Adjusting to a Better Life

Welcome to Haug Chiropractic

Patient Information

Date: _____

Name: _____
Address: _____
City: _____
Zip: _____
Phone number: _____
Email: _____
Date of Birth: _____

Who referred you into our office? _____

Emergency Contact person: _____
Emergency contact phone: _____
Relationship: _____

Please allow us to copy any insurance cards that you want to be billed on your behalf.

Welcome to Haug Chiropractic! We are happy that you are here and look forward to helping you as much as we possibly can. First, could you tell us the reason for your starting care at our office? (check all that apply)

___ I am here because Dr. Haug practices Atlas / Cranio-Cervical Junction Chiropractic.
___ I am here for laser therapy.
___ I am here for nutritional advice.

___ I am looking for help with my pain.
___ I am looking for help with improving the health of my spine.
___ I am looking for help with improving my general health.

Please tell us how your pain / health problem started and how it has developed up till now.

Please tell us some things that you have found helpful so far.

Please tell us some things that make your symptoms worse.

Please tell us how your symptoms are affecting your life.

Some general yes / no questions:

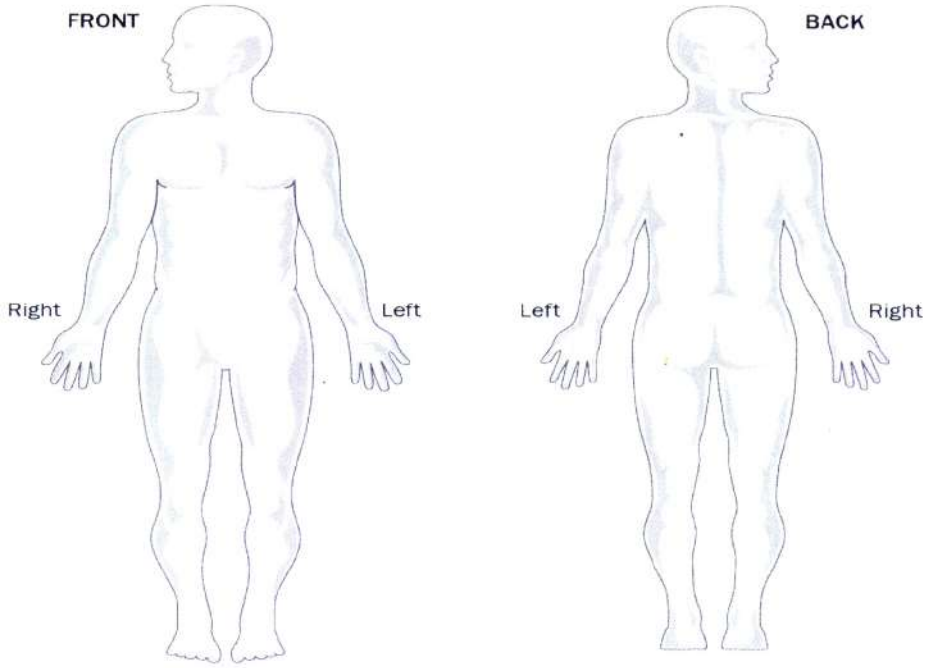
Yes / No The pain is worse when I wake up in the morning.
Yes / No The pain is worse with sitting.
Yes / No Pain / numbness goes down an arm or leg.
Yes / No I have been in a car accident.
Yes / No I played in contact sports.
Yes / No I have trouble managing my stress levels.
Yes / No I have had a concussion or head injury.

Description of Symptoms

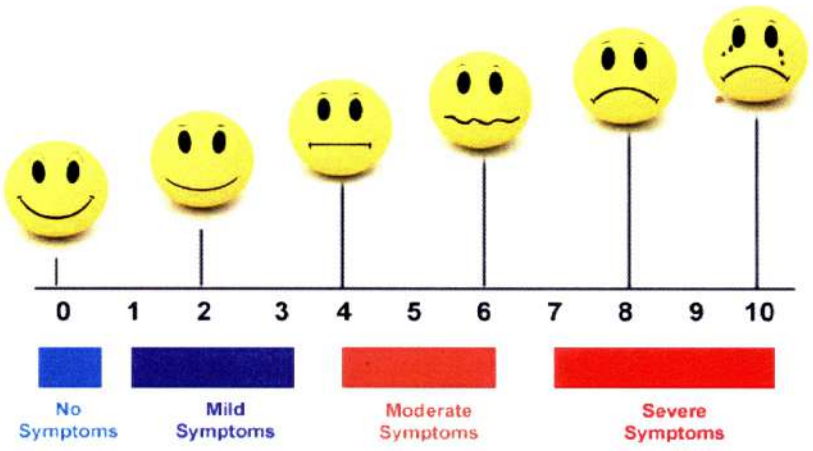
Date: _____ Name: _____

Draw the location of your pain on the body outlines and mark how bad it is on the pain line at the bottom of the page.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
~~	****	@@@@	.....	/////	XXXX



Circle the number that relates to the pain intensity of your symptoms. For multiple symptoms, label each circle.



My symptoms are present up to how much of the time (circle the amount):

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

FINANCIAL AGREEMENT

I elect to use the following payment plan to finance my care at Haug Chiropractic :

- **CASH:** I understand that payment is due at the time of service.

- **INSURANCE COVERAGE:**

  - O **Blue Cross Blue Shield PPO:**

Dr. Haug is a preferred provider for BCBS PPO. Dr. Haug has agreed to reduce his fees to align with BCBS fee schedule. Dr. Haug will bill my visits to BCBS on my behalf. I understand that I am responsible for all co-pays / co-insurance payments. I also understand that I am responsible for paying the reduced fees until my deductible is satisfied.

  - O **MEDICARE:**

I understand that payment is due in full at the time of service. I understand that Haug Chiropractic will bill medicare on your behalf. It is typical for medicare to reimburse 80% of the allowed amount after the deductible is satisfied. We are enrolled with medicare as a non participating provider. This means that I agree to reduce my fees to the medicare allowed amount. (*Estimated benefits include a $155 deductible; up to 12 adjustments are allowed per year; x-rays and exam are required annually but are not paid for by Medicare).*

  - O **All other Insurance companies:**

I understand that all charges incurred at Haug Chiropractic are my responsibility. I understand that, as a courtesy, Haug Chiropractic will bill my visits to my insurance company. Haug Chiropractic will not accept assignment for your claim which means that any and all payments made by your insurance company will be mailed directly to you.

- **PERSONAL INJURY:** I understand that any balance remaining after settlement by the insurance company or lawsuit is my responsibility unless there is an attorney's lien.

My signature on this Agreement serves as an assignment of benefits for my insurance carrier and a request that payment be made to Haug Chiropractic Wellness Center at the address shown on the claim form for services rendered.

Patient's Signature: _____ **Date:** _____

_____**Date:** _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

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

- ❑ 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 causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 5 – HEADACHES

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

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – 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 can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50] BENCHMARK -5 = _____

HEADACHE DISABILITY INDEX

Patient Name: _____ **Date**: _____

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headaches: **(1)** 1 Per month **(2)** More then 1 but less than 4 per month **(3)** More then one per week

2. My headaches are: **(1)** Mild **(2)** Moderate **(3)** Severe

Please Read Carefully: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your headache only.

YES	SOMETIMES	NO		
			E1	Because of my headaches I feel handicapped.
			E2	Because of my headaches I feel restricted in performing my routine daily activities.
			E3	No one understands the effect my headaches have on my life.
			E4	I restrict my recreational activities (eg. Sports, Hobbies) because of my headaches.
			E5	My headaches make me angry.
			E6	Sometimes I feel that I am going to lose control because of my headaches.
			E7	Because of my headaches I am less likely to socialize.
			E8	My Spouse (significant other), or family and friends have no idea what I am going through because of my headaches.
			E9	My headaches are so bad that I feel that I am going to go insane.
			E10	My outlook on the world is affected by my headaches.
			E11	I am afraid to go outside when I feel that a headache is starting.
			E12	I feel desperate because of my headaches.
			E13	I am concerned that I am paying penalties at work or at home because of my headaches.
			E14	My headaches place stress on my relationships with family or friends.
			E15	I avoid being around people when I have a headache.
			E16	I believe my headaches are making it difficult for me to achieve my goals in life.
			E17	I am unable to think clearly because of my headaches.
			E18	I get tense (eg. Muscle tension) because of my headaches.
			E19	I do not enjoy social gatherings because of my headaches.
			E20	I feel irritable because of my headaches.
			E21	I avoid traveling because of my headaches.
			E22	My headaches make me feel confused.
			E23	My headaches make me feel frustrated.
			E24	I find it difficult to read because of my headaches.
			E25	I find it difficult to focus my attention away from my headaches and on other things.

OTHER COMMENTS:

Examiner: _____

With permission from: Jacobson GP, Ramadan NM, et al. *The Henry Ford Hospital headache disability inventory (HDI)*. Neurology 1994: 44:837-842