

PATIENT APPLICATION for BARRETT SPINAL CARE, PC

Name: _____ (Age) _____ Gender: M F
Name you would like us to call you: _____
Home Address: _____ Primary Phone: () _____ home/cell?
City, State, Zip: _____ Other Phone: () _____ home/cell?
Email Address: _____ Work Phone: () _____
Birth Date: ____/____/____ Social Security #: ____ - ____ - ____ Marital Status: S M D W
Names of Children: _____ Ages: _____
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Spouse's Employer: _____ Occupation: _____
How were you referred to this office? _____
Emergency Contact: _____ Relationship: _____ Phone Number: _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? _____ When? _____
Reason for visits: _____ How did you respond? _____
Did your previous chiropractor take before and after x-rays? Yes No Did you know posture affects your health? Yes No
Are you aware of any of your poor posture habits? Yes No Explain: _____
Are you aware of any poor posture habits in your spouse or children? Yes No Explain: _____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____
What activities? Running/Jogging Weight Training Cycling Yoga Pilates Swimming _____
Do you smoke? Yes No How much? _____ Do you drink alcohol? Yes No How much / week? _____
Do you drink coffee? Yes No How many cups / day? _____
Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Medications: (please use the back of this sheet for additional space)

Medication (name, dosage, frequency, reason for taking)	Medication (name, dosage, frequency, reason for taking)
_____	_____
_____	_____
_____	_____

Surgeries: (please use the back of this sheet for additional space)

Date / Type of Surgery	Date / Type of Surgery
_____	_____
_____	_____

Females/ Pregnancies and outcomes: (please use the back of this sheet for additional space)

Pregnancies/Date of Delivery/Outcome	Pregnancies/Date of Delivery/Outcome
_____	_____
_____	_____

Family Health History:

Do you have a family history of? (Please indicate all that apply)
 Cancer Strokes/TIA's Headaches Cardiac disease Neurological diseases Adopted/Unknown Diabetes
 Cardiac disease below age 40 Psychiatric disease Other _____ None of the above

Cause of parents or siblings death/ Age at death	Cause of parents or siblings death/ Age at death
_____	_____
_____	_____

CERVICAL SPINE (NECK):

Do you experience...?

- Neck Pain
- Pain into your shoulders/arms/hands
- Numbness/tingling in arms/hands
- Hearing disturbances
- Weakness in grip
- Headaches
- Dizziness
- Visual disturbances
- Coldness in hands
- Low Energy/Fatigue
- TMJ/Pain/Clicking

THORACIC SPINE (MID BACK):

Do you experience...?

- Mid Back Pain
- Pain on Deep Inspiration/Expiration
- Pain into your Ribs/Chest
- Indigestion/Heartburn
- Shortness of Breath
- Reflux

LUMBAR SPINE (LOW BACK):

Do you experience...?

- Low back pain
- Weakness/injuries in your hips/knees/ankles
- Pain into your hips/legs/feet
- Numbness/tingling in your legs/feet
- Coldness in your legs/feet
- Muscle cramps in your legs/feet
- Constipation / Diarrhea
- Sexual dysfunction

REVIEW OF SYSTEMS

Have you had any of the following issues?

PULMONARY (LUNG-RELATED)

- Asthma/difficulty breathing
- COPD
- Emphysema
- Other _____

NEUROLOGICAL (NERVE-RELATED)

- Visual changes/loss of vision
- History of seizures
- One-sided weakness of face or body
- Headaches
- One-sided decreased feeling in the face or body
- Memory loss
- Tremors
- Vertigo
- Strokes/TIAs
- Loss of sense of smell
- Other _____

RENAL (KIDNEY-RELATED)

- Renal calculi/stones
- Hematuria (blood in the urine)
- Incontinence (can't control)
- Bladder Infections
- Difficulty urinating
- Kidney disease
- Dialysis
- Other _____

HEMATOLOGICAL (BLOOD-RELATED)

- Anemia
- Sickle-cell anemia
- Hemophilia
- Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/ Aleve, etc.)
- HIV positive
- Enlarged lymph nodes
- Regular aspirin use
- Abnormal bleeding/bruising
- Anticoagulant therapy
- Hypercoagulation or deep venous thrombosis(history of blood clots)
- Other _____

PSYCHOLOGICAL

- Psychiatric diagnosis
- Depression
- Suicidal ideations
- Bipolar disorder
- Homicidal ideations
- Schizophrenia
- Psychiatric hospitalizations
- Other _____

CARDIOVASCULAR (HEART-RELATED)

- Heart surgeries
- Congestive heart failure
- Murmurs or Valvular disease
- Heart attacks/MIs
- Heart disease/problems
- Hypertension
- Pacemaker
- Angina/chest pain
- Irregular heartbeat
- Other _____

ENDOCRINE (GLANDULAR/HORMONAL)

- Thyroid disease
- Hormone replacement therapy
- Injectable steroid replacements
- Diabetes
- Other _____

GASTROENTEROLOGICAL (STOMACH-RELATED)

- Nausea
- Difficulty swallowing
- Ulcerative disease
- Frequent abdominal pain
- Hiatal hernia
- Constipation
- Pancreatic disease
- Irritable bowel
- Hepatitis or liver disease
- Bloody/black tarry stools
- Vomiting blood
- Bowel incontinence
- Gastroesophageal reflux/heartburn
- Other _____

DERMATOLOGICAL (SKIN-RELATED)

- Significant burns
- Significant rashes
- Skin grafts
- Psoriatic disorders
- Other _____

MUSCULOSKELETAL (BONE/MUSCLE-RELATED)

- Rheumatoid arthritis
- Gout
- Osteoarthritis
- Broken bones
- Spinal fracture
- Spinal surgery
- Arthritis (unknown type)
- Scoliosis
- Metal implants
- Joint surgery
- Other _____

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient's Name: _____ If patient is a Minor, Parent's Name: _____

Signature: _____ Date: _____

NEW PATIENT HISTORY FORM

Symptom 1 (Main reason for visit; **Circle One**) Neck Mid-Back Low Back Other: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
Did the symptom begin suddenly or gradually? (circle one)
How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
other (please describe): _____
- What makes the symptom better? (circle all that apply):
Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 (Second reason for visit; **Circle One**) Neck Mid-Back Low Back Other: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
Did the symptom begin suddenly or gradually? (circle one)
How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
other (please describe): _____
- What makes the symptom better? (circle all that apply):
Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
Morning Afternoon Evening Night Unaffected by time of day

For additional symptoms, please see the office staff for another history form.

FINANCIAL POLICY

This agreement is between Barrett Spinal Care, P.C. as creditor, and the Patient/Debtor named on this form.

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies. By executing this agreement, you are agreeing to pay for all services that are received.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.
2. You may be entitled to a network contractual discount under the following circumstances:
 - a. We are a participating provider in your health plan.
 - b. You are covered by a State or Federal program with a mandated fee schedule.
 - c. You are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Ask our staff for more information.
 - d. Beginning March 1, 2019, our office accepts Care Credit for financing options. There is a credit application process, and if accepted, an APR applies. It is not an interest free credit card. Ask staff for more information.

Payment Options: ALL PAYMENTS ARE DUE ON THE DAY THAT THE SERVICES ARE RENDERED. If you have insurance, we require that your deductible and your percentage be paid at the time of service. **You may choose to pay cash, check or credit card and CareCredit.** There is a fee (currently \$35.00) for any checks returned by the bank and may be turned over to the District Attorney's office for restitution.

Insurance: I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. Barrett Spinal Care, PC is NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is merely an estimate and not a guarantee of payment, it is the insurance company that makes the final determination of your eligibility. The Doctors office will provide required information to aid in insurance reimbursement of services, but you understand that insurance carriers may deny any claim and that you are ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. It is also your responsibility to keep track of any annual insurance maximums. Claims are submitted promptly after treatment is rendered and if not paid by your insurance company by the 61st day after treatment, you will be billed, and a finance charge will be charged on the balance remaining.

Finance Charges: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one-half percent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is \$.50. If the past due account is sent to collections, there will be an overall 30% added to the account for collection services (this is after the monthly finance charges have been added).

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the costs of the collection costs which incurred. The overall amount added to the account is 30% of the past due amount. If we must refer collection of the balances to a lawyer or collection agency, you agree to pay all lawyer's fees which we incur, plus all court costs. In case of suit, you agree the venue shall be in Cherokee County, Oklahoma. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record. I authorize Barrett Spinal Care, PC to contact me via current and any future cellular phone number(s), email addresses, or wireless device(s) regarding my delinquent account(s) I owe to Barrett Spinal Care, PC. I authorize Barrett Spinal Care and its agents, representatives and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls or emails, in their effort to contact me for purposes of collecting and portion of my account which is past due.

Personal Injury / Accident: Currently, Barrett Spinal Care does not accept auto accident insurance as a form of payment. If you have been involved in an accident, payment will need to be made by you.

No-Show Policy: We make every effort to provide prompt medical care to all our patients. If you are unable to keep a scheduled appointment, please let us know **in advance**. A No-Show is when a patient fails to keep a scheduled appointment. A No-Show will generate a **\$25** fee and three no shows may require that you seek your medical care elsewhere. If you have a special circumstance regarding your missed appointment, please contact our office manager. We understand that there may be issues beyond your control and want to be understanding of special circumstances. If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled. If you are a walk-in patient, please understand that there are patients who have scheduled appointments, and you will be seen at the next available time slot. We strongly encourage you to call the office for an appointment first. The No-Show fee will be charged directly to the patient/guardian, NOT the patient's insurance company or Medicare. All No-show fees must be paid prior to the next appointment in order to be seen and cannot be paid with any Health Benefit Savings cards or Discount Medical Plans. If not paid, this balance can be turned over to our collection agency.

Patient's Name: _____ Date: _____

If patient is a Minor, Parent's Name: _____

Signature: _____

IF YOU HAVE PRIVATE OR GROUP INSURANCE, PLEASE READ AND SIGN THE RED SECTION (I). IF YOU HAVE MEDICARE OR A MEDICARE POLICY, PLEASE READ AND SIGN THE BLUE SECTION (II). PRIVACY CONSENTS ARE THE PURPLE SECTION (III). INITIAL ANY THAT YOU CONSENT TO. ONE ITEM MUST BE INITIALED, EVEN IF IT IS THE LAST ITEM. IF YOU ARE A PARENT/GUARDAIN, PLEASE READ AND SIGN THE GREEN SECTION (IV).

(I) ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature each and every claim to be submitted for myself and/or other dependants, and that I will be bound by the signature, though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of Insured) (Name of Insurance Company)
to pay and hereby assign directly to **Barrett Spinal Care, PC** all benefits, if any, otherwise payable to me for his/her service as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Barrett Spinal Care, PC**, will be credited to my account, in accordance with the above said assignment.

(Authorized Signature of Subscriber)

(Date)

(II) MEDICARE AUTHORIZATION

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to **Barrett Spinal Care, PC** for any services provided to me by that provider. I authorize any holder of medical information about me to the Center for Medicare and Medicaid Services (CMS) and it agents any information needed to determine these benefits payable to related services.

(Signature of Beneficiary)

(Date)

(III) PRIVACY/MEDIA CONSENTS

Please initial by each group if you consent to the items listed. **ATLEAST ONE ITEM MUST BE INITIALED!**

_____ Here are a few examples of items you may receive in the mail:

- Appointment Reminder Cards / Reschedule Appointment Cards
- Complimentary Service Offers/ Special offers on discounts
- Greeting Cards / Birthday Cards

_____ I agree to allow a staff member of Barrett Spinal Care, PC to call and/or leave messages on my answering machine or voicemail regarding my appointments or other related information.

_____ I agree to allow a staff member of Barrett Spinal Care, PC send me electronic submissions regarding my appointments or other related information. (please check those that apply) _____texts _____ emails _____ other _____

_____ We will occasionally use your name or story in our office or on our media outlets (Facebook, www.barrettspinalcare.com, KEOK Radio, KTLQ Radio, Twitter, etc.) to help in the education of future patients.

- Patient Story Book / Patient Testimonies
- Internet Referral Board

_____ I do not consent to any of the above listed Privacy/ Media Consents.

(IV) CONSENT FOR MINOR

I know that I am responsible for, and agree to pay, all fees incurred at this office by my minor child. I understand that any insurance benefits that I may have, for my minor child, are a contracted arrangement between me and the insurance company. This office will be responsible for preparing notes, billing receipts, and informational reports as needed to aid in insurance payment/reimbursement. I realize that this office is not responsible to negotiate disputed benefits for me regarding my minor child. I understand that if my child is accepted as a patient at Barrett Spinal Care, PC, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request. I am choosing for my child to be treated, for today and all future visits at this office, through the use of various types of chiropractic manipulations, diagnostic x-rays, and several types of physiologic modalities (physical therapy). I realize there is no guarantee of results and have been informed that some risks of treatment do exist. These risks could include, but are not limited to: sprains, dislocations, fractures, strokes, and disc injury. While I do expect my doctor to use his best judgment to choose the most appropriate care for my child's condition, I agree that the Doctor cannot foresee every possible complication or risk which could arise in my child's treatment.

Patient's Name: _____ If patient is a Minor, Parent's Name: _____

Signature: _____ Date: _____

Doctor's Name: **Ryan Barrett, DC** Doctor's Signature: _____

INFORMED CONSENT

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

The nature of the chiropractic adjustment.

The primary treatment I use as Doctor of Chiropractic is a spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "click" or "pop", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

- | | | | |
|------------------------------|-----------------|-----------------------|-----------------------------|
| ·Spinal Manipulative Therapy | ·Palpation | ·Vital Signs | ·Range of Motion Testing |
| ·Orthopedic Testing | ·Ultrasound | ·Postural Analysis | ·Muscle Strength Testing |
| ·Hot/Cold Therapy | ·EMS | ·Radiographic Studies | ·Basic Neurological Testing |
| ·Massage Therapy | ·Manual Therapy | ·Myofascial Release | ·Trigger Point Therapy |
- Other (please explain): _____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke. Some patients may feel some stiffness and soreness during the first few days after treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from underlying weakness of the bone which I check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your treatment may include, but not limited to:

- | | |
|--|------------------|
| ·Self administered, over-the counter analgesics and rest | ·Hospitalization |
| ·Medical care and prescription drugs such as anti-inflammatory, muscle relaxers and pain killers | ·Surgery |

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reverse mobility, which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making more difficult and less effective the longer it is postponed.

For Women only

To the best of my knowledge I (am _____) / (am NOT _____) pregnant and any staff member of Barrett Spinal Care, PC, has my permission to x-ray me for diagnostic interpretation. _____ (please initial)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have the above explanation of the chiropractic adjustment and related treatment. I have discussed/ will discuss it with Dr. Ryan Barrett and have had/ will have my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved with undergoing treatment and decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consents to that treatment.

Patient's Name: _____ If patient is a Minor, Parent's Name: _____

Signature: _____ Date: _____

Doctor's Name: Ryan Barrett, DC Doctor's Signature: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FOR BARRETT SPINAL CARE, PC

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used by Barrett Spinal Care, PC to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you, and created or received by this office.

*You will be given a copy of Patient Privacy Policy for your records, or it is available on our website at barrettspinalcare.com.

I have a received a copy of the Notice of Patient Privacy Policy. _____ **Patient Initials**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Notice of Treatment in Open or Common Areas

Describe and notify private areas in our office available upon request.

Are there any other persons with whom we have permission to contact to discuss your (or your child's) medical condition? If so, please list them below.

Contact 1: _____
Name Relationship Phone Number

Contact 2: _____
Name Relationship Phone Number

By my signature below I give my permission to use and disclose my health information.

Patient's Name: _____ If patient is a Minor, Parent's Name: _____

Signature: _____ **Date:** _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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NEW PATIENT HISTORY FORM cont'd

Symptom 3 (Third reason for visit; please use line to describe area) _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
Did the symptom begin suddenly or gradually? (circle one)
How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
other (please describe): _____
- What makes the symptom better? (circle all that apply):
Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 (Fourth reason for visit; please use line to describe area) _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
Did the symptom begin suddenly or gradually? (circle one)
How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
other (please describe): _____
- What makes the symptom better? (circle all that apply):
Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
Morning Afternoon Evening Night Unaffected by time of day