RODERICK WHITE CHIROPRACTIC

2101 Magnolia Avenue S.
Magnolia Building # 411
Birmingham, AL 35205
P (205) 847-1633

1960 Chandalar Drive
Suite E
Pelham, AL 35124
P (205) 664-8881

Fax (844) 965-9141

Chiropractic Case History/Patient Information

First Name:_____ MI:_____ Last Name:_____ DOB:_____

Address:_____ City:_____ State:_____ Zip:_____

E-mail Address (we **only** use your e-mail address for appointment reminders and office communications):

_____

Cell Phone:_____ Home Phone:_____

Best number to reach you regarding appointments: ☐ Home ☐ Cell ☐ Work

Age:_____ Race:_____ Marital Status: M S W D Social Security #:_____

Occupation:_____ Employer:_____

Employer's Address:_____ Work Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

Names and Ages of Children:_____

Name of Nearest Relative:_____ Address:_____ Phone:_____

How did you find out about our office?_____

Family Medical Doctor:_____

May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company:_____

Policy Holder:_____ Relationship to Patient:_____

Policy Holder's DOB:_____ SS#:_____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Authorizations, Releases and Acknowledgements

HIPAA/Notice of Privacy Policy Acknowledgement
I have received, read and understand the "Notice of Privacy Practices" containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the "Notice of Privacy Practices" from time to time, and that I may contact Dr. Roderick White / Roderick White Chiropractic to obtain a copy of the "Notice of Privacy Practices" at any time.
_____ Initials

Consent for treatment:
I, the undersigned patient, consent to and authorize the performance of any diagnostic exam(s) and the treatment as deemed necessary by Dr. Roderick White.
_____ Initials

Consent for the treatment of a minor:
Anyone under the age of 18 will not be treated without a parent or legal guardian present, unless the patient is an emancipated minor. I, the parent or legal guardian of the patient, consent to and authorize the performance of any diagnostic exam(s) and the treatment as deemed necessary by my physician(s) at Dr. Roderick White / Roderick White Chiropractic.
_____ Initials

Pregnancy Disclosure:
I acknowledge that I am not pregnant and authorize Dr. Roderick White to perform diagnostic images
_____ Initials

Attorney Medical Authorization:
I fully authorize Dr. Roderick White to discuss all information pertaining to my medical bills and records including diagnostic images, evaluations and case details with the law firm who is representing me for my case both verbally and in writing. This authorization is at my request. I may revoke this authorization at any time in writing. Revoking this request will not affect actions already taken in reliance upon this authorization form. Dr. Roderick White / Roderick White Chiropractic will follow HIPAA rules and regulations when handling information.
_____ Initials

Payment of Benefits:
I hereby authorize my insurance company to pay Dr. Roderick White for any benefits allowable as payment toward the total charges for professional services rendered. I instruct my insurance company to release medical payment benefits information to Dr. Roderick White including but not limited to medical payment policy limits.
_____ Initials

Messages:
Dr. Roderick White has my permission to contact me via phone/voicemail regarding medical matters & appointments ___Yes___No
Dr. Roderick White has my permission to email me regarding medical matters & appointments ___Yes___No
Dr. Roderick White has my permission to text me regarding medical matters & appointments ___Yes___No
Calls/Texts/Emails will be made according to the information provided on the "Patient Information Sheet"
_____ Initials

Office Policies:
I understand that Dr. Roderick White sees patients by appointments and not walk-ins. I understand that if I am early to my appointment, I might have to wait until my scheduled appointment time. I further understand that if I am more than 15 minutes late, my appointment will be rescheduled. I agree to contact Dr. Roderick White.
_____ Initials

Agreement:
By signing below I certify that I have read, understand and agree that all information provided is truthful and accurate to the best of my knowledge.

_____ _____
Patient/Parent/Guardian/Authorized Representative Date

Name: _____ Today's Date: _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ☐ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ☐ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ☐ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ☐ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ☐ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ☐ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ☐ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ☐ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ☐ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ☐ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ☐ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ☐ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ☐ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

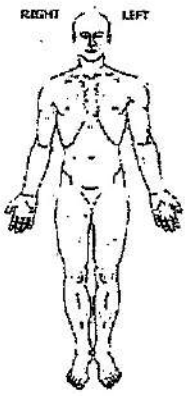
RODERICK WHITE [redacted] CHIROPRACTIC

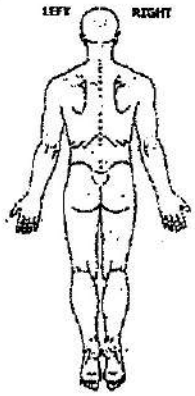
COMPLAINT
(Initial Exam, Daily Note, Follow Up/Final Exam)

Complaint #__ -

Please place an X on one part of the body where you are experiencing pain or discomfort and list your complaints in the order of severity. (If you do not see your complaint on the picture, please list the complaint on the Other line.

Please grade pain 0-10 (10 is the highest) ⓿ · ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿





Other: _____

This complaint came on:	◻ Gradually	◻ Immediately	
It is getting:	◻ Improving	◻ Staying the same	◻ Getting Worse
The intensity of this complaint is:	◻ Minimal ◻ Slight	◻ Moderate	◻ Severe
The frequency of this complaint is: ◻Intermittent	◻ Occasional	◻ Frequent	◻ Constant
The pain is:	◻ Dull	◻ Sharp	◻ Aching
	◻ Shooting	◻ Spasm	◻ Throbbing
	◻ Burning	◻ Spasm	◻ Tingling
The pain is located on:	◻ Left side	◻ Right side	◻ Both sides

Actions effecting this complaint:

Morning	◻ Brings On	◻ Aggravates	◻ Relieves
Afternoon	◻ Brings On	◻ Aggravates	◻ Relieves
Cold	◻ Brings On	◻ Aggravates	◻ Relieves
Heat	◻ Brings On	◻ Aggravates	◻ Relieves
Medication	◻ Brings On	◻ Aggravates	◻ Relieves
Resting	◻ Brings On	◻ Aggravates	◻ Relieves
Straining	◻ Brings On	◻ Aggravates	◻ Relieves
Standing	◻ Brings On	◻ Aggravates	◻ Relieves
Sitting	◻ Brings On	◻ Aggravates	◻ Relieves
Lying down	◻ Brings On	◻ Aggravates	◻ Relieves
Bending forward	◻ Brings On	◻ Aggravates	◻ Relieves
Bending back	◻ Brings On	◻ Aggravates	◻ Relieves
Bending left	◻ Brings On	◻ Aggravates	◻ Relieves
Twisting left	◻ Brings On	◻ Aggravates	◻ Relieves
Twisting right	◻ Brings On	◻ Aggravates	◻ Relieves
Lifting	◻ Brings On	◻ Aggravates	◻ Relieves
Coughing	◻ Brings On	◻ Aggravates	◻ Relieves
Sneezing	◻ Brings On	◻ Aggravates	◻ Relieves

RODERICK WHITE CHIROPRACTIC

INITIAL EVALUATION – Automobile Accident

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

What brings you into our office? ☒ **Automobile Accident**

When did this accident happen? _____

What was your position in the vehicle?

☐ Driver ☐ Front Passenger ☐ Left Rear Passenger
☐ Middle Front Passenger ☐ Middle Rear Passenger ☐ Right Rear Passenger

What was the damage to the vehicle? ☐ Mild ☐ Moderate ☐ Extensive ☐ Totaled

How was the visibility on the road? ☐ Poor ☐ Fair ☐ Good

And the weather was:

☐ Clear ☐ Raining ☐ Windy ☐ Foggy ☐ Snowing

How did the accident happen?

☐ I hit another vehicle ☐ Another vehicle hit me ☐ I hit an object

What was the point of impact on our vehicle?

☐ Left ☐ Front end ☐ Rear end ☐ Right
☐ Left front ☐ Left rear ☐ Right front ☐ Right rear

Did you see the accident coming? ☐ Yes ☐ No

Were you braced for the impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, does the seatbelt have a shoulder strap? ☐ Yes ☐ No

Does your vehicle have an airbag? ☐ Yes ☐ No

Did it deploy during the accident? ☐ Yes ☐ No

Does your vehicle have headrests? ☐ Yes ☐ No

What is the position of the headrest: ☐ Even with top of my head
☐ Even with bottom of my head
☐ Middle of neck

Did you strike anything inside the vehicle? ☐ Yes ☐ No

INITIAL EVALUATION – Automobile Accident

RODERICK WHITE CHIROPRACTIC

What inside your vehicle did you strike?

☐ Airbag	☐ Armrest	☐ Center Console	☐ Dashboard	☐ Gear shift lever/knob
☐ Headrest	☐ Rearview mirror	☐ Roof	☐ Rear window	☐ Seatback
☐ Side door	☐ Side window	☐ Wheel	☐ Windshield	
☐ Other:_____				

Immediately after the accident, did you feel dazed? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Which way was your head turned during the accident?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Was your head injured? ☐ Yes ☐ No

Immediately after the accident, did you experience: ☐ Headache ☐ Neck Pain ☐ Low Back Pain

Did you see another doctor before coming here? ☐ Yes ☐ No

Did you go to a hospital after the accident? ☐ Yes ☐ No If yes, which hospital? _____

How did you get to the hospital? ☐ Ambulance ☐ Drove self ☐ Somebody else ☐ Police

Were any of the following tests performed at the hospital?
☐ X-Rays ☐ MRI ☐ CT Scan ☐ Lab Work

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities: ☐ Yes ☐ No
If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

Activities of Daily Living — Please select all activities which you are currently experiencing problems:

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating	☐ Hearing	☐ Insomnia
☐ Dressing	☐ Reading	☐ Typing	☐ Writing	☐ Grasping	☐ Using the toilet
☐ Standing	☐ Leaning	☐ Walking	☐ Stooping	☐ Squatting	☐ Loss of sexual drive
☐ Bending	☐ Twisting	☐ Carrying	☐ Lifting	☐ Pushing	☐ Restful sleeping
☐ Sitting	☐ Driving	☐ Sports	☐ Exercising	☐ Reclining	☐ Loss of concentration
☐ Irritable	☐ Riding in car	☐ Air travel	☐ Climbing	☐ Pulling	☐ Changes in personality
☐ Grooming	☐ Pinching	☐ Kneeling	☐ Reaching	☐ Nervous	☐ Tactile feeling

RODERICK WHITE CHIROPRACTIC

□ Bathing □ Holding

Past Medical History Please select all conditions that you have had or are currently having:

□ None	□ Other	□ Abdominal pain	□ Weight gain/loss	□ Angina
□ Anorexia	□ Anxiety	□ Aortic aneurysm	□ Arthritis	□ Asthma
□ Bladder infection	□ Blood disorder	□ Breast lumps	□ Breast soreness	□ Bronchitis
□ Cancer	□ Cardiovascular Dx	□Chest pain	□Chronic cough	□ Chronic sinusitis
□ Colitis	□ Constipation	□ Convulsions	□COPD	□ Depression
□ Dermatitis, Eczema/Rash	□ Diabetes	□ Difficulty in swallowing	□ Dizziness	□ Emphysema
□ Endometriosis	□ Epilepsy	□Excessive thirst	□Fainting	□ Frequent urination
□ General fatigue	□ Gout	□ Hand pain	□ Headache	□ Heart attack
□ Heart disease	□ Heartburn/Indigestion	□ Hepatitis	□ High Blood Pressure	□ High cholesterol
□ High PSA	□ High triglycerides	□ Hypertension	□ Irregular menstrual flow	□ Irritable colon
□ Jaw pain	□ Kidney disorders	□ Kidney stones	□ Liver / Gallbladder Problems	□ Loss of appetite
□ Loss of bladder control	□ Low back pain	□ Lung disease	□ Mental Disease	□ Mid back pain
□ Muscular in coordination	□Neck pain	□ Osteoarthritis	□ Pain in ankle or foot	□ Pain in lower leg or knee
□ Pain in upper arm or elbow	□Pain in upper leg and hip	□ Painful urination	□ PMS	□ Pneumonia
□ Profuse menstrual flow	□Prostate problems	□ Rapid heartbeat	□ Renal disease	□Rheumatiod arthritis
□Scoliosis	□Shoulder pain	□Stroke	□ Swelling/stiffness joints	□Thyroid disease of
□Tinnitus/ ear noises	Tuberculosis	□ Tumor	□ Ulcer	□ Visual disturbances
□ Wrist pain				

INITIAL EVALUATION – Automobile Accident

RODERICK WHITE CHIROPRACTIC

Family History

Please select all conditions that run in your family:

◻ None	◻ Other	◻ Abdominal pain	◻ Weight Gain/loss	◻ Angina
◻ Anorexia	◻ Anxiety	◻ Aortic aneurysm	◻ Arthritis	◻ Asthma
◻ Bladder infection	◻ Blood disorder	◻ Breast lumps	◻ Breast soreness	◻ Bronchitis
◻ Cancer	◻ Cardiovascular Dx	◻ Chest pain	◻ Chronic cough	◻ Chronic Sinusitis
◻ Colitis	◻ Constipation	◻ Convulsions	◻ COPD	◻ Depression
◻ Dermatitis, Eczema/Rash	◻ Diabetes	◻ Difficulty swallowing	◻ Dizziness	◻ Emphysema
◻ Endometriosis	◻ Epilepsy	◻ Excessive thirst	◻ Fainting	◻ Frequent urination
◻ General fatigue	◻ Gout	◻ Hand pain	◻ Headache	◻ Heart attack
◻ Heart disease	◻ Heartburn/Indigestion	◻ Hepatitis	◻ HBP	◻ High cholesterol
◻ High PSA	◻ High triglycerides	◻ Hypertension	◻ Irregular menstrual flow	◻ Irritable colon
◻ Jaw pain	◻ Kidney disorders	◻ Kidney stones	◻Liver/Gallbladder problems	◻ Loss of appetite
◻ Loss of bladder control	◻ Low back pain	◻ Lung disease	◻ Mental disease	◻ Mid back pain
◻ Muscular coordination	◻ Neck pain	◻ Osteoarthritis	◻ Pain in ankle or foot	◻ Pain in lower leg or knee
◻ Pain in upper arm or elbow	◻ Pain in upper leg and hip	◻ Painful urination	◻ PMS	◻ Pneumonia
◻ Profuse menstrual flow	◻ Prostate problems	◻ Rapid heartbeat	◻ Renal Dx	◻ Rheumatoid arthritis
◻ Scoliosis	◻ Shoulder pain	◻ Stroke	◻ Swelling/stiffness of joints	◻ Thyroid disease
◻ Tinnitus/ ear noises	◻ Tuberculosis	◻ Tumor	◻ Ulcer	◻ Visual disturbances
	◻ Wrist pain			

INITIAL EVALUATION – Automobile Accident

RODERICK WHITE CHIROPRACTIC

Surgical History Please select all surgeries that you have had in the past.

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty	☐ Abortion
☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty	☐ Appendectomy	☐ Bone Fracture Repair
☐ Breast Lump Removal	☐ Bunion Removal	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery
☐ Cholecystectomy	☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery	☐ Hernia Repair
☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant	☐ Knee Arthroscopy	☐ Knee Joint Replacement
☐ Knee Surgery	☐ LASIK Eye Surgery	☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy
☐ Prostate Removal	☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

☐ Surgical History was reviewed:
Not contributory

Medications Please select all medications that you are currently taking:

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	
☐ OTC	☐ Pain	☐ Steroids	☐ Thyroid	

Allergies Please select all items that you are allergic to:

☐ None	☐ Chemical	☐ Environmental	
☐ Food	☐ Medication	☐ Seasonal	☐ Other

Social History Please answer the following

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee

Letter of Protection

Patient: _____ Attorney: _____

Address: _____ Date of Accident: _____

_____ Acct #: _____

Phone: _____ Auto Insurance Co _____

I fully authorize Dr. Roderick White to discuss all information pertaining to my bill and medical records at Dr. Roderick C. White, LLC or d/b/a Roderick White Chiropractic related to an incident which occurred on the above date of accident with my above said attorney. I understand that this authorization will be valid until Dr. Roderick White has received payment from my above said attorney. I understand that I may revoke this authorization at any time in writing. I further understand that the revocation will not apply to any information that was released prior to my written request.

I, the undersigned patient, hereby assign any and all benefits of insurance under applicable automobile and/or health and/ or casualty insurance (hereinafter collectively called "Insurance") from any and all claims now or in the past with the above named insurance company for services rendered to me. I further agree to pay any application deduction or co-payment not covered by Insurance. I hereby authorize Power of Attorney for the endorsement of Insurance checks for services rendered, which may be received by the provider directly.

I hereby authorize and direct my attorney to pay Dr. Roderick C. White, LLC, or d/b/a Roderick White Chiropractic or Cahaba Wellness such sums as may be due and owing for professional services rendered to me and to withhold such sums from any settlement, judgement, or verdict which may be paid to you, my attorney, or myself as the result of my injuries for which I have been treated for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said provider for all professional bills submitted. This agreement is made solely for Dr. Roderick White. I further understand that such payment is not contingent on any settlement, judgement, verdict by which I may eventually recover said fee. Further, I understand that if I am no longer being represented by an attorney, I will be responsible for making arrangements to pay my debt to Dr. Roderick C. White LLC, d/b/a Roderick White Chiropractic or Cahaba Wellness.

I hereby also instruct and direct my current attorney to notify the provider in writing within 3 days or by the telephone followed by a letter of significant change of my case as follows:

1. The date of the closing of my case with or without recovery
2. The date of changing legal representation. Indicating the name and address of the law firm or anyone, including myself, to whom my case has been transferred.

Date: _____ Patient's Signature: _____

Date: _____ Witness's Signature: _____

I understand, being attorney or record or authorized representative of insurance carrier for the above patient, do hereby acknowledge receipt of the above lien, and do agree to honor the same to protect adequately said patient.

Date: _____ Authorized Signature: _____

NOTICE: The signature for the above attorney is only to acknowledge receipt of the above lien, but in no way is the above attorney personally responsible for any bills on behalf of the above client. Please, date, sign, and fax to the above address.

Medical Records and Diagnostic Imaging Release

I, the undersigned, voluntarily authorize the disclosure of information from my health records. I hereby release and forever discharge the aforesaid doctor from any and all responsibility or liability pertaining to my case in each and every respect, forevermore. The release of these records are at my request. The purpose of my request is to receive my medical history information from the hospital and/or clinic listed below.

Patient Information:

Patient Name _____

Date of Birth _____

Address _____

_____

Phone _____

Health Care Provider Information:

Hospital/Clinic _____

City/ State _____

Requested Information:

___ All Medical Records

___Date of Service _____(Date(s) seen at hospital/clinic
___Date of Service _____(Date(s) seen at hospital/clinic
___Date of Service _____(Date(s) seen at hospital/clinic

Please send records to:

Dr. Roderick White
2101 Magnolia Ave South/Suite 411
Birmingham, AL 35205
Phone 205-847-1633
Fax: 844-965-9141

_____ _____

Patient Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

Please provide as soon as possible for the benefit and convenience of the patient.

06.2019

RODERICK WHITE CHIROPRACTIC

REVISED OSWESTRY DISABILITY INDEX (for LOW BACK PAIN/DYSFUNCTION)

LAST NAME: _____ FIRST NAME: _____ MI: ___ Date: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section **only the ONE box** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that **most closely** describes your problem.

Section 1 – 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 severe and does not vary much.

Section 2 – 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 and dressing without help.

Section 3 - 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, but I manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ 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.

Section 4 – Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than one 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.

Section 5 – 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 one hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

Section 6 – Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on 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 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

Section 7 – 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 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal night's sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, 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.

Section 9 – Travelling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel makes 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.

Section 10 – Changing Degree Of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but is definitively 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.

RODERICK WHITE [redacted] CHIROPRACTIC

NECK DISABILITY INDEX QUESTIONNAIRE

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. 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 lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.
- ☐ I cannot drive my car at all.

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 – Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.