

Patient Type

MM  Self Pay  PI  PIA  W/C  MC

**Confidential Patient Health Record**

**Personal History**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female  
Email Address: \_\_\_\_\_  
Circle One: Married Single Widowed Divorced Separated Number of Children: \_\_\_\_  
Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_  
Spouse's Social Security #: \_\_\_\_\_ (if insurance under his/her name)  
Spouse's Employer: \_\_\_\_\_  
Who referred you to our office: \_\_\_\_\_  
Who is responsible for your bill?  Self  Spouse  Worker's Comp  Auto Insurance  
 Medicare  Personal Health Insurance (name) \_\_\_\_\_  
Is condition:  Work Injury  Auto Accident  Home injury  Fall  Other: \_\_\_\_\_  
.  
Please list all medications: \_\_\_\_\_  
Do you suffer from any condition other than what you are here for?

**Health History**

When did this condition begin? (Date of Injury) \_\_\_\_\_  
Major surgery/operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  
 Back Surgery  Broken Bones  Hysterectomy  Other: \_\_\_\_\_  
Major accidents or falls: \_\_\_\_\_

PLEASE PRESENT YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST

**Assignment/Authorization**

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also drive Meyer Chiropractic Center and Dr. Meyer the right to release any records, and pertinent material to any third party. I hereby instruct, direct, and authorize my insurance company to pay directly to Dr. Paul Meyer, Meyer Chiropractic Center, for any professional services.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY SAME.

PATIENT SIGNATURE \_\_\_\_\_

If the patient is a minor: I hereby give Permission to the doctors of this office and whomever they designate to treat the patient. I am his/her guardian.

GUARDIAN SIGNATURE \_\_\_\_\_

**MEYER CHIROPRACTIC CENTER**

**CONFIDENTIAL PATIENT CASE HISTORY**

---

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

\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

\_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

\_\_\_\_\_

Do any positions make it feel worse? \_\_\_\_\_

Do any positions make it feel better? \_\_\_\_\_

Is this condition:  Improved  Unchanged  Getting Worse

Is this condition interfering with your:  Work  Sleep  Daily Routine  Other \_\_\_\_\_

Other doctors or therapists who have treated THIS condition \_\_\_\_\_

What do you think caused this condition? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

\_\_\_\_\_

Do you have a family physician? Name \_\_\_\_\_

Medications, dosage and frequency: \_\_\_\_\_

\_\_\_\_\_

Have you been in an auto accident or had any other personal injury?  Yes  No

Describe: \_\_\_\_\_

\_\_\_\_\_

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

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

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

## 1. Describe your symptoms

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

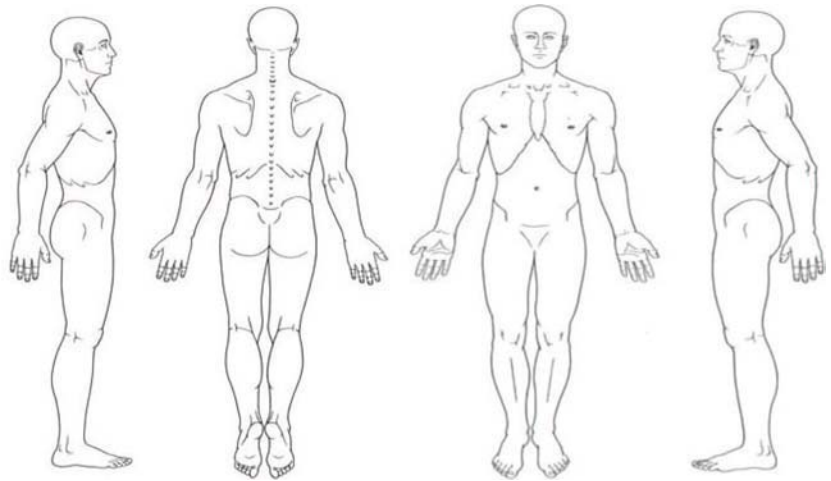
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



## 3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

## 4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

## 5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

## 6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

## 7. In general would you say your overall health right now is...

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

## 8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

\_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

## 10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

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

**REVIEW OF SYSTEMS** Check only the ones you now have or have had in the past.

**GENERAL**      **NOW**   **PAST**

- Weakness       N  P
- Fatigue         N  P
- Fever           N  P
- Chills          N  P
- Night Sweats  N  P
- Fainting        N  P

**SKIN**

- Color Changes       N  P
- Nail Changes         N  P
- Hair Changes        N  P
- Moles                 N  P
- Rashes                N  P
- Sores                 N  P
- Weakness            N  P

**HEAD**

- Headaches          N  P
- Injuries              N  P
- Bumps                N  P
- Last Eye Exam      N  P
- Glasses              N  P
- Contacts             N  P
- Cataracts            N  P

**EARS**

- Hard of Hearing      N  P
- Deafness            N  P
- Ringing              N  P
- Discharge            N  P
- Earache              N  P
- Itching               N  P
- Dizziness            N  P
- Room Spins          N  P

**NOSE**

- Decreased Smell    N  P
- Bleeding             N  P
- Pain                  N  P
- Discharge           N  P
- Obstruction         N  P
- Post Nasal Drip    N  P
- Deviated Septum    N  P
- Runny Nose         N  P
- Sinus Congestion  N  P

**MOUTH**

- Bleeding Gums      N  P
- Sores                 N  P
- Dental Problems    N  P
- Bad Breath          N  P
- Loss of Taste       N  P
- Dry Mouth           N  P
- Ulcers                N  P
- Blisters             N  P

**THROAT**

- Soreness            N  P
- Bad Tonsils         N  P
- Hoarseness         N  P
- Pain                 N  P
- Trouble Swallowing  N  P
- Recurrent Infections  N  P

**NECK**

- Neck Enlargement  N  P
- Stiff Neck          N  P
- Soreness            N  P
- Lumps               N  P
- Masses              N  P

**BREASTS**

- Discharge          N  P
- Lumps               N  P
- Pain                 N  P
- Bleeding            N  P
- Nipple Changes    N  P
- Skin Changes       N  P
- Bloated             N  P

**LUNGS**

- Cough              N  P
- Phlegm             N  P
- Blood               N  P
- Short of Breath    N  P
- Wheezing          N  P
- Pain                 N  P
- Congestion        N  P
- Inhalant Exposure  N  P

**HEART**

- Murmur             N  P
- Palpitations        N  P
- Rapid Heartbeat    N  P
- Swollen Extremities  N  P
- Cold Extremities  N  P
- Chest Pain/Pressure  N  P
- Varicose Veins    N  P
- Blood Clots        N  P
- Blue Extremities  N  P

**BLOOD**

- Anemia             N  P
- Low Blood Iron     N  P
- Easy Bruising      N  P
- Easy Bleeding      N  P
- Swollen Nodes     N  P
- Painful Nodes      N  P
- Sugar in Blood     N  P
- Red Spots          N  P

**GASTROINTESTINAL**      **NOW**   **PAST**

- Abdominal Pain      N  P
- Nausea               N  P
- Bloated              N  P
- Belching             N  P
- Heartburn            N  P
- Indigestion          N  P
- Irregular Bowel Habits  N  P
- Constipation        N  P
- Diarrhea             N  P
- Gas                   N  P
- Hemorrhoids         N  P
- Poor Appetite       N  P
- Food Intolerance    N  P
- Bloody Stools       N  P
- Black Stools         N  P

**GENITOURINARY**

- Urgency             N  P
- Incontinence       N  P
- Straining           N  P
- Back Pain           N  P
- Frequent Voiding    N  P
- Stones              N  P
- Burning             N  P
- Bed Wetting         N  P
- Small Stream       N  P
- Discharge           N  P
- Impotence          N  P
- Dribbling           N  P
- Cloudy Urine       N  P
- Urine Color \_\_\_\_\_

- Spotting Between  N  P
- Periods             N  P
- Menstrual Cramps  N  P
- Discharge          N  P
- Itching              N  P
- Painful Intercourse  N  P
- Irregular Periods  N  P
- Hot Flashes        N  P

- Contraception Type \_\_\_\_\_
- Age at First Period \_\_\_\_\_
- Duration of Cycle \_\_\_\_\_
- Duration of Flow \_\_\_\_\_
- No. of Pregnancies \_\_\_\_\_
- No. of Births \_\_\_\_\_
- No. of Miscarriages \_\_\_\_\_
- No. of Abortions \_\_\_\_\_
- Menstrual Flow  Heavy  Mod  Light
- Last Period \_\_\_\_\_
- Last Pap Smear \_\_\_\_\_
- Last Vaginal Exam \_\_\_\_\_
- Last Mammogram \_\_\_\_\_
- Last Prostate Exam \_\_\_\_\_

NAME \_\_\_\_\_

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

NEUROLOGIC	NOW	PAST
Seizures	<input type="checkbox"/> N	<input type="checkbox"/> P
Vertigo	<input type="checkbox"/> N	<input type="checkbox"/> P
Dizziness	<input type="checkbox"/> N	<input type="checkbox"/> P
Hand Trembling	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Sensation	<input type="checkbox"/> N	<input type="checkbox"/> P
Incoordination	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Facial	<input type="checkbox"/> N	<input type="checkbox"/> P
Weak Grip	<input type="checkbox"/> N	<input type="checkbox"/> P
Paralysis	<input type="checkbox"/> N	<input type="checkbox"/> P
Difficulty Speech	<input type="checkbox"/> N	<input type="checkbox"/> P
Tingling	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Memory	<input type="checkbox"/> N	<input type="checkbox"/> P
Numbness	<input type="checkbox"/> N	<input type="checkbox"/> P

**ENDOCRINE**

Weight Loss	<input type="checkbox"/> N	<input type="checkbox"/> P
Weight Gain	<input type="checkbox"/> N	<input type="checkbox"/> P
Extremely Thin	<input type="checkbox"/> N	<input type="checkbox"/> P
Heat Intolerance	<input type="checkbox"/> N	<input type="checkbox"/> P
Cold Intolerance	<input type="checkbox"/> N	<input type="checkbox"/> P
Hair Changes	<input type="checkbox"/> N	<input type="checkbox"/> P
Breast Changes	<input type="checkbox"/> N	<input type="checkbox"/> P

**IMMUNIZATION/VACCINATION**

DPT	Y <input type="checkbox"/>
Mumps	Y <input type="checkbox"/>
Smallpox	Y <input type="checkbox"/>
Typhoid	Y <input type="checkbox"/>
Tetanus	Y <input type="checkbox"/>
Measles	Y <input type="checkbox"/>
Pneumococcal	Y <input type="checkbox"/>
Influenza	Y <input type="checkbox"/>
Polio	Y <input type="checkbox"/>
MMR	Y <input type="checkbox"/>

**BLOOD TYPE**

A +	<input type="checkbox"/>	A -	<input type="checkbox"/>
B +	<input type="checkbox"/>	B -	<input type="checkbox"/>
AB +	<input type="checkbox"/>	AB -	<input type="checkbox"/>
O +	<input type="checkbox"/>	O -	<input type="checkbox"/>
Other	_____		

**BLOOD TRANSFUSIONS**

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

PSYCHIATRIC	NOW	PAST
Hyperventilation	<input type="checkbox"/> N	<input type="checkbox"/> P
Insecurity	<input type="checkbox"/> N	<input type="checkbox"/> P
Depression	<input type="checkbox"/> N	<input type="checkbox"/> P
Troubled Sleep	<input type="checkbox"/> N	<input type="checkbox"/> P
Irritable	<input type="checkbox"/> N	<input type="checkbox"/> P
Undecidedness	<input type="checkbox"/> N	<input type="checkbox"/> P
Timid	<input type="checkbox"/> N	<input type="checkbox"/> P
Hallucinations	<input type="checkbox"/> N	<input type="checkbox"/> P
Loss of Memory	<input type="checkbox"/> N	<input type="checkbox"/> P
Alcoholism	<input type="checkbox"/> N	<input type="checkbox"/> P
Drug Addiction	<input type="checkbox"/> N	<input type="checkbox"/> P
Drug Dependent	<input type="checkbox"/> N	<input type="checkbox"/> P
Suicidal Thoughts	<input type="checkbox"/> N	<input type="checkbox"/> P
Extreme Worry	<input type="checkbox"/> N	<input type="checkbox"/> P
Sexual Problems	<input type="checkbox"/> N	<input type="checkbox"/> P

**PAST MEDICAL HISTORY. Check only the ones you have had in the past .**

Hay Fever	Y <input type="checkbox"/>	Parasites	Y <input type="checkbox"/>
Mumps	Y <input type="checkbox"/>	Epilepsy	Y <input type="checkbox"/>
Rheumatic Fever	Y <input type="checkbox"/>	Paralysis	Y <input type="checkbox"/>
Allergies	Y <input type="checkbox"/>	Polio	Y <input type="checkbox"/>
Angina	Y <input type="checkbox"/>	Mental illness	Y <input type="checkbox"/>
Cancer	Y <input type="checkbox"/>	Alcoholism	Y <input type="checkbox"/>
Tumor	Y <input type="checkbox"/>	Depression	Y <input type="checkbox"/>
Blood Disease	Y <input type="checkbox"/>	Nervous Breakdown	Y <input type="checkbox"/>
Leukemia	Y <input type="checkbox"/>	Migraine	Y <input type="checkbox"/>
Heart Trouble	Y <input type="checkbox"/>	Gout	Y <input type="checkbox"/>
Varicose Veins	Y <input type="checkbox"/>	Hemorrhoids	Y <input type="checkbox"/>
Phlebitis	Y <input type="checkbox"/>	Prostate Problems	Y <input type="checkbox"/>
Hypertension	Y <input type="checkbox"/>	Sexual Problems	Y <input type="checkbox"/>
Stroke	Y <input type="checkbox"/>	Gonorrhea	Y <input type="checkbox"/>
Ulcers	Y <input type="checkbox"/>	Syphilis	Y <input type="checkbox"/>
Jaundice	Y <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/>
Skin Trouble	Y <input type="checkbox"/>	Bladder Trouble	Y <input type="checkbox"/>
Gallstones	Y <input type="checkbox"/>	Kidney Stones	Y <input type="checkbox"/>
Liver Trouble	Y <input type="checkbox"/>	Kidney Infections	Y <input type="checkbox"/>
Hepatitis	Y <input type="checkbox"/>	Dysentery	Y <input type="checkbox"/>

Date of Last Chest X-Ray \_\_\_\_\_  Normal  Abnormal

Last TB Skin Test \_\_\_\_\_  Normal  Abnormal

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

**SOCIAL HISTORY** Check the boxes and fill in.

Current Weight \_\_\_\_\_ Have you recently lost or gained weight? \_\_\_\_\_

Mental Work  Heavy  Moderate  Light Hours per day \_\_\_\_\_

Physical Work  Heavy  Moderate  Light Hours per day \_\_\_\_\_

Exercise  Heavy  Moderate  Light Hours per week \_\_\_\_\_ Type \_\_\_\_\_

Smoking  Current  Previous Packs/Day \_\_\_\_\_ No. of years \_\_\_\_\_

Alcohol Beer/Week \_\_\_\_\_ Liquor/Week \_\_\_\_\_ Wine/Week \_\_\_\_\_ No. of Years \_\_\_\_\_

Caffeine (Coffee, Tea, Cola) Cups/Day \_\_\_\_\_ No. of Years \_\_\_\_\_

Aspirin No./Day \_\_\_\_\_ No. of Years \_\_\_\_\_ Others \_\_\_\_\_

**MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:**

Aches ^^^^ Numbness oooo Pins/Needles ···· Stabbing ////

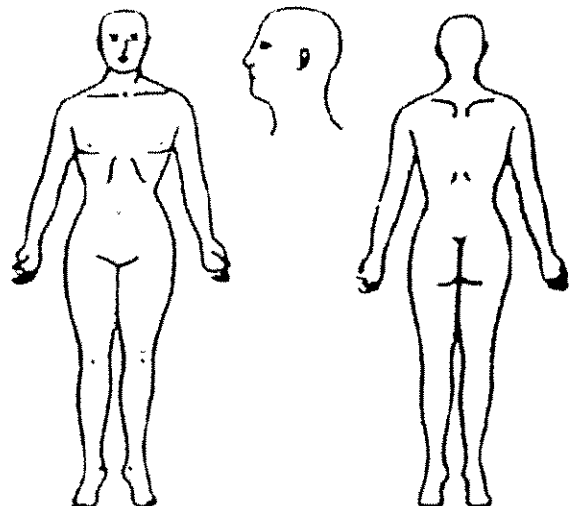
**MARK AN "X" ON THE LINES:**

How bad are your symptoms now?

-----  
None Most Severe

How bad have they been in the past?

-----  
None Most Severe



Patient Name \_\_\_\_\_ Number \_\_\_\_\_ 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**

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓟ The pain comes and goes and is very severe.
- Ⓡ The pain is very severe and does not vary much.

## **Sleeping**

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓡ Pain prevents me from sleeping at all.

## **Sitting**

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓡ I avoid sitting because it increases pain immediately.

## **Standing**

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓡ I avoid standing because it increases pain immediately.

## **Walking**

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓡ I cannot walk at all without increasing pain.

## **Personal Care**

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓟ Because of the pain I am unable to do some washing and dressing without help.
- Ⓡ Because of the pain I am unable to do any washing and dressing without help.

## **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.
- Ⓨ 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.

## **Traveling**

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓡ Pain restricts all forms of travel.

## **Social Life**

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

## **Changing degree of pain**

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓡ 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 NI-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

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

## Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

## Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

## Concentration

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

## Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

## Personal Care

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

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

## Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

## Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

## Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ 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

# **Informed Consent for Examination and Treatment**

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I (we) hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.  
Date of last menstrual period \_\_\_\_\_.

\_\_\_\_\_  
Patient's Name (Print)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or authority if not signed  
By patient

\_\_\_\_\_  
Witness

**Meyer Chiropractic Center  
5520 S. Cooper, Ste 111  
Arlington, TX 76017**

**HIPAA  
Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I have received a copy of Meyer Chiropractic Center 'Notice of Privacy Practices'. This Notice describes how Meyer Chiropractic center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to federal and state reporting agencies. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on the consent.

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(Printed Name of Patient)

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(Signature of Patient, or Personal Representative)

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(Date)

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(Relationship to Patient)