Brandywine Total Health Care, Inc.

Patient Health History

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Briefly list your main health problems: _____

_____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Your Occupation _____ **Your Employer**_____

Home email _____ **Work Email** _____

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **Your SSN** _____

Spouse's Name _____ **Spouse's Phone** _____

Spouse's Date of Birth _____ **Spouse's Employer** _____

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Current medications, including dosage if known.
If there are no current medications, check here: ❑

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) _____ 3) _____

2) _____ 4) _____

Previous Chiropractic Care _____ **When?** _____

Doctor of Chiropractic consulted: _____ **Results?** _____

Who Referred you to our office: _____

Are your problems today the results of an accident? ❑ Yes ❑ No ❑ Auto Accident ❑ Work related ❑ Other
If yes, date of accident? _____
Have you made a report of the accident? ❑ Yes ❑ No To : ❑ Auto Insurance ❑ Employer ❑ Other
Have you retained an attorney? ❑ Yes ❑ No Name: _____
Have you ever been disabled? ❑ Yes ❑ No If yes, when? _____
Have you ever been in a car accident? ❑ Yes ❑ No If yes, when? _____

Have you ever had any sports accidents? ❑ Yes ❑ No If yes, when? _____
Have you had any other type of accident? ❑ Yes ❑ No If yes, what type and when? _____

_____

<u>Your Health History</u>

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker
If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker
If yes, what is your level of interest in quitting smoking?
❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Do you currently drink coffee? ❑ Yes ❑ No If yes, how much? _____
Do you currently drink alcohol? ❑ Yes ❑ No If yes, how much? _____
Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, when? _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

Have you ever broken any bones? ❑ Yes ❑ No If yes, which ones and when? _____

_____

Have you ever been knocked unconscious? ❑ Yes ❑ No If yes, how and when? _____

Have you ever been on crutches? ❑ Yes ❑ No If yes, when?_____

Do you have any implanted devices (insulin pump, pacemaker, etch)? ❑ Yes ❑ No If yes, what and when?_____

Have you ever had any surgery of any type? ❑ Yes ❑ No If yes, what surgeries and when?_____

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Do you currently exercise? ❑ Yes ❑ No If yes, what type of exercise and how many days per week ?

_____

Are you allergic to:

Aspirin ❑ Yes ❑ No

Eggs ❑ Yes ❑ No

Fish or Shellfish ❑ Yes ❑ No

Latex ❑ Yes ❑ No

Milk or Lactose ❑ Yes ❑ No

Peanuts ❑ Yes ❑ No

Penicillin ❑ Yes ❑ No

Soy ❑ Yes ❑ No

Sulfites ❑ Yes ❑ No

Wheat/Gluten ❑ Yes ❑ No

Other _____

Your Family's Health History

Does anyone in your family (parents or siblings) have or had:

Back Disease? ❑ Yes ❑ No If yes, who ?_____

Arthritis? ❑ Yes ❑ No If yes, who ?_____

Heart Disease? ❑ Yes ❑ No If yes, who ?_____

High Blood Pressure? ❑ Yes ❑ No If yes, who ?_____

Cancer? ❑ Yes ❑ No If yes, who ?_____

Kidney Problems? ❑ Yes ❑ No If yes, who ?_____

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

Emergency Contact Information:

Name:_____ **Phone #**_____ **Relationship:**_____

Financial Policy:

- It is our office policy that all services rendered in this office are charged directly to you, the patient, and you are personally responsible for all payments, regardless of whether or not we accept insurance assignment.
- All payments (deductible, co-pays, and/or co-insurance) are due at the time of service.
- Insurance assignment patients must provide valid insurance cards on the first visit so claims may be submitted in a timely manner.
- Returned checks will be assessed a $35 fee. Balances more than 30 days past due may be subject o additional collection fees and interest charges of 1 ¼% per month.

Appointment Policy:

Please sign in at the front desk upon arrival. We attempt to see each patient at their scheduled time. If you arrive very late or very early, you may have to wait to be seen.

If you are unable to keep an appointment, please call as soon as possible to reschedule your visit. We ask for 24 hours cancellation notice. *We reserve the right to charge $35 for a missed appointment or those cancelled without 24 hour notice.*

It is your obligation to make up a missed appointment within 7 days of cancellation. If you call to reschedule the same appointment more than 3 times, the doctor may call to discuss the status of your condition and the reasons for constant rescheduling.

Medicare/Insurance Authorization
Signature onFile

- I authorize use of this form on all insurance submissions.
- I authorize release of information to all my insurance carriers.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.

I, _____, do hereby authorize the doctor and staff of Brandywine Total Health Care, Inc. to release my Personal Health Information (PHI) and to obtain my PHI from my primary care physician/organization.

Family Doctor: _____ Office Location: _____

Phone number of Family Doctor: _____

I understand that I may revoke this authorization at any time by notifying the practice in writing. If I do revoke the authorization, it will not have any effect on any actions taken before the practice received the revocation.

My signature confirms that I have completed this history to the best of my ability and read through and accepted the Financial Policy, Medicare/Insurance Authorization and authorize the release of my records.

Today's Date [/ /] Signature of Patient_____

Review of Systems – Please check any condtions that you are currently experiencing or have experienced in the past

Name_____

Cardiovascular:	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Vascular Disease			
Heart Attack			
Chest Pain (Angina)			
High Cholesterol			
Pacemaker			

Ears/Nose/Throat:	Present	Past	No
Dizziness			
Hearing loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			
Tubes in ears			
Ringing in ears			

Genitourinary:	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in Urine			
Kidney Stone			

Eyes:	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			
Retinal Detachment			
Changes in Vision			
Eye Pain/weakness			

Hematology/Lymph:	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fever/Chills/Sweats			
Hemochromatosis			

Allergic/Immunology:	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergies/Hay Fever			
Allergy Shots			
Cortisone Use			
Lyme's Disease			
Chronic Fatigue			

Psychiatric:	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional:	Present	Past	No
Weight Loss/Gain			
Poor Energy Level			
Difficulty Sleeping			

Review of Systems – Please check any condtions that you are currently experiencing or have experienced in the past

Name _____

Respiratory:	Present	Past	No
Asthma			
Tuberculosis			
Short of Breath			
Emphysema			
Cold/Flu			
Chronic Cough			
Coughing Phlegm			
Wheezing			
Chest Pain			
Coughing Blood			

Musculoskeletal:	Present	Past	No
Gout			
Arthritis			
Muscle Weakness			
Joint Stiff/Swollen			
Osteoporosis			
Broken Bones			
Joints Replaced			
Herniated Discs			
Spinal Curvature			
Twitching/Tremors			

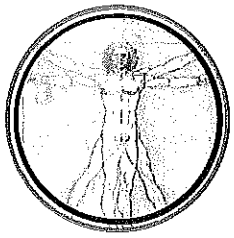
Gastrointestinal:	Present	Past	No
Gallbladder Issues			
Bowel Problems			
Constipation			
Diarrhea			
Nausea/Vomiting			
Ulcers			
Liver Problems			
Belching			
Gas			
Bloody Stools			
Poor Appetite			
Changes in Taste			
Food Allergies			

Neurological:	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Integumentary:	Present	Past	No
Eczema			
Psoriasis			
Rashes			
Nail Fungus			
Skin Eruptions			

Endocrine:	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
PMS			
Ovarian Cysts			
PCOS			
Miscarriage			

Patient's Signature _____ Date _____



Brandywine Total Health Care, Inc.

Good health begins here

Relief for:
Headaches

Shoulder & Arm pain

Carpal Tunnel

Back & Neck pain

Hip & Knee pain

Convenient care:

We treat the Whole family

Walk-ins Welcome

Automobile Accidents

Workers' Comp.

Most Insurance Accepted & Filed

Nutritional Counseling

Visa, MasterCard & Discover Accepted

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent/Guardian (circle one)

Donald F. Feeney, DC, DACBN, CCN
ACBN Board Certified in Nutrition
Certified Clinical Nutrition
chirodoc71@aol.com

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Wilmington, DE 19810

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC – INFORMED CONSENT

ANALYSIS

Chiropractic adjustment and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results.

DIAGNOSIS

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient make it known or to learn through health care procedures whatever he/she is suffering from latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

RESULTS

The purpose of Chiropractic services is to promote natural health. Since there are so many variables, it is difficult to predict the time frame of efficacy of the Chiropractic adjustment. Many medical failures find quick relief through Chiropractic. In turn, we acknowledge that conditions which do not respond to Chiropractic care may come under control or be helped through medical science. The fact is the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems.

I have read and understand this Informed Consent.

_____ _____

Patient Signature Date

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE 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 normally 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 every day in most aspects of self care.
F.	I do not get dressed, I 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 weights off the floor, but I can manage if they are conveniently positioned, for example, 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 to with no pain in my neck.
B.	I can read as much as I want to 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 cannot read as much as I want 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 have a great deal of difficulty in concentrating when I want to.
F.	I cannot concentrate at all.

Section 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 my car without any neck pain.
B.	I can drive my car as long as I want with slight pain in my neck.
C.	I can drive my car as long as I want with moderate pain in my neck.
D.	I cannot drive my car 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 hour sleepless).
C.	My sleep is mildly disturbed (1-2 hours sleepless).
D.	My sleep is moderately disturbed (2-3 hours sleepless).
E.	My sleep is greatly disturbed (3-5 hours sleepless).
F.	My sleep is completely disturbed (5-7 hours sleepless).

Section 10 - Recreation	
A.	I am able to engage in all of my recreational activities, with no neck pain at all.
B.	I am able to engage in all of my recreational activities, with some pain in my neck.
C.	I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D.	I am able to engage in a few of my usual recreational activities because of pain in my neck.
E.	I can hardly do any recreational activities because of pain in my neck.
F.	I cannot do any recreational activities at all.

Comments: _____

_____

Patient Signature: _____ Date: _____

BRANDYWINE TOTAL HEALTH CARE, Inc.
3214 Naamans Road
Wilmington, DE 19810
Telephone: (302) 478-3028

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 - Pain Intensity	
A.	The pain comes and goes and is very mild.
B.	The pain is mild and does not vary much.
C.	The pain comes and goes and is moderate.
D.	The pain is moderate and does not vary much.
E.	The pain comes and goes and is severe.
F.	The pain is severe and does not vary much.

Section 2 - Personal Care (Washing, Dressing, etc.)	
A.	I would not have to change my way of washing or dressing in order to avoid pain.
B.	I do not normally change my way of washing or dressing even though it caused some pain.
C.	Washing and dressing increased the pain, but I manage not to change my way of doing it.
D.	Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E.	Because of the pain, I am unable to do some washing and dressing without help.
F.	Because of the pain, I am unable to do any washing or dressing without help.

Section 3 - Lifting	
A.	I can lift heavy weights without extra pain.
B.	I can lift heavy weights, but it causes extra pain.
C.	Pain prevents me from lifting heavy weights off the floor.
D.	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E.	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F.	I can only lift very light weights, at the most.

Section 4 - Walking	
A.	Pain does not prevent me from walking any distance.
B.	Pain prevents me from walking more than one mile.
C.	Pain prevents me from walking more than 1/2 mile.
D.	Pain prevents me from walking more than 1/4 mile.
E.	I can only walk while using a cane or on crutches.
F.	I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting	
A.	I can sit in my chair as long as I like without pain.
B.	I can only sit in my favorite chair as long as I like.
C.	Pain prevents me from sitting more than one hour.
D.	Pain prevents me from sitting more than 1/2 hour.
E.	Pain prevents me from sitting more than ten minutes.
F.	Pain prevents me from sitting at all.

Section 6 - Standing	
A.	I can stand as long as I want without pain.
B.	I have some pain while standing, but it does not increase with time.
C.	I cannot stand for longer than one hour without increasing pain.
D.	I cannot stand for longer than 1/2 hour without increasing pain.
E.	I cannot stand for longer than ten minutes without increasing pain.
F.	I avoid standing, because it increased the pain straight away.

Section 7 - Sleeping	
A.	I get no pain in bed.
B.	I get pain in bed, but it does not prevent me from sleeping well.
C.	Because of pain, my normal nights sleep is reduced by less than one-quarter.
D.	Because of pain, my normal night's sleep is reduced by less than one-half.
E.	Because of pain, my normal night's sleep is reduced by less than three-quarters.
F.	Pain prevents me from sleeping at all.

Section 8 - Social Life	
A.	My social life is normal and gives me no pain.
B.	My social life is normal, but increases the degree of my pain.
C.	Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D.	Pain has restricted my social life and I do not go out very often.
E.	Pain has restricted my social life to my home.
F.	I have hardly a social life because of the pain.

Section 9 - Traveling	
A.	I get no pain while traveling.
B.	I get some pain while traveling, but none of my usual forms of travel make it any worse.
C.	I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D.	I get extra pain while traveling which compels me to seek alternative forms of travel.
E.	Pain restricts all forms of travel.
F.	Pain prevents all forms of travel except that done lying down.

Section 10 - Changing Degree of Pain	
A.	My pain is rapidly getting better.
B.	My pain fluctuates, but overall is definitely getting better.
C.	My pain seems to be getting better, but improvement is slow at present.
D.	My pain is neither getting better nor worse.
E.	My pain is gradually worsening.
F.	My pain is rapidly worsening.

Comments: _____

_____

Patient Signature: _____ Date: _____

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