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

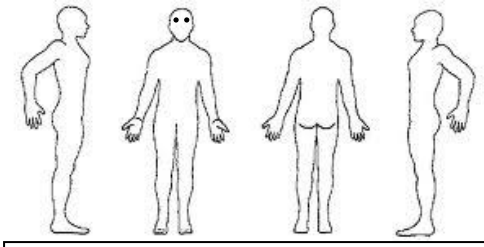
What are your chief complaints? PS-Pain Scale 1-10

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.*

Authorization and Consent

1) **Assignment of benefits:** I hereby authorize Delta Chiropractic Center and Active Role Chiropractic to examine and treat my condition as they deem appropriate. I authorize payment directly to the provider of any and all benefits for charges for exams and care received by me or my dependents. I also authorize benefit payers to release all information requested regarding such benefits and payment to the provider above. I also authorize the provider to release all information needed to obtain those benefits. I also agree that I am responsible for all bills incurred at this office. As an estimate of the fees for your proposed treatment plan, we may bill your insurance company for your exam and x-rays, as well as $60 per adjustment. I understand that while DCC will do their best to monitor my benefits, they highly recommend that I contact them also, because what is not covered by insurance, I will pay. Delta Chiropractic Center will not be held responsible for any medical condition or diagnosis. **Initial Here:** *____

2) **Informed Consent:** Chiropractors do not diagnose diseases. Our job is to find areas of nerve interference and to remove it. We suggest that you visit your medical doctor in order to care for any health concerns other than Nerve Impingement. We also want you to realize there are risk factors involved in any form of health care. Surgery may have death risk factors of anywhere from 1/1,000 to 1 in 100. Medication may cause serious reactions in 1/100,000 to 1 in a thousand cases. Proper chiropractic adjustments almost never result in serious reactions: less than 1 in a million, but may include sprain, cerebrovascular accident or disc damage. The risks of refusing chiropractic care include degeneration, nerve damage, and increased duration, frequency, and intensity of your symptoms. **Initial Here:** *____

3) **X-rays:**
    a. I understand that all x-rays are taken to provide more accurate information concerning my care. The value of this information outweighs the minimal radiation risks involved. (The radiation in these studies is very small, and is minimized by our regular upkeep and calibration of our equipment. You receive more radiation from your television set, from natural background radiation, and even from the foods you eat. The doctor will not ask you to do anything he does not ask of his own family.) **Initial Here:** *____

    b. I am not pregnant. **Initial Here:** *____

    c. I understand and agree that fees paid to the office for x-rays are for information and analysis only. **By state law**, I have the right to obtain the information gained from these x-rays, but **the films themselves will remain the property of Delta Chiropractic Center** or Active Role Chiropractic Clinic, and **the original films will not be allowed to leave the office**. Copies can be obtained for $10.00 per view, with three days notice. A brief written or oral report may be obtained at no charge. **Initial Here:** *____

    d. If you bring x-rays to the office for reading and analysis, there is a $30.00 fee for each series. Insurance will not cover this fee and I will pay it. **Initial Here:** _____

Signature: *_____ Date: _____

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