SYMPTOM SURVEY FORM
(Restricted to Professional Use)

PATIENT ______________________ AGE ______ DOCTOR ____________________________ DATE __________

INSTRUCTIONS: Number the boxes which apply to you. Use (1) for MILD symptoms (occur once or twice a month), (2) for MODERATE symptoms (occur several times a month), and (3) for SEVERE symptoms (you are aware of it almost constantly).

GROUP ONE

1 ☐ Acid foods upset
2 ☐ Get chilled, often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meal
6 ☐ Keyed up - fail to calm
7 ☐ Cuts heal slowly
8 ☐ Gag Easily
9 ☐ Unable to relax, startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach frequent

GROUP TWO

21 ☐ Joint stiffness after arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seem hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP THREE

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep - hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression - "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP FOUR

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed room
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black and blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head, or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP FIVE

- 73 ☐ Dizziness
- 74 ☐ Dry skin
- 75 ☐ Burning feet
- 76 ☐ Blurred vision
- 77 ☐ Itching skin and feet
- 78 ☐ Excessive falling hair
- 79 ☐ frequent skin rashes
- 80 ☐ Bitter, metallic taste in mouth in mornings
- 81 ☐ Bowel movements painful or difficult
- 82 ☐ Worrier, feels insecure
- 83 ☐ Feeling queasy; headache over eyes
- 84 ☐ Greasy foods upset
- 85 ☐ Stools light-colored
- 86 ☐ Skin peels on foot soles
- 87 ☐ Pain between shoulder blades
- 88 ☐ Use laxatives
- 89 ☐ Stools alternate from soft to watery
- 90 ☐ History of gallbladder attacks or gallstones
- 91 ☐ Sneezing attacks
- 92 ☐ Dreaming, nightmare type bad dreams
- 93 ☐ Bad breath (halitosis)
- 94 ☐ Milk products cause distress
- 95 ☐ Sensitive to hot weather
- 96 ☐ Burning or itching anus
- 97 ☐ Crave sweets

GROUP SIX

- 98 ☐ Loss of taste for meat
- 99 ☐ Lower bowel gas several hours after eating
- 100 ☐ Burning stomach sensations, eating relieves
- 101 ☐ Coated tongue
- 102 ☐ Pass large amounts of foul-smelling gas
- 103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours
- 104 ☐ Mucous colitis or “irritable bowel”
- 105 ☐ Gas shortly after eating
- 106 ☐ Stomach “bloating” after eating

GROUP SEVEN

(A)

- 107 ☐ Insomnia
- 108 ☐ Nervousness
- 109 ☐ Can’t gain weight
- 110 ☐ Intolerance to heat
- 111 ☐ Highly emotional
- 112 ☐ Flush easily
- 113 ☐ Night sweats
- 114 ☐ Thin, moist skin
- 115 ☐ Inward trembling
- 116 ☐ Heart palpitates
- 117 ☐ Increased appetite without weight gain
- 118 ☐ Pulse fast at rest
- 119 ☐ Eyelids and face twitch
- 120 ☐ Irritable and restless
- 121 ☐ Can’t work under pressure

(B)

- 122 ☐ Increase in weight
- 123 ☐ Decrease in appetite
- 124 ☐ Fatigue easily
- 125 ☐ Ringing in ears
- 126 ☐ Sleepy during day
- 127 ☐ Sensitive to cold
- 128 ☐ Dry or scaly skin
- 129 ☐ Constipation
- 130 ☐ Mental sluggishness
- 131 ☐ Hair coarse, falls out
- 132 ☐ Headaches upon arising wear off during day
- 133 ☐ Slow pulse, below 65
- 134 ☐ Frequency of urination
- 135 ☐ Impaired hearing
- 136 ☐ Reduced initiative

(C)

- 137 ☐ Failing memory
- 138 ☐ Low blood pressure
- 139 ☐ Increased sex drive
- 140 ☐ Headaches, “splitting or rendering” type
- 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
- 143 ☐ Bloating of abdomen
- 144 ☐ Weight gain around hips or waist
- 145 ☐ Sex drive reduced or lacking
- 146 ☐ Tendency to ulcers, colitis
- 147 ☐ Increased sugar tolerance
- 148 ☐ Women: menstrual disorders
- 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
- 151 ☐ Headaches
- 152 ☐ Hot flashes
- 153 ☐ Increased blood pressure
- 154 ☐ Hair growth on face or body (female)
- 155 ☐ Sugar in urine (not diabetes)
- 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
- 158 ☐ Chronic fatigue
- 159 ☐ Low blood pressure
- 160 ☐ Nails, weak, ridged
- 161 ☐ Tendency to hives
- 162 ☐ Arthritic tendencies
- 163 ☐ Perspiration increase
- 164 ☐ Bowel disorders
- 165 ☐ Poor circulation
- 166 ☐ Swollen ankles
- 167 ☐ Crave salt
- 168 ☐ Brown spots or bronzing of skin
- 169 ☐ Allergies - tendency to asthma
- 170 ☐ Weakness after colds, influenza
- 171 ☐ Exhaustion - muscular and nervous
- 172 ☐ Respiratory disorders

SYMPTOM SURVEY FORM - Page 3

GROUP EIGHT

- 173 ☐ Apprehension
- 174 ☐ Irritability
- 175 ☐ Morbid fears
- 176 ☐ Never seems to get well
- 177 ☐ Forgetfulness
- 178 ☐ Indigestion
- 179 ☐ Poor appetite
- 180 ☐ Craving for sweets
- 181 ☐ Muscular soreness
- 182 ☐ Depression; feelings of dread
- 183 ☐ Noise sensitivity
- 184 ☐ Acoustic hallucinations
- 185 ☐ Tendency to cry without reason
- 186 ☐ Hair is coarse and/or thinning
- 187 ☐ Weakness
- 188 ☐ Fatigue
- 189 ☐ Skin sensitive to touch
- 190 ☐ Tendency toward hives
- 191 ☐ Nervousness
- 192 ☐ Headache
- 193 ☐ Insomnia
- 194 ☐ Anxiety
- 195 ☐ Anorexia
- 196 ☐ Inability to concentrate; confusion
- 197 ☐ Frequent stuffy nose; sinus infections
- 198 ☐ Allergy to some foods
- 199 ☐ Loose joints

FEMALE ONLY

- 200 ☐ Very easily fatigued
- 201 ☐ Premenstrual tension
- 202 ☐ Painful menses
- 203 ☐ Depressed feelings before menstruation
- 204 ☐ Menstruation excessive and prolonged
- 205 ☐ Painful breasts
- 206 ☐ Menstruate too frequently
- 207 ☐ Vaginal discharge
- 208 ☐ Hysterectomy/ovaries removed
- 209 ☐ Menopausal hot flashes
- 210 ☐ Menses scanty or missed
- 211 ☐ Acne, worse at menses
- 212 ☐ Depression of long standing

MALE ONLY

- 213 ☐ Prostate trouble
- 214 ☐ Urination difficult or dribbling
- 215 ☐ Night urination frequent
- 216 ☐ Depression
- 217 ☐ Pain on inside of legs or heels
- 218 ☐ Feeling of incomplete bowel evacuation
- 219 ☐ Lack of energy
- 220 ☐ Migrating aches and pains
- 221 ☐ Tire too easily
- 222 ☐ Avoids activity
- 223 ☐ Leg nervousness at night
- 224 ☐ Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent ____________ Standing ____________ Pulse ____________

Hema-Combistix Urine readings: pH ____________ Albumin per cent ____________ Glucose per cent ________

Occult Blood ________ pH of Saliva ____________ pH of Stool specimen ____________ Weight ____________

Hemoglobin ________ Blood Clotting Time ____________

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row.

MALES

Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date:	Temperature:

BP SIT ____________ BP STAND ____________

PULSE SIT ____________ PULSE STAND ____________

SALIVA PH ____________ BLOOD TYPE ____________

Confidential Patient Health Information

responsible) by or under the orders of the licensed doctors of chiropractic of the Alpine Family Chiropractic and Nutrition or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves using adjusting instruments and/or the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and soreness. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to Alpine family Chiropractic and Nutrition. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Alpine Family Chiropractic and Nutrition to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of all care, regardless of insurance coverage. I also understand and agree 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.

I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature: ______________________________ Date: ___/___/___

Printed Name: ______________________________

Consent to Treatment of a Minor Child

I hereby authorize the doctors of Alpine Family Chiropractic and Nutrition, and/or whomever they may designate as assistants, to administer treatment as deemed necessary to ______________________.

Signature of Parent or Legal Guardian: ______________________ Relationship: __________

Date: ___/___/___ Witness Signature: ______________________________

Alpine Family Chiropractic and Nutrition
Colorado Spinal Decompression
Laser Joint and Pain Therapy
Active Therapeutic Movement Therapy
28529 Mountainview Road Conifer, CO 80433
Dr. Randy Jacobs, BS, MA, DC.
Phone (303) 838-7700 Fax (303) 838-4027 www.coniferchiropractor.com

Confidential Patient Health Information

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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 HIPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request correction. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and the right to privacy, all staff has been trained in the area of patient record privacy and a complaint officer has been designated to enforce those procedures in our office. We have taken all precautions that are known by the office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Informed Consent for Chiropractic Spinal Manipulation, Diagnostic X-Rays and Treatment, Authorization and Release

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities (including but not limited to laser therapy, ATM therapy, homeopathic remedies, nutritional supplements, ice, head traction, spinal decompression, hydrotherapy) and diagnostic x-rays, on myself (or on the patient named below for whom I am legally

The Neck Disability Index

Patient name: ______________________ File#__________ Date:__________

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck 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

- ☐ 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 positioned, for example, 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 lift 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 to, with moderate pain in my neck.
- ☐ I can't 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 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 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.

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 can't 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 can't 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 can't drive my car at all.

SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs 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 neck pain at all.
- ☐ 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 few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

ALPINE FAMILY
CHIROPRACTIC & NUTRITION
Dr. Randy Jacobs, BS, MA, DC
303-838-7700
28529 Mountainview Road
Conifer, CO 80433
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MY CHIROPRACTIC STORY

Please answer all questions as completely as possible. If more space is needed PLEASE USE OTHER SIDE.

1. Describe the condition for which you consulted your chiropractor, including:
   (a) Name of disorder, if known
   (b) Symptoms
   (c) Location of pain
   (d) Duration
   (e) Severity
2. Describe previous treatment and results.
3. Tell what drugs and/or medication you were taking, if any, and if you feared addiction.
4. What led to your decision to try chiropractic?
5. Had you been to a chiropractor previously?
6. Did you have any doubts that chiropractic would help you?
7. What were your first impressions of chiropractic, this office and the doctor?
8. What recommendations were made by the chiropractor?
9. Describe your results, including time involved.
10. Is anyone else in your family a chiropractic patient? If so, for what conditions?
11. How has chiropractic helped them?
12. What would you recommend to others who are sick, suffering or in pain?
13. How many others have you told about chiropractic?
14. How do you feel about chiropractic, now that you have enjoyed its benefits?

THANK YOU VERY MUCH! PLEASE USE OTHER SIDE FOR MORE OF YOUR SUCCESS.

I hereby give my permission for all or any part of the above statements to be reproduced with or without my name, address or photograph, and to be used in the interest of telling others about the benefits of chiropractic care.

Signature

The Roland-Morris Low Back Pain and Disability Questionnaire

Patient name: ______________________ File #__________ Date:__________

Please read instructions: When your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try to get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I only stand up for short periods of time because of my back.
- ☐ Because of my back, I, try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back.
- ☐ I have trouble putting on my sock (or stockings) because of the pain in my back.
- ☐ I can only walk short distances because of my back pain.
- ☐ I sleep less well because of my back.
- ☐ Because of my back pain, I get dressed with the help of someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Instructions:

1. The patient is instructed to put a mark next to each appropriate statement.

2. The total number of marked statements are added by the clinician. Unlike the authors of the Oswestry Disability Questionnaire, Roland and Morris did not provide descriptions of the varying degrees of disability (e.g., 40%-60% is severe disability).

3. Clinical improvement over time can be graded based on the analysis of serial questionnaire scores. If, for example, at the beginning of treatment, a patient's score was 12 and, at the conclusion of treatment, her score was 2 (10 points of improvement), we would calculate an 83% (10/12 x 100) improvement.

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 ____________

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME ______________________ DATE __________ HOME PHONE __________

ADDRESS ______________________ CITY __________ STATE ______ ZIP ______ WORK PHONE __________

DATE OF BIRTH ____/____/____ AGE ______ M ☐ F ☐ MARITAL STATUS __________ NO. CHILDREN ______ FAX # __________

OCCUPATION ______________________ SS# __________ SPOUSE __________ E-MAIL __________

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ______________________ REFERRED BY ______________________

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O - OCCASIONAL
F - FREQUENT
C - CONSTANT

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness/depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Pain between shoulders

Pain or numbness in:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tail bone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal curvature
☐ ☐ ☐ Swollen joints

O F C

GASTRO-INTESTINAL

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Distension of abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE & THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Cancer
☐ Chorea
☐ Cold sores
☐ Diabetes
☐ Diphtheria
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart disease
☐ HIV/AIDS
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Stroke
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal Disease
☐ Whooping cough

Have you ever had previous chiropractic care? ______________ If yes, date of last care ______________

Do you have Health and Accident Insurance? ______________ If yes, with what company? ______________

Is this an Industrial Accident Case? ☐ Yes ☐ No

PLEASE PRINT

What is your major complaint? ______________________________

____

Other complaints ______________________________

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

What activities aggravate your condition? ______________________________

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

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other ______________

How long has it been since you really felt good? ______________________________

List previous diagnoses and treatments you have received for present condition ______________________________

____

What do you believe is wrong with you? ______________________________

List surgical operations and years: ______________________________

____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others ______________________________

Dental visits: ☐ Every six months ☐ Yearly ☐ Toothache or emergency only ☐ Complete dentures

Age of mattress: ______________ ☐ Comfortable ☐ Uncomfortable Do you use a bed board? ______________

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe ______________________________

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? ______________

Have others in your family had such disorders? ☐ Yes ☐ No When? ______________

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	______________
Used a cane, crutch, or other support?	☐	☐	______________
Been treated for a spine or nerve disorder?	☐	☐	______________
Had a fractured bone?	☐	☐	______________
Been hospitalized for other than surgery?	☐	☐	______________

DO YOU:			
Now take vitamins or minerals?	☐	☐	______________
Think you may need vitamins or minerals?	☐	☐	______________
Have an allergy to any drug?	☐	☐	______________

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS.

____

____

____

____

____

____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME ______________________________

ADDRESS ______________________________ PHONE ______________

Spinal Imaging, Inc

P.O. Box 1200 South Easton, MA 02375 1-800-659-6718

Dear Patient,

Your doctor is sending your X-rays to Spinal Imagining, Inc., the most complete Radiological Interpretation Center for Chiropractors in America.

Your doctor has instructed us to perform the following tests:

1. Pathology Reading and Report by a Board Certified Chiropractic Radiologist.
2. Complete Computerized Biomechanical Analysis with Numonic Digitization.
3. Geometric Analysis with laser Spinography.

If you have health care coverage we will bill your insurance company, healthcare provider, or workers' compensation carrier for payment. Most coverages pay our services in full. If you do not have healthcare coverage you will be billed a "Non-Profit Fee" of $20.00. If you have an attorney, we will send our bill to your attorney and will await payment until settlement of your case.

Your out-of-pocket expense will not exceed $20.00. If you are paid our fee directly by a healthcare carrier or through a legal settlement, you will be responsible to Spinal Imaging, Inc. for the amount paid. If Spinal Imaging, Inc. does not receive a lien, or if Spinal Imaging, Inc. does not receive a reply to a case status information request from your attorney, you will be billed for the full amount of service. Once Spinal Imaging, Inc. receives a reply from the attorney, you will stop being billed.

Dear Patient:

It is custom to send your X-rays taken here in our office to Spinal Imaging Inc. where Chiropractic Radiologists thoroughly study them and send back and detailed report of their findings. This greatly aids me in correcting your spinal/nerve problems.

There is a $10.00 charge for the shipping and handling of the X-rays which will be included in your first visit amount due. If you provide us with a copy of your insurance card, Spinal Imaging will bill your insurance company directly for their services.

If your insurance company doesn't cover their services or if you don't have health insurance, you will be receiving a statement from Spinal Imaging, not to exceed $20.00.

I have read and fully understand the above.

____
Patient Signature

____
Print Name

X-RAY ASSIGNMENT AGREEMENT AND CONSENT

I understand that my doctor is submitting my x-rays to Spinal Imaging, Inc. for second opinion radiological evaluation and analysis by a specialist. I also understand that the fee for such services will be submitted to my insurance company, healthcare carrier, attorney or worker's compensation carrier for payment. If I am paid directly by an insurance carrier or through a legal settlement, I will be responsible for the amount paid. If Spinal Imaging, Inc. does not receive a lien, or if Spinal Imaging, Inc. does not receive a reply to a case status information request from my attorney, I will be billed for the amount of service. Once Spinal Imaging, Inc. receives a reply from the attorney, I will stop being billed.

I also give my consent to Spinal Imaging, Inc's use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance on this consent. I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Spinal Imaging, Inc, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. **My signature authorizes the release of medical information and also authorizes the assignment of benefits to:**

Spinal Imaging, Inc.
5 Norfolk Avenue
P.O. Box 1200
South Easton, MA 02375

In the event my insurance company or attorney sends payment of services to me, I agree to promptly remit such payment to Spinal Imaging, Inc.

_______________ **Date**

_______________ **Patient Signature**

_______________ **Print Name**

Ver 4/03

Body Fat % Tests - $25.00
Bio-Meridian Test - $30.00
Missed Appointment Charge (with no 24 hour advance notice and not rescheduled) – $45.00
Bounced Check Fee per incident (Two max, then cash only) - $35.00
Fee for making copies of patient charts requested by 3rd party – Varies per amount of copies.
*These fees do not reflect promotional discounts or pre-pay program fees offered by the Center when eligibility requirements are met. The promotional discounts or pre-pay program fees will be applied by the cashier.

____
Initials

PRE-PAY PACKAGES:

4. I understand that the flat rate Pre-Pay packages are non-refundable and may not be altered, shared, transferred or combined with any other patient or with any other promotional special or discount. I understand that any unused portion of a Pre-Pay Package, upon discharge from the Center, may be applied to product purchases or is forfeited. Upon completion of the Pre-Pay Package, I shall have one year to use my free visits (free visits can only be used for office visit treatments, not products) or they are forfeited. I understand that the Center does no insurance billing, reporting, coding, processing, or annual expense reporting of any kind whatsoever.

PRE-PAY DISCOUNT SAVINGS FOR BRT:
(A) Pay for 10 O.V.'s and get 1 free (Save $45.00)
(B) Pay for 20 O.V.'s and get 2 free plus 1 free Bio-Meridian (Save $140.00)

____
Initials

5. I understand that once nutritional supplements are purchased from and leave the office, they may not be returned, exchanged, refunded or credited unless the Center determines that the order was filled incorrectly.

____
Initials

I have read and agree to the Center's above terms of service.

Signature__________________________ **Date**____________

Alpine Family Chiropractic and Nutrition
Colorado Spinal Decompression
Laser Joint and Pain Therapy
Active Therapeutic Movement Therapy
28529 Mountainview Road Conifer, CO 80433
Dr. Randy Jacobs, BS, MA, DC.
Phone (303) 838-7700 Fax (303) 838-4027 www.coniferchiropractor.com

Terms for Services and Procedures

Print Name_____________________________ **Date**_________________

1. The services in the office are not a method for preventing, diagnosing, treating, healing, relieving or curing symptoms, disease or medical conditions of any kind. I understand that when I receive treatments, exercise advice, diet advice and nutritional advice, there may be temporary side effects such as fatigue, flu-like symptoms and possible aggravation of the symptoms presented after a treatment. Any of these or other possible recovery symptoms or side effects should be reported immediately to the Center.

   ____
   Initials

2. The practitioners in our office do not provide medical care of any kind. We also do not guarantee any cures of any kind

   ____
   Initials

3. I understand that the following office visit fees apply:
   Initial Visit Evaluation for "HWM" $120.00 – a discount may be given at the workshop - $89.00 (A 24 hour cancellation or reschedule call is needed or money is forfeited)
   Digestive Evaluation $45.00
   Digestive Re-evaluation $25.00
   Hair Analysis - $125.00
   Hydro Therapy - $15.00
   Custom made Foot Orthotics - $395.00
   Neck and Low Back Support Pillows - $35.00 each
   Spinal Decompression - $65.00
   Active Therapeutic Movement Therapy - $45.00
   Cold Laser Therapy - $30.00 (per area)
   Consultation - $50.00 per 15 minutes
   ***Office Visits, each $45.00 (discounted visit fee for pre-payment programs are variable in rates) see other side**
   Chiropractic Adjustments - $45.00 Medicare Patients - $35.00
   Chiropractic Adjustments for Children under 16 - $25.00
   (IF PARENT IS A CURRENT PATIENT)