

CASE HISTORY

Name: _____

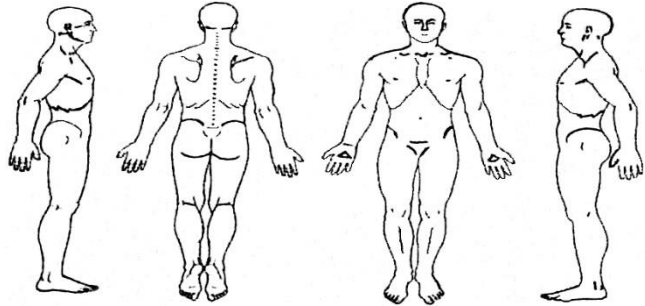
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity										Frequency (% of week)											
	Minimal					Severe					Occasional					Constant						
a. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
b. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
c. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
d. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100
e. _____	0	1	2	3	4	5	6	7	8	9	10	0	10	20	30	40	50	60	70	80	90	100

(Please mark the figures where you experience pain.)

2. Symptoms are worse in the (circle what applies)

- morning -Increase during the day
- afternoon -same all day
- night -decrease during the day



3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles

5. When did your symptoms begin (onset date)? _____

6. How did your symptoms begin? _____

7. Have you experienced these before? _____

8. Do your symptoms radiate? _____

9. Has your condition? _____ Improved _____ Gotten Worse _____ Stayed the same since it began

10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? _____ No _____ Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? _____ No _____ Yes How long ago? _____

13. What treatment did you receive? _____

14. Results of previous treatment? _____ Good _____ Poor Comments _____

15. Were you referred to our office by anyone? _____

16. Is this condition interfering with _____ Work _____ Sleep _____ Daily Routine _____ Recreation

17. List any other major injuries you have had, other than those mentioned above: _____

18. Any other Musculoskeletal problems? _____ No _____ Yes ...Neurological problems? _____ No _____ Yes

_____ Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____

Date: _____

DeTray Chiropractic Center
210 Latchaw Drive Defiance, Ohio 43512
(419) 785-4215 (p) ~ (419) 785-4274 (f)

**Patient Acknowledgement & Receipt of
Notice of Privacy Practices Pursuant to HIPAA & 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)

INFORMED CONSENT

PATIENT NAME _____

The primary treatment used by doctors of chiropractic is the spinal manipulation or adjustment.

- **The nature of the chiropractic adjustment:**
 - I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel or sense movement.
- **The material risks inherent in chiropractic adjustment:**
 - As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.
- **The probability of those risks occurring:**
 - Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and x-ray. Stroke has at most a one-in-a-million outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as “rare.”

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)

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1. What personally identifiable information is collected from you through the web site, how it is used and with whom it may be shared.
2. What choices are available to you regarding the use of your data.
3. The security procedures in place to protect the misuse of your information.
4. How you can correct any inaccuracies in the information.

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We are the sole owners of the information collected on this site. We only have access to/collect information that you voluntarily give us via email or other direct contact from you. We will not sell or rent this information to anyone.

We will use your information to respond to you, regarding the reason you contacted us. We will not share your information with any third party outside of our organization, other than as necessary to fulfill your request, e.g. to ship an order.

Unless you ask us not to, we may contact you via email in the future to tell you about specials, new products or services, or changes to this privacy policy.

Your Access to and Control Over Information

You may opt out of any future contacts from us at any time. You can do the following at any time by contacting us via the email address or phone number given on our website:

- See what data we have about you, if any.
- Change/correct any data we have about you.
- Have us delete any data we have about you.
- Express any concern you have about our use of your data.

Security

We take precautions to protect your information. When you submit sensitive information via the website, your information is protected both online and offline.

While we use encryption to protect sensitive information transmitted online, we also protect your information offline. Only employees who need the information to perform a specific job (for example, billing or customer service) are granted access to personally identifiable information. The computers/servers in which we store personally identifiable information are kept in a secure environment.

Updates

Our Privacy Policy may change from time to time and all updates will be posted on this page

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ROLAND-MORRIS QUESTIONNAIRE

DATE: _____

PATIENT INFORMATION: LAST NAME: _____ FIRST NAME: _____ M.I.: _____

SEX: MALE FEMALE DATE OF BIRTH: _____ PHONE NUMBER: _____

Please select all options that apply to your conditions today.

- I stay at home most of the time because of my back and/or leg pain.
- I walk more slowly than usual because of my back and/or leg pain.
- Because of my back and/or leg pain, I am not doing any jobs that I usually do around the house.
- Because of my back and/or leg pain, I use a handrail to get upstairs.
- Because of my back and/or leg pain, I lie down to rest more often.
- Because of my back and/or leg pain, I have to hold on to something to get out of an easy chair.
- Because of my back and/or leg pain, I try to get other people to do things for me.
- I get dressed more slowly than usual because of my back and/or leg pain.
- I only stand up for short periods of time because of my back and/or leg pain.
- Because of my back and/or leg pain, I try not to bend or kneel down.
- I find it difficult to get out of a chair because of my back and/or leg pain.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back and/or leg pain.
- I have trouble putting on my socks (or stockings) because of pain in my back and/or leg pain.
- I sleep less well because of my back and/or leg pain.
- I avoid heavy jobs around the house because of my back and/or leg pain.
- Because of back and/or leg pain, I am more irritable and bad tempered with people than usual.
- Because of my back and/or leg pain, I go upstairs more slowly than usual.
- I change position frequently to try to get my back and/or leg pain comfortable.
- My appetite is not very good because of my back and/or leg pain.
- I can only walk short distances because of my back pain and/or leg pain.
- Because of my back and/or leg pain, I get dressed with the help of someone else.
- I sit down for most of the day because of my back and/or leg pain.
- I stay in bed most of the time because of my back and/or leg pain.
- I sleep less well because of my back and/or leg pain.