PATIENT HISTORY

Date of Birth _____ **Age** _____ **Social Security #** _____

Last _____ **First** _____ **Middle Initial** _____

Address _____ **City** _____ **ST**_____ **Zip** _____

Phone (H) _____ **(W)** _____ **(C)** _____

Email _____ **May we send you our online newsletter?** ☐ Yes ☐ No

Your Occupation _____ **Employer** _____

Spouse's Name _____ **Spouse DOB** _____ **Spouse SSN:** _____

Have you been to another doctor for this problem? ☐ Yes ☐ No **Who/Where?** _____

Who may we thank for referring you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

Date when symptom first appeared _____ **Did it begin:** ☐ Gradual ☐ Sudden ☐ Progressive over time

What makes the symptoms increase? _____ **What relieves the symptoms?** _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb **Does the Pain Radiate into your:** ☐ Arm ☐ Leg ☐ Does not radiate

Do you have Numbness or Tingling? ☐ yes ☐ no **How often do you experience these symptoms?** ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____

Date when symptom first appeared _____ **Did it begin:** ☐ Gradual ☐ Sudden ☐ Progressive over time

What makes the symptoms increase? _____ **What relieves the symptoms?** _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb **Does the Pain Radiate into your:** ☐ Arm ☐ Leg ☐ Does not radiate

Do you have Numbness or Tingling? ☐ yes ☐ no **How often do you experience these symptoms?** ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10%

Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible) _____

_____

Do you have any family members who suffer from the same complaint? If so, who? _____

Do you smoke? ☐ yes ☐ no If yes, how many packs per week? _____

Have you ever smoked in the past? ☐ yes ☐ no If yes, when did you quit? _____

Do you take birth control? ☐ yes ☐ no **Have you ever taken birth control in the past?** ☐ yes ☐ no

Do you consume alcohol? ☐ yes ☐ no If yes, how many drinks per week? _____

Do you consume caffeine? ☐ yes ☐ no If yes, how many drinks per day? _____

Do you exercise? ☐ yes ☐ no If yes, how many times per week and what type? _____

Do you have a high stress level? ☐ yes ☐ no If yes, list reasons: _____

_____

Please list any medications or vitamins you are currently taking:

_____

_____

_____

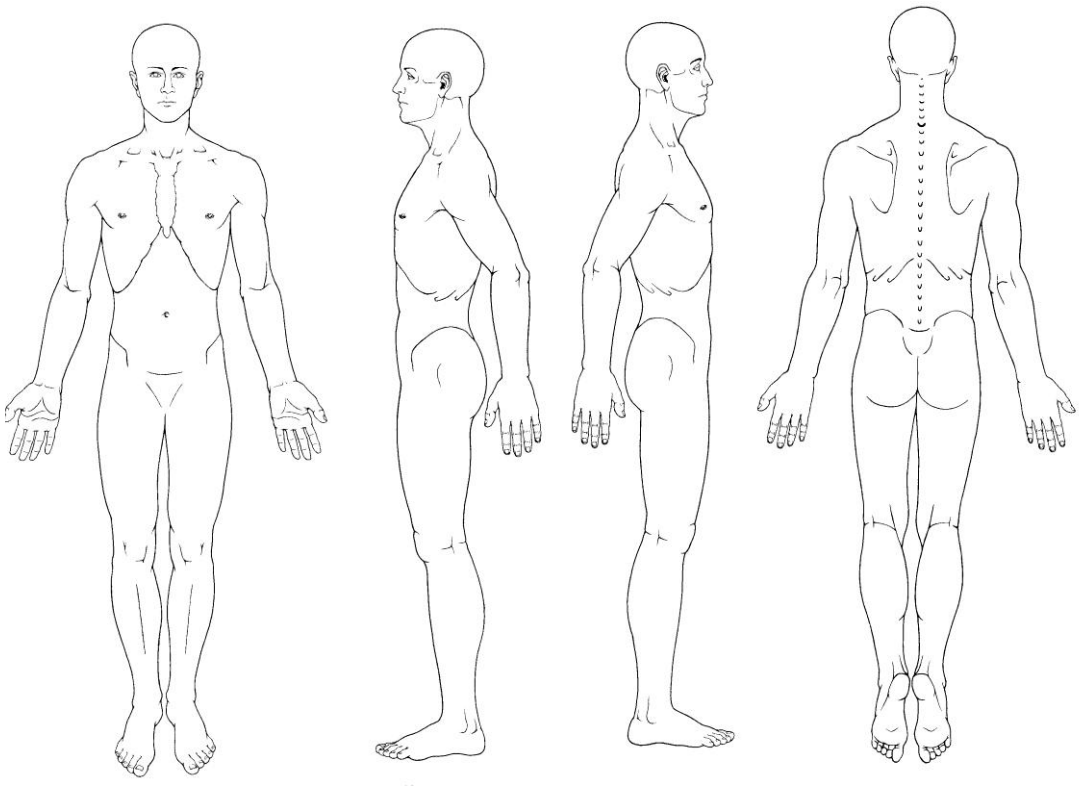
_____

_____

PATIENT SIGNATURE _____ **DATE** _____

Please mark off the areas of your complaint on the diagram above with the following indicators:

PPP = pain
NNN = numbness
TTT= tingling
BBB= burning
CCC= cramping
XXX = other



Please list all surgeries, injuries, accidents, falls, etc: _____

_____

_____

_____

_____

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Alcoholism	☐ Anemia	☐ Allergy Shots	☐ Anorexia
☐ Anorexia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorders	☐ Breast Lump
☐ Bronchitis	☐ Bulimia	☐ Cancer	☐ Cataracts	☐ Chemical Dependency
☐ Chicken Pox	☐ Diabetes	☐ Disc Degeneration	☐ Emphysema	☐ Epilepsy
☐ Epilepsy	☐ Glaucoma	☐ Goiter	☐ Gonorrhea	☐ Gout
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hernia	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Liver Disease	☐ Measles
☐ Migraine	☐ Miscarriage	☐ Mononucleosis	☐ MS	☐ Mumps
☐ Osteoporosis	☐ Pacemaker	☐ Parkinson's Disease	☐ Pinched Nerve	☐ Pneumonia
☐ Polio	☐ Prostate Problem	☐ Prosthesis	☐ Psychiatric Care	☐ Stroke
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Suicide Attempt	☐ Thyroid Problems	☐ Tonsillitis
☐ Tuberculosis	☐ Tumors/Growths	☐ Typhoid Fever	☐ Ulcers	☐ Vascular Disease
☐ Vaginal Infections	☐ Venereal Disease	☐ Whooping Cough	☐ Rheumatoid Arthritis	
Other:				

PATIENT SIGNATURE _____ **DATE** _____

Paulding Spinal Clinic

3655 Macland Road • Hiram, GA 30141 • 770-439-6063 phone

NECK PAIN QUESTIONNAIRE

Patient Name: _____ Date: _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your neck pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now.

Pain Intensity	***Concentration***
○ I have no pain at the moment.	○ I can concentrate fully when I want to with no difficulty.
○ The pain is very mild at the moment.	○ I can concentrate fully when I want to with slight difficulty.
○ The pain is moderate at the moment.	○ I have a fair degree of difficulty in concentrating when I want to.
○ The pain is fairly severe at the moment.	○ I have a lot of difficulty in concentrating when I want to.
○ The pain is very severe at the moment.	○ I have a great deal of difficulty in concentrating when I want to.
○ The pain is the worst imaginable at the moment.	○ I cannot concentrate at all.
Personal Care (Washing, Dressing, etc.)	***Work***
○ I can look after myself normally without causing extra pain.	○ I can do as much work as I want to.
○ I can look after myself normally, but it causes extra pain.	○ I can only do my usual work, but no more.
○ It is painful to look after myself and I am slow and careful.	○ I can do most of my usual work, but no more.
○ I need some help, but manage most of my personal care.	○ I cannot do my usual work.
○ I need help every day in most aspects of self care.	○ I can hardly do any work at all.
○ I do not get dressed, I wash with difficulty and stay in bed.	○ I cannot do any work at all.
Lifting	***Driving***
○ I can lift heavy weights without extra pain.	○ I can drive my car without any neck pain.
○ I can lift heavy weights, but it gives extra pain.	○ I can drive my car as long as I want with slight pain in my neck.
○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.	○ I can drive my car as long as I want with moderate pain in my neck.
○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.	○ I cannot drive my car as long as I want because of moderate pain in my neck.
○ I can lift very light weights.	○ I can hardly drive at all because of severe pain in my neck.
○ I cannot lift or carry anything at all.	○ I cannot drive my car at all.
Reading	***Sleeping***
○ I can read as much as I want to with no pain in my neck.	○ I have no trouble sleeping.
○ I can read as much as I want to with slight pain in my neck.	○ My sleep is slightly disturbed (less than 1 hour sleepless).
○ I can read as much as I want to with moderate pain in my neck.	○ My sleep is mildly disturbed (1-2 hours sleepless).
○ I cannot read as much as I want because of moderate pain in my neck.	○ My sleep is moderately disturbed (2-3 hours sleepless).
○ I cannot read as much as I want because of severe pain in my neck.	○ My sleep is greatly disturbed (3-5 hours sleepless).
○ I cannot read at all.	○ My sleep is completely disturbed (5-7 hours)
Headaches	***Recreation***
○ I have no headaches at all.	○ I am able to engage in all of my recreational activities with no neck pain at all.
○ I have slight headaches which come infrequently.	○ I am able to engage in all of my recreational activities with some pain in my neck.
○ I have moderate headaches which come infrequently.	○ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
○ I have moderate headaches which come frequently.	○ I am able to engage in a few of my recreational activities because of pain in my neck.
○ I have severe headaches which come frequently.	○ I can hardly do any recreational activities because of pain in my neck.
○ I have headaches almost all the time.	○ I cannot do any recreational activities at all.

Paulding Spinal Clinic

3655 Macland Road • Hiram, GA 30141 • 770-439-6063 phone

LOW BACK PAIN QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your low back pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice which most closely describes your problem right now

Pain Intensity
- ○ The pain comes and goes and is very mild.
- ○ The pain is mild and does not vary much.
- ○ The pain comes and goes and is moderate.
- ○ The pain is moderate and does not vary much.
- ○ The pain comes and goes and is severe.
- ○ The pain is severe and does not vary much.

Standing
- ○ I can stand as long as I want without pain.
- ○ I have some pain while standing, but it does not increase with time.
- ○ I cannot stand for longer than one hour without increasing pain.
- ○ I cannot stand for longer than 1/2 hour without increasing pain.
- ○ I cannot stand for longer than ten minute without increasing pain.
- ○ I avoid standing, because it increases the pain straight away.

Personal Care
- ○ I would not have to change my way of washing or dressing in order to avoid pain.
- ○ I do not normally change my way of washing or dressing even though it causes some pain.
- ○ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ○ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ○ Because of the pain, I am unable to do some washing and dressing without help.
- ○ Because of the pain, I am unable to do any washing or dressing without help.

Sleeping
- ○ I get no pain in bed.
- ○ I get pain in bed, but it does not prevent me from sleeping well.
- ○ Because of pain, my normal night's sleep is reduced by less than one than one quarter.
- ○ Because of pain, my normal night's sleep is reduced by less than one-half.
- ○ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ○ Pain prevents me from sleeping at all.

Lifting
- ○ I can lift heavy weights without extra pain.
- ○ I can lift heavy weights, but it causes extra pain.
- ○ Pain prevents me from lifting heavy weights off the floor.
- ○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
- ○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ○ I can only lift very light weights, at the most.

Social Life
- ○ My social life is normal and gives me no pain.
- ○ My social life is normal, but increases the degree of my pain.
- ○ Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.
- ○ Pain has restricted my social life and I do not go out very often.
- ○ Pain has restricted my social life to my home.
- ○ I have hardly any social life because of the pain.

Walking
- ○ Pain does not prevent me from walking any distance.
- ○ Pain prevents me from walking more than one mile.
- ○ Pain prevents me from walking more than 1/2 mile.
- ○ Pain prevents me from walking more than 1/4 mile.
- ○ I can only walk while using a cane or on crutches.
- ○ I am in bed most of the time and have to crawl to the toilet.

Traveling
- ○ I get no pain while traveling.
- ○ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ○ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ○ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ○ Pain restricts all forms of travel.
- ○ Pain prevents all forms of travel except that done lying down.

Sitting
- ○ I can sit in any chair as long as I like without pain.
- ○ I can only sit in my favorite chair as long as I like.
- ○ Pain prevents me from sitting more than one hour.
- ○ Pain prevents me from sitting more than 1/2 hour.
- ○ Pain prevents me from sitting more than ten minutes.
- ○ Pain prevents me from sitting at all.

Changing Degree of Pain
- ○ My pain is rapidly getting better.
- ○ My pain fluctuates, but overall is definitely getting better.
- ○ My pain seems to be getting better, but improvement is slow at present.
- ○ My pain is neither getting better nor worse.
- ○ My pain is gradually worsening.
- ○ My pain is rapidly worsening.

Informed Consent to Treatment

The nature of chiropractic treatment: The doctor may use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic laser, acupuncture or mechanical traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment. I am here solely for the purpose of my health, and I represent no other agency, group, organization other than myself.

Patient Printed Name	Patient Signature	Date

Witness Printed Name	Witness Signature	Date

Paulding Spinal Clinic
3655 Macland Road • Hiram, GA 30141
770-439-6063 phone

How We Protect Your Private Health Information

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I consent to the use or disclosure of my protected health information by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that **Dr. Jordan Haugh** may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above states purposes. My signature on this document is evidence of this consent.

I understand I have a right to request a restriction as to how my personal health information is used or disclosed to carry out treatment, payment or health care operations at the practice. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding.

I understand I have a right to review this office's Notice of Privacy practices prior to signing this document. This office's Notice of Privacy has been provided to me. This Notice of Privacy Practices describes the type of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of this office. The Notice of Privacy Practices for this office is also provided upon request at the main administrative desk of this office. Notice of Privacy Practices also describes my rights and this office's duties with respect to my protected health information.

This office has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the Privacy Officer at **770-439-6063** and requesting a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that this office or **Dr. Jordan Haugh** have taken action in reliance on this consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding the Privacy Policies, and all my questions have been answered fully and satisfactorily.

Patient Printed Name	Patient Signature	Date
Witness Printed Name	Witness Signature	Date

Paulding Spinal Clinic
3655 Macland Road • Hiram, GA 30141 • 770-439-6063 phone