Pain across the shoulders
_____ Pain between the shoulder blades
_____ Muscle tension across the shoulders
_____ Muscle spasms between shoulder blades
_____ Pinched nerve under/around shoulder blade

MIDDLE BACK

_____ Middle back pain
_____ Middle back stiffness
_____ Middle back pain & stiffness
_____ Middle back muscle spasms
_____ Mild _____ Occasional
_____ Moderate _____ Frequent
_____ Severe _____ Constant
_____ Middle back back feels out of place
_____ Pinched nerve
_____ Muscle spasms in the middle back
_____ Arthritis in the middle back

LOW BACK

_____ Low back pain
_____ Low back stiffness
_____ Low back pain & stiffness
_____ Mild _____ Occasional
_____ Moderate _____ Frequent
_____ Severe _____ Constant
_____ Low back pain with movement
- _____ forward
- _____ backward
- _____ turning to the left
- _____ turning to the right
- _____ bending to the left
- _____ bending to the right

_____ Pinched nerve
_____ Low back feels out of place
_____ Muscle spasms in the low back
_____ Arthritis in the low back

Is the pain worse with any of these activities:

_____ Working _____ Lifting
_____ Stooping _____ Standing
_____ Sitting _____ Bending
_____ Walking _____ Lying down
_____ Coughing _____ Sleeping

ARMS & HANDS

_____ Pain in the arms R L
_____ Pain in the hands R L
_____ Pain in the fingers R L
_____ Numbness in the arms R L
_____ Numbness in the hands R L
_____ Numbness in the fingers R L
_____ Tingling in the arms R L
_____ Tingling in the hands R L
_____ Tingling in the fingers R L
_____ Loss of grip strength R L

PELVIS, LEGS & FEET

_____ Pain down the leg R L
_____ Pain down both legs
_____ Pain in the hip joint R L
_____ Pain in the SI joint R L
_____ Pain in the buttocks R L
_____ Numbness in the legs R L
_____ Numbness in the feet R L
_____ Numbness in the toes R L
_____ Tingling in the legs R L
_____ Tingling in the feet R L
_____ Tingling in the toes R L

REVIEW OF SYSTEMS: Circle Yes (Y) or No (N):

Constitutional			**Respiratory**			**Gastrointestinal**			**Dermatology**		
Recent weight loss	Y	N	Cough	Y	N	Abdominal pain	Y	N	Rashes	Y	N
Fever	Y	N	Wheezing	Y	N	Heartburn	Y	N	Sores	Y	N
Chills	Y	N	Short of breath	Y	N	Bloody stool	Y	N	Blisters	Y	N
									Dry or sensitive skin	Y	N
Endocrine			**Allergy**			**Psychology**			Hives	Y	N
Excessive thirst	Y	N	Runny nose	Y	N	Depression	Y	N	Suspicious moles	Y	N
Excessive sweating	Y	N	Itchy eyes	Y	N	Mood swings	Y	N	Suspicious lesions	Y	N
Excessive urination	Y	N	Stuffy nose	Y	N	Anxiety	Y	N	Itching	Y	N
Urology			**ENT**			**Genitourinary (Female)**			**Hematologic/Lymphatic**		
Frequent urination	Y	N	Nose bleeds	Y	N	Pelvic pain	Y	N	Easy bruising	Y	N
Difficulty urinating	Y	N	Sore throat	Y	N	Irregular periods	Y	N	Swollen glands	Y	N
Blood in urine	Y	N	Change in voice	Y	N	Recurrent infections	Y	N	Fatigue	Y	N
Cardiology			**Ophthalmology**			**Musculoskeletal**			**Neurology**		
Palpitations	Y	N	Eye irritation	Y	N	Muscle aches	Y	N	Dizziness	Y	N
Chest pains/tightness	Y	N	Blurred vision	Y	N	Joint pain	Y	N	Headaches	Y	N
High blood pressure	Y	N	Eye drainage	Y	N	Joint swelling	Y	N	Seizures	Y	N
Varicose veins	Y	N	Visual changes	Y	N	Joint stiffness	Y	N	Weakness	Y	N

FAMILY HISTORY: Does anyone in your family have a history of diabetes, rheumatoid arthritis, heart problems, stroke, cancer or multiple sclerosis? Yes or No. **If yes**, please specify_____

_____

Has anyone in your family ever had a spine problem similar to the one you are currently experiencing? **Please circle**

Mother Father Sister Brother Grandmother Grandfather

List **ALL** prescription and over-the-counter medications you are currently taking_____

_____

Past surgeries_____

Past fractures/dislocations_____

Past car accidents_____

Past traumas_____

List **ALL** allergies_____

EXERCISE	**WORK ACTIVITY**	**HABITS**	
None	Sitting	Smoking/Snuff	Packs or cans/day_____
1-3 x / wk	Standing	Alcohol	Drinks/wk_____
4-6 x / wk	Light Labor	Coffee/Caffeine Drinks	Cups/Day_____
Daily	Heavy Labor	High Stress Level	Reason_____

I authorize payment to the Richland Chiropractic Center. Richland Chiropractic Center may use and share your health information without your written authorization, for activities relating to treatment, payment, and health care operations. I have received a copy of the Notice of Privacy & Patient Rights for the Richland Chiropractic Center.

Signature_____ ***Date***_____

Doctor comments/notes: _____

_____

_____

_____

BCBS BCBS State UHC Aetna Cigna Medicare/Supp Humana(Medicare) Medicare/COB

Medicaid/Ambetter/Magnolia/UHC Medicare/Medicaid CHIPS Self Pay Other_____

Neck Pain Disability Oswestry Revised Questionnaire

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1: ***Pain Intensity***

A – I have no pain at the moment.
B – The pain is very mild at the moment.
C – The pain is moderate at the moment.
D – The pain is fairly severe at the moment.
E – The pain is very severe at the moment.
F – The pain is the worst imaginable at the moment.

SECTION 2: ***Personal Care***

A – I can look after myself normally without causing extra pain.
B – I can look after myself normally, but it causes extra pain.
C – It is painful to look after myself and I am slow and careful.
D – I need some help, but manage most of my personal care.
E – I need help every day in most aspects of self-care.
F – I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3: ***Lifting***

A – I can lift heavy weights without extra pain.
B – I can lift heavy weights, but it causes extra pain.
C – Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E – I can lift very light weights.
F – I cannot lift or carry anything at all.

SECTION 4: ***Reading***

A – I can read as much as I want to with no pain in my neck.
B – I can read as much as I want to with slight pain in my neck.
C – I can read as much as I want to with moderate pain in my neck.
D – I cannot read as much as I want because of moderate pain in my neck.
E – I cannot read as much as I want because of severe pain in my neck.
F – I cannot read at all.

SECTION 5: ***Headaches***

A – I have no headaches at all.
B – I have slight headaches which come infrequently.
C – I have moderate headaches which come infrequently.
D – I have moderate headaches which come frequently.
E – I have severe headaches which come frequently.
F – I have headaches almost all the time.

SECTION 6: ***Concentration***

A – I can concentrate fully when I want to with no difficulty.
B – I can concentrate fully when I want to with slight difficulty.
C – I have a fair degree of difficulty in concentrating when I want to.
D – I have a lot of difficulty in concentrating when I want to.
E – I have a great deal of difficulty in concentrating when I want to.
F – I cannot concentrate at all.

SECTION 7: ***Work***

A – I can do as much work as I want to.
B – I can only do my usual work, but no more.
C – I can do most of my usual work, but no more.
D – I cannot do my usual work.
E – I can hardly do any work at all.
F – I cannot do any work at all.

SECTION 8: ***Driving***

A – I can drive my car without any neck pain.
B – I can drive my car as long as I want with slight pain in my neck.
C – I can drive my car as long as I want with moderate pain in my neck.
D – I cannot drive my car as long as I want because of moderate pain in my neck.
E – I can hardly drive at all because of severe pain in my neck.
F – I cannot drive my car at all.

SECTION 9: ***Sleeping***

A – I have no trouble sleeping.
B – My sleep is slightly disturbed (less than 1 hour sleepless).
C – My sleep is mildly disturbed (1-2 hours sleepless).
D – My sleep is moderately disturbed (2-3 hours sleepless).
E – My sleep is greatly disturbed (3-5 hours sleepless).
F – My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10: ***Recreation***

A – I am able to engage in all of my recreational activities with no neck pain at all.
B – I am able to engage in all of my recreational activities with some pain in my neck.
C – I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D – I am able to engage in a few of my recreational activities because of pain in my neck.
E – I can hardly do any recreational activities because of pain in my neck.
F – I cannot do any recreational activities at all.

Comments:_____

_____

Name:_____ Date:_____ Score:_____

Oswestry Disability Index 2.0

Name _____ Date _____ Score: _____

Please Read: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life

Please answer every section. Circle only one in each section that most closely describes you **today.**

Section 1 - Pain Intensity	**Section 6 - Standing**
A. I have no pain at the moment	A. I can stand as long as I want without extra pain
B. The pain is very mild at the moment	B. I can stand as long as I want but it gives me extra pain
C. The pain is moderate at the moment	C. Pain prevents me from standing for more than 1 hour
D. The pain is fairly severe at the moment	D. Pain prevents me from standing for more than 1/2 hour
E. The pain is very severe at the moment	E. Pain prevents me from standing for more than 10 minutes
F. The pain is the worst imaginable at the moment	F. Pain prevents me from standing at all
Section 2 - Personal care (washing, dressing, etc)	**Section 7 - Sleeping**
A. I can look after myself normally without extra pain	A. My sleep is never disturbed by pain
B. I can look aftr myself normally but it is very painful	B. My sleep is occasionally disturbed by pain
C. It is painful to look after myself and I am slow and careful	C. Because of pain, I have less than 6 hours of sleep
D. I need some help but manage most of my personal care	D. Because of pain, I have less than 4 hours of sleep
E. I need help everyday in most aspects of self care	E. Because of pain, I have less than 2 hours of sleep
F. I do not get dressed, wash with difficulty and stay in bed	F. Pain prevents me from sleeping at all
Section 3 - Lifting	**Section 8 - Sex Life**
A. I can lift heavy weights without extra pain	A. My sex life is normal and causes me no extra pain
B. I can lift heavy weights, but it causes extra pain	B. My sex life is normal, but causes some extra pain
C. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned	C. My sex life is nearly normal but is very painful
	D. My sex life is severly restricted by pain
D. Pain prevents me from lifting heavy weights but I can manage light/medium weights if they are conveniently positioned	E. My sex life is nearly absent because of pain
	F. Pain prevents any sex life at all
E. I can only lift very light weights at the most	
F. I cannot lift or carry anything at all	
Section 4 - Walking	**Section 9 - Social Life**
A. Pain does not prevent me from walking any distance	A. My social life is normal and causes me no extra pain
B. Pain prevents me from walking more than 1 mile	B. My social life is normal, but increases the degree of pain
C. Pain prevents me from walking more than 1/4 mile	C. Pain has no significant effect on my social life apart from limiting my more energetic interests (sports, etc)
D. Pain prevents me from walking more than 100 yards	D. Pain has restricted my social life and I do not go out as often
E. I can only walk while using a stick or crutches	E. Pain has restricted my social life to home
F. I am in bed most of the time and have to crawl to the toilet	F. I have no social life because of the pain
Section 5 - Sitting	**Section 10 - Traveling**
A. I can sit in any chair as long as I like	A. I can travel anywhere without pain
B. I can only sit in my favorite chair as long as I like	B. I can travel anywhere but it causes extra pain
C. Pain prevents me from sitting more than 1 hour	C. Pain is bad but I manage journeys over 2 hours
D. Pain prevents me from sitting more than 1/2 hour	D. Pain restricts me to journeys of less than 1 hour
E. Pain prevents me from sitting more than 10 minutes	E. Pain restricts me to short necessary journeys under 30 min.
F. Pain prevents me from sitting at all	F. Pain prevents me from traveling except to receive treatment

Comments: _____

_____

_____

_____

Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine 25(24)3115-24