CONFIDENTIAL PATIENT INFORMATION

How did you hear about us?

☐ Patient ☐ Friend ☐ Health Care Provider ☐ Yelp ☐ Internet ☐ Website ☐ Other:

Full Name (First, Middle, Last): ____________________

Home Phone: ____________ Cell Phone: ____________ Email: ____________

Preferred contact method: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Address: ____________________

City: ____________ State: ________ Zip: ____________

DOB: ____________ Age: ________ Sex: M / F

Social Security Number: ____________ Driver's License: ____________

Marital Status: S / M / D / W Spouse's Name: ____________ # of Children: ________

Occupation: ____________ Business/Employer Name: ____________

Primary Care Physician: ____________ Phone: ____________

☐ I hereby give permission to release information related to my care to my family physician.

Emergency Contact: ____________ Phone: ____________

IF YOU WERE INVOLVED IN AN ACCIDENT PLEASE COMPLETE THE FOLLOWING:

Did the injury occur at **WORK?** Yes / No **DATE OF INJURY:** ____________ **TIME:** ________

Has the injury been reported to your supervisor? Yes / No **SUPERVISOR NAME**: ____________

Is the injury a result of an **AUTOMOBILE ACCIDENT?** Yes / No **OTHER?** ____________

Do you have an **ATTORNEY?** Yes / No **ATTORNEY NAME**: ____________ **PHONE**: ____________

I hereby certify that the preceding questions have been answered truthfully and completely to the best of my knowledge and belief.

Patient/Guardian Signature: ____________________ **Date:** ____________

CHIROPRACTIC
INFORMED CONSENT / SHARED DECISION MAKING

Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

I agree to have a physical examination. I understand some testing may provoke existing symptoms but that these tests are necessary to arrive at a diagnosis.

____ ________________

Patient Signature (Guardian if Minor) Date

The nature of the chiropractic adjustment*:* Dr. David Mashadian D.C. may use his hands or a device to manipulate the area being treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment may also include activity advice, exercise, hot or cold packs, electric stimulation or other types of therapy. Dr. David Mashadian D.C. will recommend treatment that is most appropriate for your condition.

Possible risks: Chiropractic treatment is safe and the majority of patients experience improvement. Approximately 30% of patients experience slight pain in the treated area, possibly due to a minor strain of muscle, tendon, or ligament. When this occurs, the pain is brief and self-limiting over the next few days. Temporary minor pain may also occur with exercise, heat, cold and electrical stimulation. Possible skin irritations, burns, or electrical shocks may occur with thermal or electrical therapy but are rare. Some soft tissue treatments may produce local discomfort, reddening of the skin, and superficial tissue bruising/soreness during and post treatment.

Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many factors can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illnesses, diseases or conditions. When complicating factors are present, chiropractic treatment may be associated with serious adverse events such as fracture, dislocation, or aggravation of existing injuries. Dr. David Mashadian D.C. is aware that symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care and will assess for symptoms and signs of stroke if appropriate. The incidence of stroke associated with neck adjustments is exceedingly rare (1 in 1 to 5 million) and while current research does not refute a causal relationship, it strongly suggests associated strokes are already in progress at the start of the visit rather than the result of the care provided.

Please inform Dr. David Mashadian D.C. of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical conditions, including osteoporosis, heart disease, numbness, cancer, stroke, fracture, or previous severe injury.

Other options for treatment include: do nothing and live with it, over-the-counter medications, physical therapy, medical care, injections, surgery, and many others. Most treatments that have

potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment and may use the space below for this purpose.

Before your treatment begins, the following questions should be answered to your satisfaction:

- What is my diagnosis?
- Why do you think I have this diagnosis?
- What caused this diagnosis?
- What will happen if I do not get any treatment?
- What is the name of the proposed treatment?
- How is this treatment performed?
- What are the specific goals of this treatment?
- How much does each treatment cost, how many will I need, and how much will I need to pay out of pocket?
- Which aspects of my health will this treatment improve?
- How much of an improvement is expected and how long will it last?
- How will we measure this improvement?
- What are the factors that can help predict outcomes with this treatment?
- What could go wrong with this treatment?
- How often does something go wrong with this treatment?
- What are the consequences if something goes wrong?
- When should this treatment not be performed?
- What are some of the other treatment options available?
- What are the advantages of other treatment options?
- What are the disadvantages of other treatment options?
- When would you consider referring me to someone else?

My signature below confirms that I have read the paragraphs above and that I understand what Dr. David Mashadian D.C. has told me about possible risks of chiropractic treatment and that I have had the opportunity to ask questions and have my questions answered. In addition, I have told Dr. David Mashadian D.C. about my medical history regarding the above-specified complicating factors, if any.

Patient's Name: ______________________________ Date: ______________________

Patient Signature: ____________________________

PATIENT HISTORY

Name: ________________________

Date: __________________________

Do you smoke? ☐ Yes ☐ No

Chief Complaint

Symptoms in: ☐ Low back ☐ Buttock ☐ Thigh ☐ Leg ☐ Foot ☐ Neck ☐ Arm ☐ Hand ☐ Other

How did this begin?

When did this begin?

Previous Testing

Please indicate previous tests you have had for your back, when they were performed and the results.

Test	Date	Results
☐ X-ray		
☐ MRI		
☐ CT		
☐ Lab		
☐ Other		

Previous Treatment

Please indicate previous treatments you have had for your back, when they were performed and the results:

Treatment	Results / Comments
Medication:	
☐ Ibuprofen	☐ Helped ☐ Worsened ☐ No effect
☐ Naprosyn	☐ Helped ☐ Worsened ☐ No effect
☐ Prednisone	☐ Helped ☐ Worsened ☐ No effect
☐ Medrol dose pack	☐ Helped ☐ Worsened ☐ No effect
☐ Other (specify)	
Spinal injection:	
☐ Epidural steroid injection	☐ Helped ☐ Worsened ☐ No effect
☐ Facet block	☐ Helped ☐ Worsened ☐ No effect
☐ Selective nerve block	☐ Helped ☐ Worsened ☐ No effect

Treatment	Results / Comments
☐ Spinal surgery Date:	☐ Helped ☐ Worsened ☐ No effect
Conservative care:	
☐ Acupuncture	☐ Helped ☐ Worsened ☐ No effect
☐ Chiropractic	☐ Helped ☐ Worsened ☐ No effect
☐ Physical Therapy	☐ Helped ☐ Worsened ☐ No effect
☐ Other	

Current Work Status

Employer: Job title: Time at position:

Work status: ☐ Regular duty ☐ Modified duty ☐ Off work - Date began modification or off work:

Description of your normal job activities:

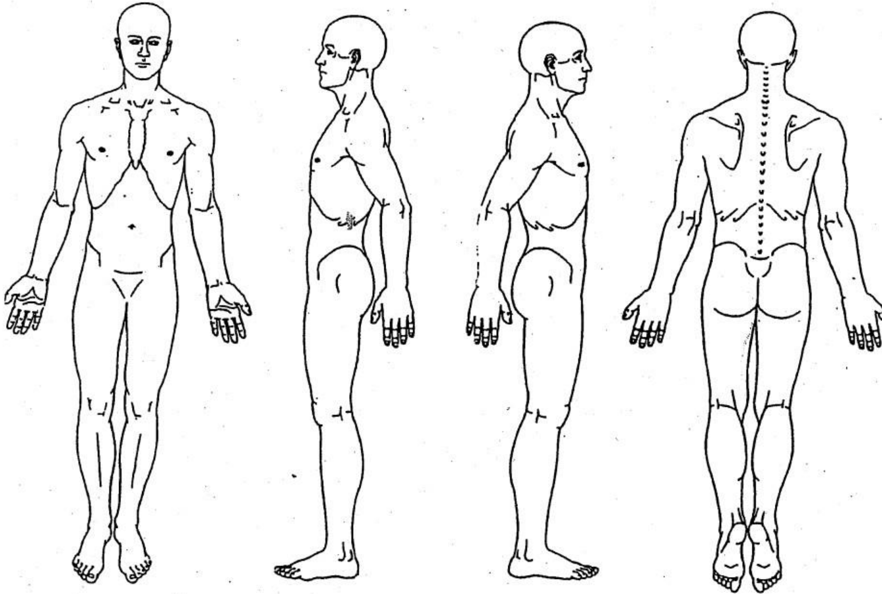
	Sitting	Standing	Walking	Driving	Lifting*
Total hours in a normal work day					
Max duration at one time at work					

* If lifting at work, what is the average weight? How many times do you lift per hour?

Name ____ Date ______________________________

Using the following descriptive symbols, draw the location of your pain on the body outlines below

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
^^^^	=======	000000000	………………………	/////////	xxxxx



Describe other pain not listed:

____

____

Over the past week, on average, how would you rate your pain?

0	1	2	3	4	5	6	7	8	9	10

No pain — *Worst possible pain*

Right now, how would you rate your pain?

0	1	2	3	4	5	6	7	8	9	10

No pain — *Worst possible pain*

How confident are you in your ability to overcome your problem?

0	1	2	3	4	5	6	7	8	9	10

Total confidence — *No confidence*

How depressed do you feel as a result of your current problem?

0	1	2	3	4	5	6	7	8	9	10

Not at all — *Extremely*

What are two important activities that you cannot do or are having trouble doing? (i.e., "I can't get dressed without help," "I can't play golf," "I can't go to work.")

Activity 1. ____

Please rate activity

0	1	2	3	4	5	6	7	8	9	10

Able to perform at same level as before problem — *Unable to perform*

Activity 2. ____

Please rate activity

0	1	2	3	4	5	6	7	8	9	10

Able to perform at same level as before problem — *Unable to perform*

Pt name: DOB: Trial No: Physio: Date:

STarT Back: For these questions, please think about your back pain over the last few days.

1st Time Score | 2nd Time Score | Change score

1. How **bothersome** has **pain spreading down your legs from your back** been in the **last few days**?

Not at all	Slightly	Moderately	Very much	Extremely
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

2. How **bothersome** has pain in your **shoulder** or **neck** been in the **last few days**?

Not at all	Slightly	Moderately	Very much	Extremely
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

For each of the following, please cross one box to show how much you agree or disagree with the statement, thinking about the **last few days.**

3. In the last **few days**, I have **dressed more slowly** than usual because of my back pain.

Completely disagree — Strongly agree

0	1	2	3	4	5	6	7	8	9	10

4. In the last **few days**, I have only **walked short distances** because of my back pain.

Completely disagree — Strongly agree

0	1	2	3	4	5	6	7	8	9	10

5. It's **really not safe** for a person with a condition like mine to be **physically active.**

Completely disagree — Strongly agree

0	1	2	3	4	5	6	7	8	9	10

6. **Worrying thoughts** have been going through my mind a lot of the time in the last **few days**.

Completely disagree — Strongly agree

0	1	2	3	4	5	6	7	8	9	10

7. I feel that **my back pain is terrible** and that **it is never going to get any better**.

Completely disagree — Strongly agree

0	1	2	3	4	5	6	7	8	9	10

8. In general, in the last **few days**, I have **not enjoyed** all the things I used to enjoy.

Completely disagree — Strongly agree

0	1	2	3	4	5	6	7	8	9	10

9. Overall, how **bothersome** has your **back pain** been in the **last few days**?

Not at all	Slightly	Moderately	Very much	Extremely
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name ____ **Date** ________________________

Please read carefully:

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

SECTION 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

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

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading

A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 - Headaches

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I cannot concentrate at all.

SETION 7 – Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving

A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-5 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation

A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

OTHER COMMENTS:

____

____

____

____
Examiner

With Permission from: Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

HEALTH QUESTIONNAIRE

Name: ____Date: ____________________

Past Medical History

For each condition, please place an “X” in the appropriate column.

	Have now	Had in past, but not now		Have now	Had in past, but not now		Have now	Had in past, but not now
MAJOR PAST HISTORY								
Cancer			Diabetes			Heart attack		
Seizures			Pace maker			TIA/stroke		
Headaches/migraine			High blood pressure			Immune disorders		
Other/comments:								
GENERAL / ENDOCRINE								
Alcoholism			Anemia			Anxiety		
Depression			Thyroid disorders			Low blood sugar		
Other/comments:								
GASTROINTESTINAL								
Gall bladder problem			Blood/mucus in stool			Stomachache		
Colitis			Vomiting			Polyps/Diverticulosis		
Heartburn			Constipation			Poor appetite		
Nausea			Recent weight gain			Liver disease/hepatitis		
Diarrhea			Recent weight loss					
Other/comments:								
CARDIOVASCULAR								
Pain or unusual feelings in chest			Coronary arterial disorder			Varicose veins		
Palpitations			High cholesterol			Heart failure		
Swelling in ankles			Irregular heartbeat			Arterial aneurysm		
Shortness of breath			Low blood pressure			Heart murmur		
Other/comments:								
NERVOUS SYSTEM								
Fainting			Memory loss			Tremor of limbs		
Dis-coordination			Speech difficulty			Paralyzed limbs		
Dizziness/ lightheadedness			Other/comments:					
EYES, EARS, NOSE & THROAT								
Vision problems/ blurry /double vision			Ear noises/ringing in ears			Nose bleeds		
Sinus problems			Dental problems			Difficulty swallowing		
Ear problems			Other/comments:					
RESPIRATORY								
Coughing up blood			Difficulty breathing			Chronic obstructive pulmonary disease		
Chronic cough			Asthma					
Other/comments:								

	Have now	Had in past, but not now		Have now	Had in past, but not now		Have now	Had in past, but not now
URINARY TRACT								
Blood in urine			Kidney stones			Puffy face/eyelids		
Painful urination			Bladder infection			Leg/foot edema		
Inability to control urination			Other/comments:					
WOMEN ONLY								
Hysterectomy			Menopausal symptoms			C-sections		
Irregular periods			Painful breasts			Genital tumors		
Lumps in breasts			Vaginal discharge			Excessive flow		
Premenstrual symptoms, e.g. cramps, headaches, mood changes			Other/comments:					
MEN ONLY								
Prostate problems			Need to urinate at night			Hernias		
Feeling of incomplete urination			Difficulty starting urination			Dripping after urination		
Blood in urine			Sexual dysfunction					
Other/comments:								
NEUROMUSCULOSKELETAL								
Headaches			Low back pain			Arthritis		
Neck pain			Upper extremity pain			Numbness / tingling		
Mid-back pain			Lower extremity pain					
Other/comments:								

Please list any:	**Date(s)**	**Comments**
Surgeries (including minor and cosmetic)		
Hospitalizations		
Pregnancies & births		
Significant traumas (concussions, auto accidents, falls, etc.)		
Allergies (drugs, foods, chemicals)		
Medications (prescription and over-the counter) taken within the past two months		
Vitamins, supplements, herbs taken within the past two months		

Family Medical History

Have any immediate or secondary family ever been diagnosed with:			**Family member(s) diagnosed:**
Cancer	yes	no	
Diabetes	yes	no	
High Blood Pressure	yes	no	
Heart Disease	yes	no	
Stroke	yes	no	
Arthritis	yes	no	
Seizures	yes	no	

Lifestyle / Health Promotion

1. How many hours of sleep do you get per night on average?	0 1 2 3 4 5 6 7 8 9 10 11 12
2. How would you rate your sleep quality?	Excellent Good Average Fair Poor
3. Are you following a special diet (vegan, vegetarian, Weight Watchers, etc.)? If yes, briefly explain.	Yes No
4. How many meals do you usually eat per day?	0 1 2 3 4 5 6 more than 6
5. Do you usually snack in between meals?	No Yes
6. How often do you usually eat out each week?	0-3 4-6 7-10 10+
7. How many servings of fruits & vegetables do you usually eat per day?	0 1 2 3 4 5 6 more than 6
8. How many cups of water do you usually drink per day? (1 cup = 8 ounces)	0 1 2 3 4 5 6 7 8 9 10 11 12
9. How many days per week do you exercise on average?	0 1 2 3 4 5 6 7
10. Briefly describe your exercise program.	
11. Have you ever habitually smoked cigarettes?	Yes No
12. Do you presently smoke cigarettes?	Yes No
13. Do you drink alcohol?	Yes No
14. Do you use any recreational drugs?	Yes No
15. Describe any habits you feel are affecting your health.	
16. How would you rate your stress level?	Very High High Medium Low Very Low
17. What are your stressors?	
18. Do you feel sad a good deal of the time?	Yes No
19. How would you describe your health in general?	Excellent Good Fair Poor
20. Does your health prevent you from: a. Working b. Participating in social activities? c. Participating in hobbies? d. Being sexually active?	 Yes No Yes No Yes No Yes No