

**PLEASE PRINT CLEARLY**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age \_\_\_\_\_

Home phone: \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers license # \_\_\_\_\_

Business Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business phone: \_\_\_\_\_ can you be contacted there? \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Business phone: \_\_\_\_\_

Names and ages of children: \_\_\_\_\_

Referred to this office by: \_\_\_\_\_ Phone # \_\_\_\_\_

Name of emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Workers' Comp \_\_\_\_\_ Auto Ins. \_\_\_\_\_

Who is responsible for your bill: You \_\_\_\_\_ Spouse \_\_\_\_\_

Medicare \_\_\_\_\_ Parent \_\_\_\_\_ Health card # \_\_\_\_\_

Personal Health Insurance Name: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, is for examination and x-rays only. The X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or spouse's  
Signature authorizing care \_\_\_\_\_ Date: \_\_\_\_\_

CASE NO. \_\_\_\_\_

NAME \_\_\_\_\_  
 SS # \_\_\_\_\_ DR. LIC. # \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_

SPOUSE \_\_\_\_\_ # OF CHILDREN \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX  M  F  
 PHONE \_\_\_\_\_ (WORK) \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_  
 REFERRED BY \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Other complaints: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

Work Injury?  Auto Accident?  Slip/Fall?  Unknown?  Illness?  Other?  When? \_\_\_\_\_

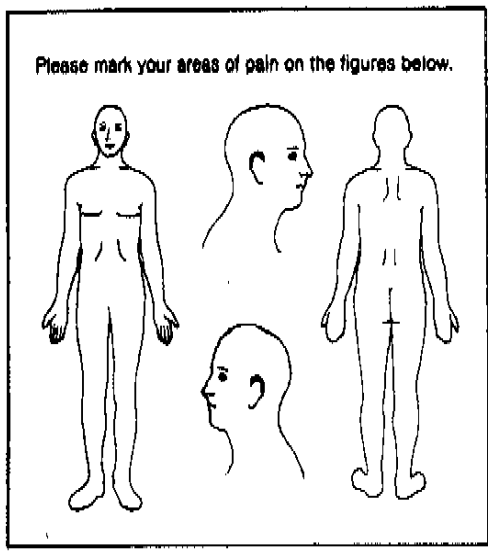
Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes

CIRCLE ACTIVITIES WHICH AGGRAVATE YOUR CONDITION:

A) Walking B) Standing C) Sitting D) Lying E) Bending F) Lifting G) Twisting H) Other \_\_\_\_\_

In what position do you sleep? A) Rt. Side B) Lt. Side C) Back D) Stomach E) Hands Above Head

Do you read or watch T.V.? A) In Bed B) On Couch C) Lying on Floor D) Sitting in Chair



- PLEASE CHECK YOUR CURRENT COMPLAINTS
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Numbness         | <input type="checkbox"/> Low Back Problems      | <input type="checkbox"/> Vision Problems         |
| <input type="checkbox"/> Loss of Feeling  | <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Ear Pain                |
| <input type="checkbox"/> Paralysis        | <input type="checkbox"/> Neck Problems          | <input type="checkbox"/> Ear Noises              |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Arm Problems           | <input type="checkbox"/> Blood Pressure Problems |
| <input type="checkbox"/> Fainting         | <input type="checkbox"/> Leg Problems           | <input type="checkbox"/> Fatigue                 |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Swollen Joints         | <input type="checkbox"/> Irritable               |
| <input type="checkbox"/> Muscle Jerking   | <input type="checkbox"/> Painful Joints         | <input type="checkbox"/> Loss of Appetite        |
| <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Stiff Joints           | <input type="checkbox"/> Loss of Sleep           |
| <input type="checkbox"/> Forgetfulness    | <input type="checkbox"/> Sore Muscles           | <input type="checkbox"/> Jaw Pain                |
| <input type="checkbox"/> Confusion        | <input type="checkbox"/> Weak Muscles           | <input type="checkbox"/> Nausea                  |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Walking Problems       | <input type="checkbox"/> Diarrhea                |
| <input type="checkbox"/> Eye Strain       | <input type="checkbox"/> Ruptures               | <input type="checkbox"/> Constipation            |
| <input type="checkbox"/> Eye Inflammation | <input type="checkbox"/> Broken Bones           | <input type="checkbox"/> Other _____             |

This is a new/old illness. It was not/was treated before. If treated before, what was done? \_\_\_\_\_

Have you had any other personal injury or auto accident? Describe: \_\_\_\_\_

Have you ever had surgery or been hospitalized?  No  Yes Describe: \_\_\_\_\_

Medications you now take: \_\_\_\_\_

Have you ever been X-rayed before?  No  Yes What parts? \_\_\_\_\_

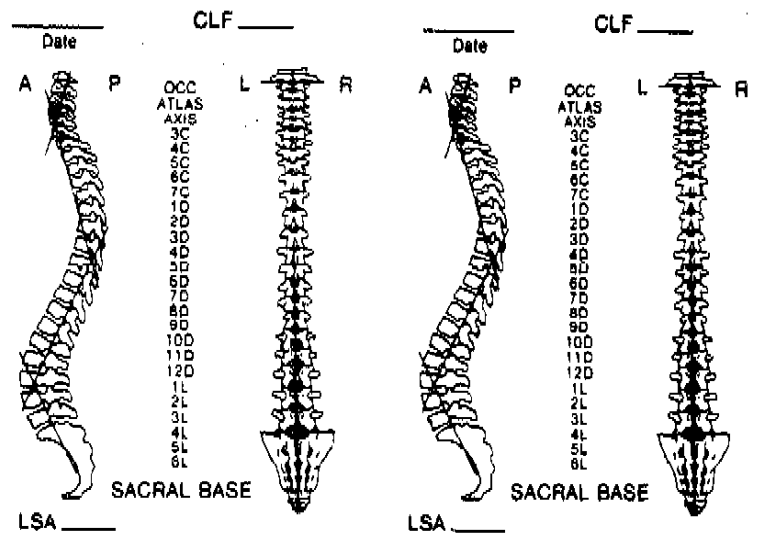
Date of last chiropractic treatment: \_\_\_\_\_ Reason: \_\_\_\_\_

**(FOR DOCTORS USE ONLY)**

PHYSICAL FINDINGS: \_\_\_\_\_

X-RAY PATHOLOGY: \_\_\_\_\_

REMARK: \_\_\_\_\_



***Chapman Chiropractic Center***  
**Karen A. Proescholdt, D.C.**  
**1025 E. Chapman Ave.**  
**Orange, CA 92866**  
**714-639-4655**

AT TIMES IT IS NECESSARY TO SEND X-RAY FILMS OUT FOR A SECOND OPINION. THERE WILL BE A \$40.00 FEE PER AREA OF THE BODY THAT IS X-RAYED. (For example, if we took 2 views of your neck, it would be \$40.00 for those 2 views to be analyzed).

I \_\_\_\_\_ UNDERSTAND AND AGREE TO THIS POLICY  
 (Patient Name)

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

page 1

**CHAPMAN CHIROPRACTIC CENTER***Karen A Proescholdt, D.C.**1025 E. Chapman Avenue**Orange, CA 92666**714-639-4655***PATIENT-DOCTOR AGREEMENTS**

Welcome to Chapman Chiropractic Center.

The purpose of these agreements is to allow us to more completely serve you and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreements get the best results.

**SIGNING IN**

When you arrive to our office, please sign in. You will be called and assigned a treatment room in the order you signed in for your doctor. Other patients treated by another doctor may be called before you because their doctor is available, not because they are taken out of turn. When you go to the assigned treatment room, place the folder in the door tray and **face up**. Rest and relax, the doctor will be in as soon as possible.

**EXTENDED CONSULTATIONS**

~Stress and Wellness Workshops~

It is mandatory that all patients attend our extended Health Consultation Workshop. This consultation explains how the body functions, how chiropractic works and how results are produced. Family and friends are always welcome. There is no charge for the consultation. If you are not able to attend, extra time will be set aside on one of your visits and there will be an additional personal charge.

Seminars and lectures on different aspects of health care are often scheduled and may be attended at no cost. Please bring family and friends. Look for announcements regarding these programs. The extended consultation is, in part, a workshop and we ask you to bring a partner to assist in the procedures we will teach.

**PAYMENT OF BILLS**

Services are to be paid for on the date they are rendered. We will expect you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, advise our staff immediately so new arrangements can be made. We do not bill patients. If we are forced to bill you, you will receive a service charge. Our policy is that a patient not have a cash personal balance owing.

Page 2

Insurance companies will be billed. Any checks sent to your home by the insurance company should be brought or sent to our office within three (3) days. Please also send the attached stub to indicate which services were paid. Failure of the patient to make payment of an overdue account or to otherwise communicate will result in unnecessary upset.

### MISSING OR CHANGING APPOINTMENTS

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time is required for us to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day. If the same day is not possible, be sure to make up the missed appointment within one week. If you miss/cancel an appointment without a two (2) hour notice, there will be a personal 20.00 service charge.

### PROGRESSIVE EVALUATIONS AND RE-EXAMINATIONS

During your treatment series, progress evaluations and check-ups may take place. The fee for these services should be paid for according to the payment agreement made with our office.

### DIETS AND FOOD SUPPLEMENTS

Diets should be followed and food supplements taken if recommended. Any problem you may have with these recommendations should be communicated. We do not prescribe, but will make recommendations to help speed your recovery. You are expected to pay for food supplements at the time of purchase.

### UPSETS

We are here to serve you. Please speak with your doctor about any upsetting matter. We see your comments as helping us to help you and others.

### HOURS

Your doctor has specific office hours. The receptionist will schedule your appointments accordingly.

I have read the above and I understand and accept these policies.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**Back Index**

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the 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**

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

**Sleeping**

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

**Sitting**

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

**Standing**

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

**Walking**

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

**Personal Care**

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

**Lifting**

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

**Traveling**

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

**Social Life**

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

**Changing degree of pain**

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

# Neck Index

ACN Group, Inc. Form NJ-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the 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

- Ⓐ I have no pain at the moment.
- Ⓛ The pain is very mild at the moment.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ 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.

## 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).

## Reading

- Ⓐ I can read as much as I want with no neck pain.
- Ⓛ I can read as much as I want with slight neck pain.
- Ⓜ I can read as much as I want with moderate neck pain.
- Ⓨ I cannot read as much as I want because of moderate neck pain.
- Ⓩ I can hardly read at all because of severe neck pain.
- Ⓟ I cannot read at all because of neck pain.

## Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- Ⓛ I can concentrate fully when I want with slight difficulty.
- Ⓜ I have a fair degree of difficulty concentrating when I want.
- Ⓨ I have a lot of difficulty concentrating when I want.
- Ⓩ I have a great deal of difficulty concentrating when I want.
- Ⓟ I cannot concentrate at all.

## Work

- Ⓐ I can do as much work as I want.
- Ⓛ I can only do my usual work but no more.
- Ⓜ I can only 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.

## Personal Care

- Ⓐ 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 I 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.

## 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 can manage if they are conveniently positioned (e.g., on a table).
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓩ I can only lift very light weights.
- Ⓟ I cannot lift or carry anything at all.

## Driving

- Ⓐ I can drive my car without any neck pain.
- Ⓛ I can drive my car as long as I want with slight neck pain.
- Ⓜ I can drive my car as long as I want with moderate neck pain.
- Ⓨ I cannot drive my car as long as I want because of moderate neck pain.
- Ⓩ I can hardly drive at all because of severe neck pain.
- Ⓟ I cannot drive my car at all because of neck pain.

## Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- Ⓛ I am able to engage in all my usual recreation activities with some neck pain.
- Ⓜ I am able to engage in most but not all my usual recreation activities because of neck pain.
- Ⓨ I am only able to engage in a few of my usual recreation activities because of neck pain.
- Ⓩ I can hardly do any recreation activities because of neck pain.
- Ⓟ I cannot do any recreation activities at all.

## Headaches

- Ⓐ I have no headaches at all.
- Ⓛ I have slight headaches which 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

## THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.  
**Today, do you or would you have any difficulty at all with:**

Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1 Army of your usual work, housework, or school activities.	0	1	2	3	4
2 Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3 Getting into or out of the bath.	0	1	2	3	4
4 Walking between rooms.	0	1	2	3	4
5 Putting on your shoes or socks.	0	1	2	3	4
6 Squatting.	0	1	2	3	4
7 Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8 Performing light activities around your home.	0	1	2	3	4
9 Performing heavy activities around your home.	0	1	2	3	4
10 Getting into or out of a car.	0	1	2	3	4
11 Walking 2 blocks.	0	1	2	3	4
12 Walking a mile.	0	1	2	3	4
13 Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14 Standing for 1 hour.	0	1	2	3	4
15 Sitting for 1 hour.	0	1	2	3	4
16 Running on even ground.	0	1	2	3	4
17 Running on uneven ground.	0	1	2	3	4
18 Making sharp turns while running fast.	0	1	2	3	4
19 Hopping.	0	1	2	3	4
20 Rolling over in bed.	0	1	2	3	4
<b>Column Totals:</b>					

**Minimum Level of Detectable Change (90% Confidence): 9 points**

**SCORE: \_\_\_\_\_ / 80**

Please submit the sum of responses to ASH

*Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network. The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application. Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.*