Welcome to Delta Chiropractic Center of Lansing!

517.321.3030

We are pleased that you have chosen to join our team as you seek answers to your health goals. The following information will help us find the best answers to your challenges and goals. Please fill out each page completely and print it off and bring it with you to your first visit. Any blank lines will have to be filled out before your consultation, exam and treatment. While ALL information is crucial, items with an asterisk (*) MUST be filled out.

If you need to change your appointment, please let us know at least 24 hours prior to that date. We have many patients waiting for open appointment times, so we'd like to be able to allow them access to that appointment if you cannot keep it.

Your for Better Health,
Delta Chiropractic Center of Lansing
6130 W. Saginaw Hwy.
Lansing, MI 48917

PATIENT INFORMATION

A. Name *_____Date _____Birthdate *_____

Address *_____City *_____State_____Zip _____

Home # _____Cell# *_____Work # _____SS# _____

E-mail Address *_____ Sex *M F* Marital Status *S M W D* # Children ____

Referred By _____ Insurance Company *_____

Employer _____ Job Title _____Job Description _____

B. Medications: _____

Vitamins: _____

Allergies to Medications: _____

Prev. Chiro. Care: _____ Prev. x-rays: _____

Name of Primary Care Physician: _____

May we send a report to them? Y N Your current weight: _____ Height _____ Shoe size _____

Previous car accidents or falls: *_____

Surgeries: _____

Broken bones: _____

Other traumas? _____ Previous Stroke or TIA?_*_____

Sleeping posture ❑ side ❑ stomach ❑ back **Posture** ❑ good ❑ fair ❑ poor

Current Hobbies, Sports, Activities: _____

Is there a chance that you could be pregnant? Y N

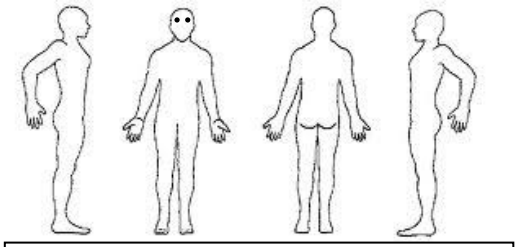
What are your chief complaints? PS-Pain Scale 1-10

1.*_____ PS*___

2._____ PS____

3._____ PS____

4._____PS____



Circle on the body any area you're currently having pain

Date First Noticed _____ Ever had it before? Y N

It was caused by _____ Missed work due to this? Y N

What have you done to treat this? _____

Other professionals seen for this? _____

Is this a car or work accident? Y N Date and time of accident _____

Hurts more when: Sitting / Bending / Lifting / Twisting / Riding in car / Working / Sleeping / Standing / House Work / Walking / Straining / Constant / Other: _____

Hurts less when: ❑ OTC meds ❑ Prescription ❑ Rest ❑ Lay down ❑ Sleep ❑ Sit ❑ Stretch

❑ More active ❑ With ice ❑ With heat ❑ Massage ❑ Other _____

Description: ❑ Sharp ❑ Dull ❑ Throb ❑ Radiating ❑ Shooting ❑ Numb ❑ Tingling ❑ Stiff

**My goals for my care here: ***_____

Caffeine ❑ None ❑ Some ❑ Much
Cigarettes ❑ None ❑ Some ❑ Much
Alcohol ❑ None ❑ Some ❑ Much

Energy Level:	No Energy	1	2	3	4	5	6	7	8	9	10	Energetic
Flexibility:	Can't Move	1	2	3	4	5	6	7	8	9	10	Very Flexible
Stress Level:	No Stress	1	2	3	4	5	6	7	8	9	10	Much Stress
Spiritual Interest:	No Interest	1	2	3	4	5	6	7	8	9	10	Very Interested

Overall State __ Fever __ Chills __ Fatigue __ Loss of appetite __ Weight loss or gain __ None	**Emotional Issues** __Irritability __ Depression __ Poor Sleep __ Anxiety __ None	**Urinary System Issues** __ Frequent urination __ Urgency __ Burning __ Loss of control __ None
Vision Issues __ Blurred __ Double __ None	**Heart Issues** __ Chest pains __ Palpitations __ Fainting __ None	**Breathing Issues** __ Coughing / Wheezing __ Shortness of breath __ Asthma __ None
Digestion Issues __ Nausea __ Vomiting __ Diarrhea __ Less than 2 Bowel Movements Daily __ None	**Joint Issues** __ Joint pains __ Joint weakness __ Muscle cramps __ None	**Skin Issues** __ Rash / Itchiness __ Dryness __ Open wounds __ None
Immune System Issues __ Lymph nodes enlarged __ Allergies __ Frequent infections __ None	**Endocrine Issues** __ Diabetes / Low blood sugar __ Thyroid issues __ Weak spells, tiredness __ Shakiness before meals __ None	**Neurological Issues** __ Seizures __ Headaches / Migraines __ Tingling __ Numbness __ Poor coordination __ None
Circulation Issues __ Anemia __ Bleeding __ Bruising __ Cold extremities __ None	**Skeletal Issues** __ Osteoporosis __ Osteopenia __ Neck pain __ Back pain __ None	

Do you:
__ Eat only few vegetables?
__ Eat fast foods?

Family History of:
__ Arthritis
__ High Cholesterol
__ High Blood Pressure
__ Diabetes
__ Heart Disease
__ Cancer

INITIALS: _____

Low Back (Oswestry) Questionaire *

NAME_____ **DATE**_____

Please answer ***every section***. Mark ***one letter only*** in each section.

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 6 - Standing*** **A__ I can stand as long as I want without extra pain.** **B__ I can stand as long as I want but it gives me extra pain.** **C__ Pain prevents me from standing for more than 1 hour.** **D__ Pain prevents me from standing for over 1/2 hour.** **E__ Pain prevents me from standing for over 10 minutes.** **F__ Pain prevents me from standing at all.**
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 is very painful.** **C__ It is painful to care for myself and I am slow and careful.** **D__ I need help but manage most of my personal care.** **E__ I need help every day in most aspects of self care.** **F__ I do not get dressed, wash with difficulty, and stay in bed.**	***SECTION 7 - Sleeping*** **A__ My sleep is never disturbed by pain.** **B__ My sleep is occasionally disturbed by pain.** **C__ Because of pain I have less than 6 hours' sleep.** **D__ Because of pain I have less than 4 hours' sleep.** **E__ Because of pain I have less than 2 hours' sleep.** **F__ Pain prevents me from sleeping at all.**
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, but I can manage if they are conveniently positioned, e.g. on a table.** **D__ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.** **E__ I can only lift very light weights, at the most.** **F__ I cannot lift or carry anything at all.**	***SECTION 8 - Traveling*** **A__ I can travel anywhere without pain.** **B__ I can travel anywhere but it gives extra pain.** **C__ Pain is bad but I manage journeys over 2 hours.** **D__ Pain restricts me to journeys of less than 1 hour.** **E__ Pain restricts me to short necessary journeys under 30 minutes.** **F__ Pain prevents me from traveling except to receive treatment.**
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 1/4 mile.** **D__ Pain prevents me from walking more than 100 yards.** **E__ I can only walk while using a stick or crutches.** **F__ I am in bed most of the time and have to crawl to the toilet.**	***SECTION 9 - Recreation*** **A__ My social life is normal and causes me no extra pain.** **B__ My social activities increase the degree of pain.** **C__ Pain limits my more energetic interests, e.g., sport, etc.** **D__ Pain has restricted my social life and I do not go out as often.** **E__ Pain has restricted my social life to my home.** **F__ I have no social life because of the pain.**
***SECTION 5 -* Sitting** **A__ I can sit in any chair as long as I like.** **B__ I can only sit in my favorite chair as long as I like.** **C__ Pain prevents me from sitting more than 1 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 10 – Changing degree of pain** **A__ Level of pain is rapidly improving.** **B__ Level of pain fluctuates but is improving.** **C__ Level of pain is slowing improving.** **D__ Level of pain is unchanging.** **E__ Pain level is gradually worsening.** **F__ Pain level is rapidly worsening.**

COMMENTS:

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Delta Chiropractic Center – Neck Disability Index *

NAME_____ **DATE**_____

Please answer ***every section***. Mark ***one letter only*** in each section.

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 6 - Concentration*** A__ I can concentrate fully when I want to with no difficulty. B__ I can concentrate when I want to with slight difficulty. C__ I have a fair degree of difficulty in concentrating. D__ I have a lot of difficulty in concentrating. E__ I have a great deal of difficulty in concentrating. F__ Pain prevents me from concentrating at all.
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 is painful. C__ It is painful to care for myself and I am slow and cautious. D__ I need help but manage most of my personal care. E__ I need help every day in most aspects of self care. F__ I do not get dressed, wash with difficulty, and stay in bed.	***SECTION 7 - Work*** A__ Pain does not prevent me from working at all. B__ Pain prevents me from working extra hours or duties. C__ Pain prevents me from doing some of my work. D__ Pain prevents me from half of my usual work. E__ I can hardly work at all. F__ I cannot work at all.
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,but I can manage if they are conveniently positioned, e.g. on a table. D__ Pain prevents me from lifting heavy weights, but I can manage **light** weights if they are conveniently positioned. E__ I can only lift very light weights, at the most. F__ I cannot lift or carry anything at all.	***SECTION 8 - Traveling*** A__ I can ride in a car anywhere without pain. B__ I can ride anywhere but it gives extra pain. C__ Traveling causes moderate pain in my neck. D__ Pain restricts me to journeys of less than 2 hours. E__ Pain restricts me to short necessary journeys under 30 minutes. F__ Pain prevents me from driving completely.
SECTION 4 - Reading A__ I can read as long as I like with no pain. B__ I can read with slight neck pain. C__ I can read with moderate neck pain. D__ I must limit my reading due to moderate neck pain. E__ Pain prevents me from reading more than 10 minutes. F__ Pain prevents me from reading at all.	***SECTION 9 - Sleeping*** A__ My sleep is never disturbed by pain. B__ My sleep is occasionally disturbed by pain. C__ Because of pain I have less than 6 hours' sleep. D__ Because of pain I have less than 4 hours' sleep. E__ Because of pain I have less than 2 hours' sleep. F__ Pain prevents me from sleeping at all.
SECTION 5 – ***Headaches*** A__ I have no headaches at all. B__ I experience slight, infrequent headaches C__ I have moderate, infrequent headaches. D__ I have moderate, frequent headaches. E__ I have severe, frequent headaches. F__ I have almost constant headaches.	***SECTION 10 - Recreation*** A__ My social life is normal and causes me no extra pain. B__ My social activities increase the degree of neck pain. C__ Pain limits my more energetic interests, e.g., sport, etc. D__ Pain has restricted my social life and I do not go out as often. E__ Neck pain has restricted my social life to my home. F__ I cannot do recreational activities due to neck pain.

COMMENTS:

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Roland, M. and J. Fairbank (2000). "The Roland-Morris Disability Questionnaire and the Oswestry Disability Questionnaire." Spine ***25****(24): 3115-24.*

CONSENT TO RELEASE INFORMATION

As a patient of Delta Chiropractic Center, who do you authorize us to release scheduling and/or care and progress information to?

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Primary Doctor: _____ Phone:_____

If our office needs to contact **you**, where may we leave a message?

Phone #: _____

Email: _____

By signing below, you are giving our office permission to send you appointment reminders via text/email.

_____
Printed Name

*_____ _____
Signature Date

Patient Privacy Policies

To Contact Us

If you would like further information about our privacy policies and practices, please contact us at:

Delta Chiropractic Center

6130 W. Saginaw Hwy.

Lansing, MI 48917

517.321.3030

This notice will expire seven years after the date upon which the record was created.

By signing below, I acknowledge that I have been offered a copy of the Patient Privacy Policies.

_____ _____

Patient Name Printed Date

*_____ _____

Patient Signature Provider Representative

_____ _____

Guardian Printed Name Guardian Signature

_____

Guardian's relationship to, or other authority to act for, the patient