Pisker Family Chiropractic Center
1903 Kings Highway Swedesboro, NJ 08085
(856) 467-9600

Welcome to Our Office!

Case #:_____

Name:_____ Preferred Name:_____ Date: _____

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

Home Phone:_____ Cell :_____Primary Physician:_____

Occupation: _____ Employer: _____

Date of Birth:____/____/_____ SS#:_____-_____-_____ Height:_____ Weight:_____ Shoe Size:_____

Marital status: ◯Single ◯ Married ◯Separated ◯Divorced ◯ Widowed Spouse's Name:_____

Children's Name(s) & Ages:_____

Blood Pressure:_____ Ethnicity:_____ Language:_____

Are you a smoker?◯ Yes ◯ No If yes, do you plan on quitting? ◯ Yes◯ No. If you already quit, what was your approximate quit year? _____ Email Address:_____

List any prescription medications you are currently taking:_____

_____

List any prescription medications you are allergic to:_____

_____

Favorite Hobbies or Interest:_____

Have you ever had chiropractic care before: ◯ Yes◯No when and for what purpose?

_____

How did you hear about our office?_____

What are your current chief complaints?_____

When did the problem begin? _____ How did it occur? _____

Have you had the same or similar problems in the past? ◯Yes ◯ No

How many episodes have you had? ◯ N/A ◯first time ◯1 ◯ 2 ◯3 ◯Greater than 3

Have you seen another Doctor for this problem: ◯Yes ◯ No When? _____

Treatment Given? _____ Did it help? ◯ Yes ◯ No

Regarding your chief complaint (s), what makes it feel better? (ex. Ice, laying down) _____

What makes it feel worse? (ex. Lifting, sitting, bending)_____

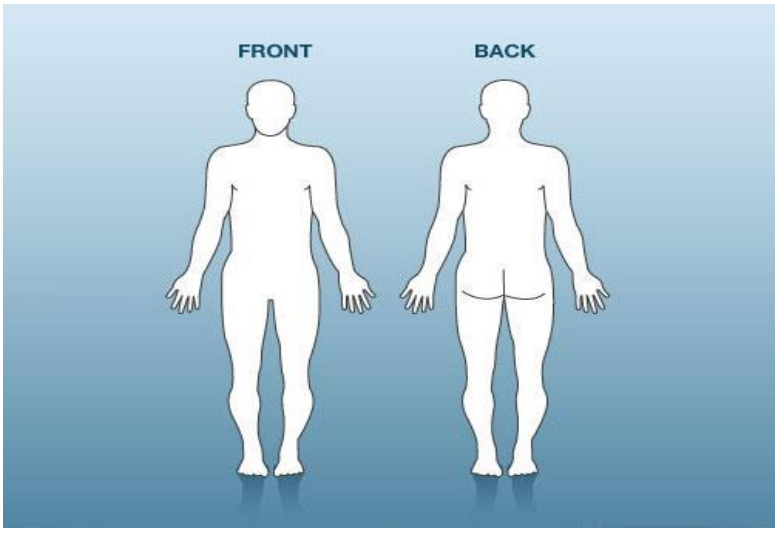
How would you describe the pain / discomfort? (ex. Sharp, stiff, numb, ache)_____

Does the pain/discomfort worsen during a particular time of day?◯ Yes ◯ No When? _____

Does the pain/discomfort radiate to another area (ex. Lower back to ankle) _____

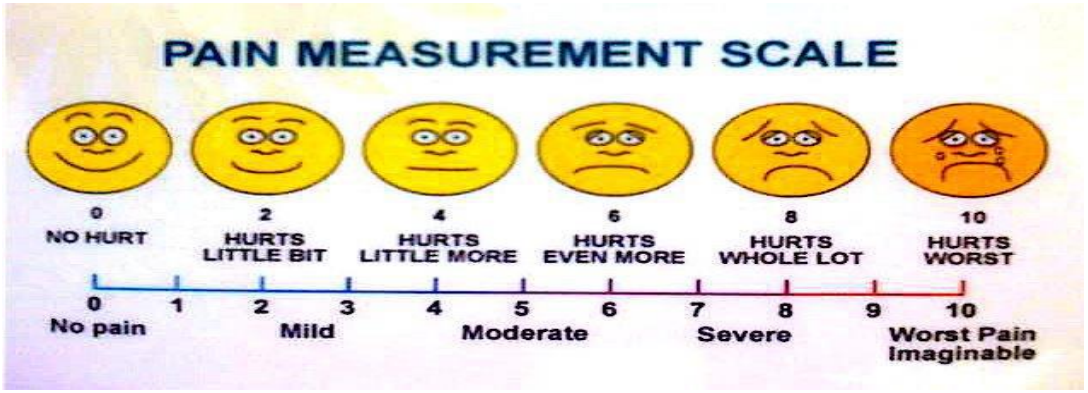
Please mark the diagram regarding your complaints.

A=Aching B=Burning S=Sharp T=Throbbing ⟹ = Radiates C=Stiff O=Other T=Tickling



Is the pain constant? ○Yes ○ No

Please rate the severity of your pain or discomfort



Do your symptoms interfere with: ○ work ○sleep ○ dressing ○ hobbies ○other: _____

Is your condition: ○ getting worse ○ more frequent ○ more intense

○ Lasting longer than past episodes

How would this problem affect your life if it gets worse over time? _____

Is there any reason that would prevent you from getting the treatment that you need to correct this problem? _____

Have you ever suffered from any of the following: **(Check all that apply)**

- ◯ Neck pain
- ◯ Low back pain
- ◯ Headache
- ◯ Migraines
- ◯ Arm / back tingling
- ◯ Shoulder pain
- ◯ Hand pain / tingling
- ◯ Leg pain / tingling
- ◯ Jaw pain
- ◯ Chest pain
- ◯ Lung problems
- ◯ Heart problems
- ◯ Abnormal blood pressure
- ◯ Irregular heartbeat
- ◯ Ankle swelling
- ◯ Cold extremities
- ◯ Blurred vision
- ◯ Vision problems
- ◯ Difficulty breathing
- ◯ Stuffy nose
- ◯ Allergies
- ◯ Fainting
- ◯ Weight loss
- ◯ Poor appetite
- ◯ Excessive appetite
- ◯ Nervousness
- ◯ Confusion
- ◯ Depression
- ◯ Dental problems
- ◯ Excessive thirst
- ◯ Frequent nausea
- ◯ Vomiting
- ◯ Prostate problems
- ◯ Breast pain / lump
- ◯ Cramps
- ◯ Painful urination
- ◯ Bladder trouble
- ◯ Excessive urination
- ◯ Discolored urine
- ◯ Gas / bloating after meals
- ◯ Heartburn
- ◯ Colitis
- ◯ Irritable bowel
- ◯ Black or bloody stools
- ◯ Constipation
- ◯ Hemorrhoids
- ◯ Liver problems
- ◯ Stroke
- ◯ Paralysis
- ◯ Tingling
- ◯ Numbness
- ◯ Fatigue
- ◯ Dizziness
- ◯ Loss of sleep
- ◯ Difficulty hearing
- ◯ Ear pain

How many hours of sleep do you get on an average night? **(Circle one)** 5 6 7 8 9 10 10+

Do you wake up refreshed? ◯ Yes ◯ No Do you feel you are under a lot of stress? ◯ Yes ◯ No

How much water do you drink per day? _____

How many meals do you eat per day? _____

Do you have digestive problems? ◯ Yes ◯ No

(Circle all that apply): Gas Bloating Heartburn diarrhea constipation

Does your jaw pop, click, or cause Pain when chewing? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No How long? ⬭ 1-5 years ⬭ 5-10 years ⬭ 10+ years

Do you drink alcohol? ◯ Daily ◯ Weekly ◯ Occasionally ◯ N/A

How much coffee _____ oz. And soda _____ oz. do you generally drink per day?

Do you exercise? ◯ Never ◯ Daily ◯ 1-2 x / wk ◯ 3-5 x / wk ◯ Aerobic strengthening ◯ Stretching

The pain/discomfort with: (Circle all that apply):

Shoulders L/R Elbows L/R Wrist/hands L/R Hips L/R Knees L/R Ankles / Feet L/R

Are you currently under the care of another Dr.? ◯ Yes ◯ No For what? _____

List surgeries you had an approximate date: _____

List broken bones or traumas (ex. Auto accident, falls, etc…) and approximate dates:

_____

Have you ever been knocked unconscious? ◯ Yes ◯ No

Are you or do you think you may be pregnant? ◯ Yes ◯ No ◯ Unsure

Are you seeking care for: ◯ Heath Maintenance / Optimization ◯ Health Problem ◯ Both

Would you be interested in attending a workshop on: (Circle all that apply)

The health benefits of chiropractic **Nutrition** **How to reduce toxins in your body**

Improving positive thinking

Is there anything else you would like us to know regarding your health?

_____

_____

Signature: _____ **Date:_____**

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Neck Disability Index

Patient Name: _____

Date: _____

1. Pain Intensity

☐ I have no pain at the moment	+0
☐ The pain is very mild at the moment	+1
☐ The pain is moderate at the moment	+2
☐ The pain is fairly severe at the moment	+3
☐ The pain is very severe at the moment	+4
☐ The pain is the worst imaginable at the moment	+5

2. Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain	+0
☐ I can look after myself normally but it causes extra pain	+1
☐ It is painful to look after myself and I am slow and careful	+2
☐ I need some help but can manage most of my personal care	+3
☐ I need help every day in most aspects of self care	+4
☐ I do not get dressed, I wash with difficulty and stay in bed	+5

3. Lifting

☐ I can lift heavy weights without extra pain	+0
☐ I can lift heavy weights but it gives extra pain	+1
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table	+2
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned	+3
☐ I can only lift very light weights	+4
☐ I cannot lift or carry anything	+5

4. Reading

☐ I can read as much as I want to with no pain in my neck	+0
☐ I can read as much as I want to with slight pain in my neck	+1
☐ I can read as much as I want with moderate pain in my neck	+2
☐ I can't read as much as I want because of moderate pain in my neck	+3
☐ I can't hardly read at all because of severe pain in my neck	+4
☐ I cannot read at all	+5

5. Headaches

☐ I have no headaches at all	+0
☐ I have slight headaches, which come infrequently	+1
☐ I have moderate headaches, which come infrequently	+2
☐ I have moderate headaches, which come frequently	+3
☐ I have severe headaches, which come frequently	+4
☐ I have headaches almost all the time	+5

6. Concentration

☐ I can concentrate fully when I want to with no difficulty	+0
☐ I can concentrate fully when I want to with slight difficulty	+1
☐ I have a fair degree of difficulty in concentrating when I want to	+2
☐ I have a lot of difficulty in concentrating when I want to	+3
☐ I have a great deal of difficulty in concentrating when I want to	+4
☐ I cannot concentrate at all	+5

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7. Work

☐ I can do as much work as I want to	+0
☐ I can only do my usual work, but no more	+1
☐ I can do most of my usual work, but no more	+2
☐ I can't do my usual work	+3
☐ I can hardly do any work at all	+4
☐ I can't do any work at all	+5

8. Driving

☐ I can drive my car without any neck pain	+0
☐ I can drive my car as long as I want with slight pain in my neck	+1
☐ I can drive my car as long as I want with moderate pain in my neck	+2
☐ I can't drive my car as long as I want because of moderate pain in my neck	+3
☐ I can hardly drive at all because of severe pain in my neck	+4
☐ I can't drive my car at all	+5

9. Sleeping

☐ I have no trouble sleeping	+0
☐ My sleep is slightly disturbed (less than 1 hr sleepless)	+1
☐ My sleep is mildly disturbed (1-2 hrs sleepless)	+2
☐ My sleep is moderately disturbed (2-3 hrs sleepless)	+3
☐ My sleep is greatly disturbed (3-5 hrs sleepless)	+4
☐ My sleep is completely disturbed (5-7 hrs sleepless)	+5

10. Recreation

☐ I am able to engage in all recreational activities with no neck pain at all	+0
☐ I am able to engage in all my recreational activities, with some pain in my neck	+1
☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck	+2
☐ I am able to engage in a few of my usual recreational activities because of pain in my neck	+3
☐ I can hardly do any recreational activities because of pain in my neck	+4
☐ I can't do any recreational activities at all	+5

Total Score:

Raw Score: Summation of Points

Raw Score: _____ Points

$$\text{Percentage Score: } \frac{\text{Raw Score}}{\#\text{ Completed Questions} * 5}$$

Percentage Score: _____ %

SIGNATURE _____ DATE _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly 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 without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ 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 self-care
- ☐ I do not get dressed, I 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 placed 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 lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra 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 eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

SIGNATURE _____ DATE _____

References

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

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TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this office:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctor of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this office, it's nature, or cost in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements,

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature of Patient or Guardian if a minor) (Date)

_____I consent to receive communication from PC via email, postal mail, text and telephone messaging in connection
(Initial) with my care. If I should withdraw my consent, I will notify the office in writing.

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete descriptions of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____
(Signature of Patient or Guardian if a minor) (Date)