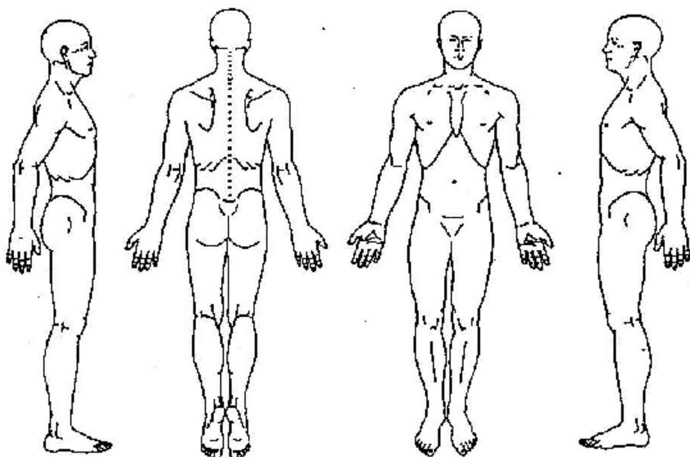
Patient Information Form

Name ______________________________ Date ______________
Address ______________________ City ____________ State ________ Zip __________

SS # ____________ DL # ______________ Home # (______) ____________ Cell # (______) ____________
Age _____ Birth Date __________ Marital __ S __ M __ D __W Sex __ M __ F E Mail ______________

Patient's Employer ______________________________ Job ______________
Address ______________________________ Work # (______) ____________

Insurance Co ____________________ Group # ____________ ID # ______________
Name of Insured ____________________ Birth Date ____________ SS # ______________
Insured's Employer ______________________________ Work # (______) ____________
Relation to Insured ____________________ Referred by ______________________



Indicate where you have pain or other symptoms

When did your symptoms start? ______________________
____

How did you symptoms begin? ______________________
____

______ All notes regarding my complaints made by my doctor or myself on this document were reviewed by me following the completion of this document.

PRIMARY condition:
__ Head __ L__ R Shoulder
__ Neck __ L__ R Elbow
__ Upper Back __ L__ R Arm/Hand
__ Mid Back __ L__ R Hip
__ Low Back __ L__ R Knee
__ Pelvis __ L__ R Leg/Foot

Please circle current pain level:
0 1 2 3 4 5 6 7 8 9 10
None Unbearable

How Often? (% of the day):
__ Constant (76-100%)
__ Recurring (51-75%)
__ Intermittent (26-50%)
__ Occasional (0-25%)

Describe your symptoms:
__ Sharp __ Shooting
__ Dull __ Burning
__ Numbness __ Tingling

What makes your symptoms worse?
__ Standing __ Walking __ Sitting
__ Lying __ Coughing __ Lifting

What makes your symptoms better?
__ Resting __ Ice __ Heat
__ Activity __ Medicine __________

Condition feels better in the:
__ Morning __ Afternoon __ Evening

Condition feels worse in the:
__ Morning __ Afternoon __ Evening

SECONDARY condition:
__ Head __ L__ R Shoulder
__ Neck __ L__ R Elbow
__ Upper Back __ L__ R Arm/Hand
__ Mid Back __ L__ R Hip
__ Low Back __ L__ R Knee
__ Pelvis __ L__ R Leg/Foot

Please circle current pain level:
0 1 2 3 4 5 6 7 8 9 10
None Unbearable

How Often? (% of the day):
__ Constant (76-100%)
__ Recurring (51-75%)
__ Intermittent (26-50%)
__ Occasional (0-25%)

Describe your symptoms:
__ Sharp __ Shooting
__ Dull __ Burning
__ Numbness __ Tingling

What makes your symptoms worse?
__ Standing __ Walking __ Sitting
__ Lying __ Coughing __ Lifting

What makes your symptoms better?
__ Resting __ Ice __ Heat
__ Activity __ Medicine __________

Condition feels better in the:
__ Morning __ Afternoon __ Evening

Condition feels worse in the:
__ Morning __ Afternoon __ Evening

ADDITIONAL conditions:
__ Head __ L__ R Shoulder
__ Neck __ L__ R Elbow
__ Upper Back __ L__ R Arm/Hand
__ Mid Back __ L__ R Hip
__ Low Back __ L__ R Knee
__ Pelvis __ L__ R Leg/Foot

Please circle current pain level:
0 1 2 3 4 5 6 7 8 9 10
None Unbearable

How Often? (% of the day):
__ Constant (76-100%)
__ Recurring (51-75%)
__ Intermittent (26-50%)
__ Occasional (0-25%)

Describe your symptoms:
__ Sharp __ Shooting
__ Dull __ Burning
__ Numbness __ Tingling

What makes your symptoms worse?
__ Standing __ Walking __ Sitting
__ Lying __ Coughing __ Lifting

What makes your symptoms better?
__ Resting __ Ice __ Heat
__ Activity __ Medicine __________

Condition feels better in the:
__ Morning __ Afternoon __ Evening

Condition feels worse in the:
__ Morning __ Afternoon __ Evening

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Jaehne Chiropractic Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Jaehne Chiropractic Clinic. I understand that diagnosis or treatment of me by Robert Jaehne, D.C. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Jaehne Chiropractic Clinic is not required to agree to the restrictions that I may request. However, if Jaehne Chiropractic Clinic agrees to a restriction that I request, the restriction is binding on Jaehne Chiropractic Clinic and Robert Jaehne, D.C. I have the right to revoke this consent, in writing, at any time, except to the extent that Robert Jaehne, D.C. or Jaehne Chiropractic Clinic has taken action in reliance on this consent.

Patient's Signature ____ Date ____________________

Informed Consent

Every type of health care is associated with some risk of potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we used trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only. This is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to the vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment". We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to the vertebral artery strokes, but no one is certain. Recent studies (Journal of the CCA, Vol 37, No. 2, June 1993) estimate that the incident of this of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and the back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there is no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there or no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there is no available statistics to quantify their probability.

Soreness: It is common to chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance or treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

Patient's Signature ____ Date ____________________

Seen other doctor for CURRENT condition(s)?	__ No	Dr's Name ____ ______________________		
Previous medical tests for CURRENT condition(s)?	__ None	__ Lab	__ X-rays	__ MRI / CT
Medications (Rx / OTC) for CURRENT condition(s)?	__ None	__ Anti-Inflammatory	__ Muscle Relax	__ Pain/Analgesic

Have you lost time from work due to CURRENT condition(s)? __ No __ Yes ____ ______________________

Have you had SIMILAR symptoms in the past? __ No __ Yes ____ ______________________

Have you had Chiropractic care before? __ No __ Yes ____ ______________________

Your Past History: (Previous Medical Care)	__ Cancer / Tumors __ Stroke __ Diabetes	__ Infection / Fever __ Neuro Disorders / MS __ Blood Pressure	__ Heart / Cardiovascular __ Auto Immune Diseases __ Dizziness	__ Anemia __ Osteoporosis __ Insomnia	__ Arthritis __ Thyroid Disease __ Digestion Problems
Grandparent's History:	__ Cancer / Tumors __ Stroke __ Diabetes	__ Infection / Fever __ Neuro Disorders / MS __ Blood Pressure	__ Heart / Cardiovascular __ Auto Immune Diseases __ Dizziness	__ Anemia __ Osteoporosis __ Insomnia	__ Arthritis __ Thyroid Disease __ Digestion Problems
Parent's History:	__ Cancer / Tumors __ Stroke __ Diabetes	__ Infection / Fever __ Neuro Disorders / MS __ Blood Pressure	__ Heart / Cardiovascular __ Auto Immune Diseases __ Dizziness	__ Anemia __ Osteoporosis __ Insomnia	__ Arthritis __ Thyroid Disease __ Digestion Problems
Sibling's History:	__ Cancer / Tumors __ Stroke __ Diabetes	__ Infection / Fever __ Neuro Disorders / MS __ Blood Pressure	__ Heart / Cardiovascular __ Auto Immune Diseases __ Dizziness	__ Anemia __ Osteoporosis __ Insomnia	__ Arthritis __ Thyroid Disease __ Digestion Problems
Your Social History:	__ Smoke	__ Drink Alcohol	__ Recreational Drugs	__ None of the previous	
Medications Now Taking:	__ Anti-Inflammatory __ Blood Pressure __ GI / Digestion	__ Antibiotics __ Blood Thinner __ Sleep / Insomnia	__ Muscle Relax __ Blood Sugar __ Thyroid	__ Pain/Analgesic __ Cholesterol __ Allergies	__ Tranquilizers __ Hormones ______________
Past Medications:	__ Anti-Inflammatory __ Blood Pressure __ GI / Digestion	__ Antibiotics __ Blood Thinner __ Sleep / Insomnia	__ Muscle Relax __ Blood Sugar __ Thyroid	__ Pain/Analgesic __ Cholesterol __ Allergies	__ Tranquilizers __ Hormones ______________
Allergies:	__ Sinus / Respiratory	__ Food / Digestion	__ Skin	______________________	

Surgeries / Hospitalized: ____

In general, my health is:	__ Excellent	__ Very Good	__ Good	__ Fair	__ Poor
Compared to a year ago, my health is	__ Better	__ Somewhat better	__ Same	__ Somewhat worse	__ Worse
Decrease of social activities during the past 4 weeks	__ Not at all	__ Slightly	__Moderately	__ Quite a bit	__ Extremely
Decrease of work activities during the past 4 weeks	__ Not at all	__ Slightly	__Moderately	__ Quite a bit	__ Extremely

To your knowledge, are you pregnant? __ No __ Yes

Are you taking birth control medicines? __ No __ Yes

Are you seeing an OB-GYN doctor regularly? __ No __ Yes Name ______________________

Review of Symptoms: Please mark all symptoms that apply to you.

General:	__ Fatigue	__ Weakness	__ Fever /Chills	__ Weight Change	__ Night Sweats
Skin:	__ Pain	__ Rash	__ Redness	__ Itching	__ Eczema
Eyes:	__ Pain	__ Discharge	__ Infection	__ Vision Trouble	
Ears:	__ Pain	__ Discharge	__ Infection	__ Hearing Trouble	__ Ringing
Nose:	__ Pain	__ Bleeding	__ Infection	__ Absence of Smell	__ Obstruction
Mouth/Throat:	__ Pain	__ Bleeding	__ Gum Disease	__ Abnormal Taste	__ Lesions
Heart:	__ Pain	__ Palpitations	__ Edema/Swelling	__ Murmur	__ Fainting
Lung:	__ Pain	__ Cough	__ Phlegm	__ Difficult Breathing	__ Bloody Discharge
Gastrointestinal:	__ Pain	__ Nausea	__ Diarrhea	__ Constipation	__ Weight Change
Genitourinary:	__ Pain	__ Discharge	__ Blood in Urine	__ Incontinence	__ Frequent Urination
	__ Sterility	__ Impotence	__ Abnormal Bleeding	__ Amenorrhea	
Endocrine:	__ Hair Loss	__ Thirsty	__ Tremors	__ Hot/Cold Intolerance	__ Sleep Issues
Psychologic:	__ Anxiety	__ Depression	__ Memory Loss	__ Mood Swings	__ Phobias
Neurologic:	__ Headaches	__ Seizures	__ Dizziness	__ Anxiety	__ Numbness

Pain Index: Please answer every section by marking 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
__ 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 very severe.
__ The pain is very severe and does not vary much.

Sleeping
__ I get no pain in bed.
__ I get pain in bed but it does not prevent me from sleeping well.
__ Because of the pain my normal sleep is reduced by less than 25%.
__ Because of the pain my normal sleep is reduced by less than 50%.
__ Because of the pain my normal sleep is reduced by less than 75%.
__ Pain prevents me from sleeping at all.

Sitting
__ I can sit in any chair as long as I like.
__ I can only sit in my favorite chair as long as I like.
__ Pain prevents me from sitting more than 1 hour.
__ Pain prevents me from sitting more than 1/2 hour.
__ Pain prevents me from sitting more than 10 minutes.
__ I avoid sitting because it increases pain immediately.

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 1 hour without increasing pain.
__ I cannot stand for longer than 1/2 hour without increasing pain.
__ I cannot stand for longer than 10 minutes without increasing pain.
__ I avoid standing because it increases pain immediately.

Walking
__ I have no pain while walking.
__ I have some pain while walking but it does not increase with distance.
__ I cannot walk more than 1 mile without increasing pain.
__ I cannot walk more than 1/2 mile without increasing pain.
__ I cannot walk more than 1/4 mile without increasing pain.
__ I cannot walk at all without increasing pain

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.
__ No lifting heavy weights off the floor, but I manage if they are conveniently positioned.
__ No lifting heavy weights off the floor, but I manage light weights conveniently positioned.
__ I can only lift very light weights.

Personal Care
__ I do 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 though it causes some pain.
__ Washing / dressing increases my pain but I manage not to change my way of doing it.
__ Washing / dressing increases my pain and I find it necessary to change my way of doing it.
__ Because of the pain I am unable to do some washing / dressing without help.
__ Because of the pain I am unable to do any washing / dressing without help.

Traveling
__ I get no pain while traveling.
__ I get some pain while traveling but none of my usual forms of travel make it worse.
__ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
__ I get extra pain while traveling which causes me to seek alternate forms of travel.
__ Pain restricts all forms of travel except that done while lying down.
__ Pain restricts all forms of travel.

Social Life
__ My social life is normal and gives me no extra pain.
__ My social life is normal but it increases the degree of pain.
__ Pain has no significant affect on my social life apart from limiting more energetic interests.
__ 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.

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.
__ My pain is neither getting better or worse.
__ My pain is gradually worsening.
__ My pain is rapidly worsening.