Landin Chiropractic Care
2010 Larkin Ave, Elgin, IL 60123
224-856-5617

PATIENT INFORMATION

DATE: _____

Name _____ Social Security # _____

Address _____City _____ State____ Zip _____

Cell Phone _____ Cell Phone Provider _____

Date of Birth ____/____/____ Age _____ Names/Ages of children _____

Marital Status: S W D M – Spouse's Name _____

E-mail Address _____

How were you referred to our office? _____

Emergency Contact_____ Phone _____

Employer _____Occupation _____ Work Phone _____

Employer's Address _____ City _____ Zip _____

Family Physician_____May we share info about your care here if they ask? ___

WOMEN: Are you or is there any possibility that you may be pregnant? YES _____ NO _____

Please check any and all insurance coverage that may be applicable in this case:

_____ Medical _____ Medicare _____ Auto Accident _____ Worker's Comp Other _____

Primary Insurance Company: _____

If Medicare, name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Landin and/or Landin Chiropractic Care. I authorize Dr. Landin and/or Landin Chiropractic Care to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. ***I understand that a quote of insurance benefits is not a guarantee of payment. I understand that I am responsible for all costs of all services/care provided by Landin Chiropractic Care, regardless of insurance coverage. If my insurance carrier deems any care not medically necessary or denies for any reason, I am responsible for payment of these services. If I suspend or terminate my schedule of care for any reason, any outstanding balance for professional services will be immediately due and payable. I understand any balances due will be charged to my credit card on file, which I have provided/authorized.*** _____**PATIENT INITIALS**

TO OUR PATIENTS: The above patient understands and agrees to allow Landin Chiropractic Care to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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 HIPAA NOTICE that is available to you at the front desk before signing this consent.

_____

Patient/Guardian Signature _____ Date _____

Chiropractic Case History

	Complaint #1	Complaint #2	Complaint #3
Today you have the following physical complaints:			
Describe:	___ Sharp ___ Dull ___ Achy ___ Throbbing ___ Numb ___ Burning ___ Electric ___ Shooting	___ Sharp ___ Dull ___ Achy ___ Throbbing ___ Numb ___ Burning ___ Electric ___ Shooting	___ Sharp ___ Dull ___ Achy ___ Throbbing ___ Numb ___ Burning ___ Electric ___ Shooting
How often do you feel this pain/complaint?	___ Constantly ___ On & Off ___ Daily ___ # times per week ___ # times per month	___ Constantly ___ On & Off ___ Daily ___ # times per week ___ # times per month	___ Constantly ___ On & Off ___ Daily ___ # times per week ___ # times per month
How long have you had this pain?			
Since it began, is it getting:	___ Better ___ Worse ___ Same	___ Better ___ Worse ___ Same	___ Better ___ Worse ___ Same
What makes it better?			
What makes it worse?			
Is there a time of day this is better or worse?			
Does the pain radiate or travel anywhere?			
On a scale of 1 - 10 Rate your discomfort	1 2 3 4 5 6 7 8 9 10 1 = Slight 10 = Excruciating	1 2 3 4 5 6 7 8 9 10 1 = Slight 10 = Excruciating	1 2 3 4 5 6 7 8 9 10 1 = Slight 10 = Excruciating
How have you taken care of this and how has it worked for you?			
This issue is affecting my:	___ sleep ___ job ___ energy ___ childcare ___ marriage ___ sex ___ activity ___ urination ___ digestion ___ range of motion	___ sleep ___ job ___ energy ___ childcare ___ marriage ___ sex ___ activity ___ urination ___ digestion ___ range of motion	___ sleep ___ job ___ energy ___ childcare ___ marriage ___ sex ___ activity ___ urination ___ digestion ___ range of motion
GOALS			

Please check the type of care desired (you may choose more than one)

___ Relief ___ Prevention ___ Correction of the Cause

___ Let Dr. Landin choose for me

Doctor's Notes:

PATIENT _____ DATE: _____

SUBJECTIVE PAIN ASSESSMENT – RATE YOUR PAIN BELOW

<u>(use only one BOX per visit)</u>

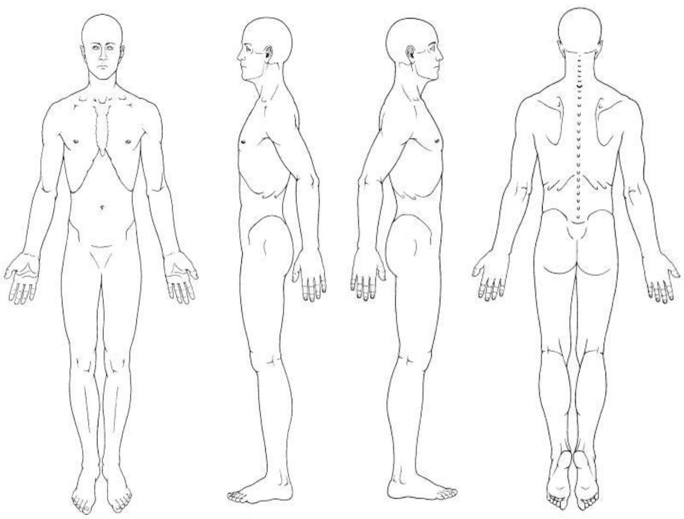
On the drawing indicate the location & type of pain you are experiencing with the letter noted below

(*Example: ST between your shoulders means you have stabbing pain between your shoulders*)

A=Ache B=Burning N=Numbness P=Pins and Needles ST=Stabbing SP=Spasm T=Throbbing

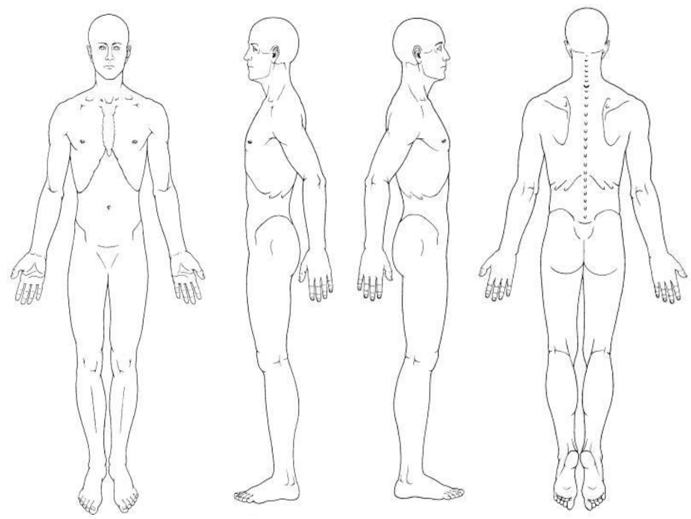
PAIN SCALE: Please circle the # that best describes your overall pain:
0 1 2 3 4 5 6 7 8 9 10 10+
NONE LITTLE MODERATE SEVERE EXCRUCIATING

DATE ________________________
Initial Exam Re-Exam New Problem



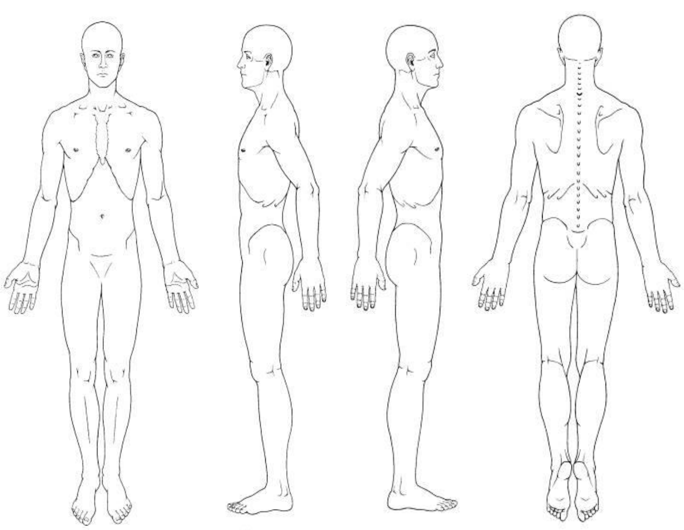
PAIN SCALE: Please circle the # that best describes your overall pain:
0 1 2 3 4 5 6 7 8 9 10 10+
NONE LITTLE MODERATE SEVERE EXCRUCIATING

DATE ________________________
Initial Exam Re-Exam New Problem



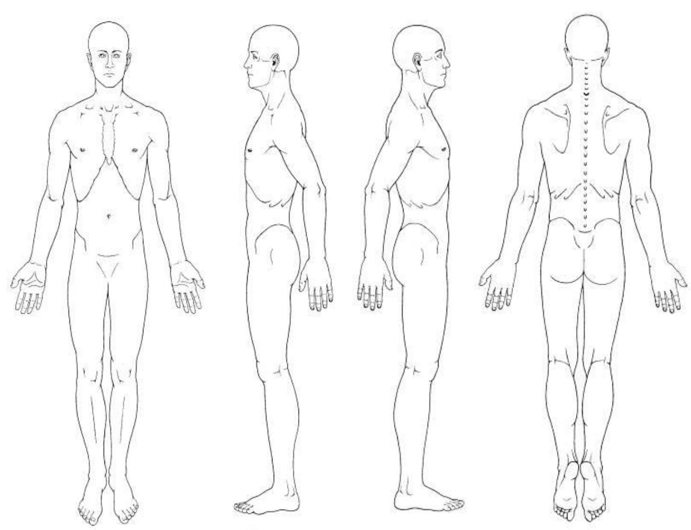
PAIN SCALE: Please circle the # that best describes your overall pain:
0 1 2 3 4 5 6 7 8 9 10 10+
NONE LITTLE MODERATE SEVERE EXCRUCIATING

DATE ________________________
Initial Exam Re-Exam New Problem



PAIN SCALE: Please circle the # that best describes your overall pain:
0 1 2 3 4 5 6 7 8 9 10 10+
NONE LITTLE MODERATE SEVERE EXCRUCIATING

DATE ________________________
Initial Exam Re-Exam New Problem



PATIENT ____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box 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 box which most closely describes your problem.

Section 1 – Pain Intensity

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

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

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

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck. (0)
- ❑ I can read as much as I want to with slight pain in my neck. (1)
- ❑ I can read as much as I want with moderate pain in my neck. (2)
- ❑ I can't read as much as I want due to moderate pain in my neck. (3)
- ❑ I can hardly read at all because of severe pain in my neck. (4)
- ❑ I cannot read at all. (5)

Section 5 – Headaches

- ❑ I have no headaches at all. (0)
- ❑ I have slight headaches that come infrequently. (1)
- ❑ I have moderate headaches which come infrequently. (2)
- ❑ I have moderate headaches which come frequently. (3)
- ❑ I have severe headaches which come frequently. (4)
- ❑ I have headaches almost all the time. (5)

Section 6 – Concentration

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

Section 7 – Work

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

Section 8 – Driving

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

Section 9 – Sleeping

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

Section 10 – Recreation

- ❑ I am able to engage in all my activities with no neck pain. (0)
- ❑ I am able to engage in all my activities with some pain in my neck. (1)
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ❑ I hardly do any recreation activities because of pain in my neck. (4)
- ❑ I cannot do any recreation activities at all. (5)

0-4	**No disability**
5-14	**Mild disability**
15-24	**Moderate disability**
25-34	**Severe disability**
> 35	**Complete disability**

PATIENT _____ DATE: _____

BACK/LEG DISABILITY INDEX

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 is very painful.
- ❑ 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 my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, 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 (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

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Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and causes me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

PATIENT _____ DATE: _____

HISTORY OF PRESENT AND PAST ILLNESS:

Date symptoms appeared/accident happened:_____Is this due to: ____ Auto Accident ____ Work Other _____
Have you ever had the same or a similar condition? _____ YES _____ NO If yes, when _____

Days lost from work: _____ Date of last physical examination: _____
Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year?_____ YES _____ NO If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies of any kind? ____ YES ____ NO If yes, describe: _____
Do you have any Congenital Condition? ____ YES ____ NO If yes, describe: _____

Do YOU OR ANY FAMILY MEMBERS
currently experience or have had in the past, any of the following symptoms/conditions?

	YOU / FAMILY					YOU / FAMILY			
Headaches	Yes	No	/ Yes	No	Frequency:_____				
Asthma/Emphysema	Yes	No	/ Yes	No	Loss of Balance/Dizziness	Yes	No	/ Yes	No
Weight Loss/Gain	Yes	No	/ Yes	No	Sleeping Problems	Yes	No	/ Yes	No
Neck Pain	Yes	No	/ Yes	No	Fainting	Yes	No	/ Yes	No
Stiff Neck	Yes	No	/ Yes	No	Loss of Smell/Taste	Yes	No	/ Yes	No
Pinched Nerve	Yes	No	/ Yes	No	Frequent Colds	Yes	No	/ Yes	No
Feet/Hands Cold	Yes	No	/ Yes	No	Fever	Yes	No	/ Yes	No
Back Pain	Yes	No	/ Yes	No	Unusual Bowel Patterns	Yes	No	/ Yes	No
Ruptures (Disc, other)	Yes	No	/ Yes	No	Difficulty Urinating	Yes	No	/ Yes	No
Muscle Spasms	Yes	No	/ Yes	No	Kidney Problems	Yes	No	/ Yes	No
Shoulder/Neck/Arm Pain	Yes	No	/ Yes	No	Ulcers	Yes	No	/ Yes	No
Numbness in Fingers	Yes	No	/ Yes	No	Indigestion Problems	Yes	No	/ Yes	No
Numbness in Toes	Yes	No	/ Yes	No	Sinus Problems	Yes	No	/ Yes	No
Joint Pain/Swelling	Yes	No	/ Yes	No	Menstrual Difficulties	Yes	No	/ Yes	No
Neuritis	Yes	No	/ Yes	No	Tension	Yes	No	/ Yes	No
Weakness in Extremities	Yes	No	/ Yes	No	Nervousness	Yes	No	/ Yes	No
Broken Bones/Fractures	Yes	No	/ Yes	No	Irritability	Yes	No	/ Yes	No
Fatigue	Yes	No	/ Yes	No	Depression	Yes	No	/ Yes	No
Lights Bother Eyes	Yes	No	/ Yes	No	Loss of Memory	Yes	No	/ Yes	No
Ears Ring	Yes	No	/ Yes	No	Scoliosis	Yes	No	/ Yes	No
Circulation Problems	Yes	No	/ Yes	No	Excessive Bleeding	Yes	No	/ Yes	No
Seizures/Epilepsy	Yes	No	/ Yes	No	Low Blood Pressure	Yes	No	/ Yes	No
Osteoarthritis	Yes	No	/ Yes	No	Pacemaker	Yes	No	/ Yes	No
Osteoporosis	Yes	No	/ Yes	No	Chest Pains/Tightness	Yes	No	/ Yes	No
Rheumatoid Arthritis	Yes	No	/ Yes	No	Stroke	Yes	No	/ Yes	No
Liver Problems	Yes	No	/ Yes	No	High Blood Pressure	Yes	No	/ Yes	No
Coughing Blood	Yes	No	/ Yes	No	Drug Addiction	Yes	No	/ Yes	No
Diabetes	Yes	No	/ Yes	No	Eating Disorder	Yes	No	/ Yes	No
Cancer	Yes	No	/ Yes	No	Alcoholism	Yes	No	/ Yes	No

SOCIAL HISTORY: Please indicate beside each activity whether you engage in it: OFTEN = O SOMETIMES = S NEVER = N

_____ Vigorous Exercise
_____ Moderate Exercise
_____ Alcohol Use
_____ Drug Use
_____ High Stress Activity
_____ Caffeine
_____ Tobacco Use
_____ Other _____
_____ Family Pressures
_____ Financial Pressures
_____ Other Mental Stresses

PATIENT _____ DATE: _____

ACTIVITIES OF DAILY LIVING AFFECTED BY YOUR CURRENT CONDITION
PLEASE BE SPECIFIC
(ie: can't walk more than 5 min w/out pain, etc)

DO NOT WRITE BELOW
DOCTOR'S USE ONLY

1 _____ ST: _____

LT: _____

2 _____ ST: _____

LT: _____

3 _____ ST: _____

LT: _____

4 _____ ST: _____

LT: _____

5 _____ ST: _____

LT: _____

6 _____ ST: _____

LT: _____

7 _____ ST: _____

LT: _____

PATIENT: _____ DATE: _____

PATIENT HEALTH INFORMATION CONSENT FORM (HIPAA)

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 HIPAA 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 corrections. 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 affect 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 right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this 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 privacy official 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.

8. HIPAA Regulations specific to Landin Chiropractic Care - I authorize Landin Chiropractic Care to leave phone messages for me on my home and cell phone. I understand that Dr. Landin provides care in a semi-open environment, where some things surrounding my PHI could be discussed and my X-Rays/PHI displayed, possibly in the presence of other individuals in the office. I understand that a private consultation room is available upon request.

9. The following person(s) have my permission to receive my personal health information:

_____ _____

_____ _____

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

_____ _____

Patient Signature Date

Failure to agree with certain terms of this notice may prevent us from acceptance of your case. HIPAA rev 4/2017