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Phone (561) 741-1316
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Spine Design Chiropractic

APPLICATION FOR CARE:

Patient First Name: _____ Last Name: _____

Address: Street_____City_____St_____Zip_____

Home Phone: (___) _____ Cell Phone: (___) _____

Work Phone: (___) _____ Email Address: _____

Out of State Address: _____ Phone: (__)_____

No. of Children and Ages: _____ Driver's License#:_____

Sex: O Male or O Female Status: O Married O Single Spouse's Name: _____
O Widowed O Divorced Spouse's Employer: _____

(Federal info needed)
Language spoken: _____ Race: White Black Asian Native-American Decline Other_____
Ethnicity: Hispanic or Non Hispanic or Decline

Date of Birth ____/____/_____ Age: _____ In Case of Emergency:_____

Whom may we thank for referring you to us? _____

EMPLOYMENT

O Full Time O Part Time
O Retired O Not Employed

STUDENT

O Full Time O Part Time
O Non Student

Patient's Employer: _____

Address: _____

City, State, Zip code: _____

Phone: (__) _____ Occupation: _____

INSURANCE INFORMATION:
Primary Insurance Company Name

_____

Membership# _____Group# _____

Complete only if Patient is not the Insured:
Insured's Name: _____
Birth Date: ___/____/____ Sex O M or O F
Patient's relationship to Insured:

_____

INSURANCE INFORMATION:
Secondary Insurance Company Name

_____

Membership# _____**Group#**_____

Complete only if Patient is not the Insured:
Insured's Name: _____
Birth Date: ___/____/____ Sex O M or O F
Patient's relationship to Insured:

AUTOMOBILE ACCIDENT / WORKER'S COMPENSATION ONLY:
Insurance Company Name: _____ Claim#: _____

Adjuster's Name: _____ Phone# (___) _____ext: ____

Attorney's Name: _____ Phone# (___) _____

Do you have a Health Savings or Flex Spending account? _____
If so, how much is available to use for your care in your account? _____

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 apply to you, but PLEASE JUST CIRCLE THEONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity
1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

Section 2 – Personal Care
1. I can look after myself normally without causing extra pain.
2. I can look after myself normally, but it causes extra pain.
3. It is painful to look after myself and I am slow and careful.
4. I need some help, but manage most of my personal care.
5. I need help every day in most aspects of self-care.
6. I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting
1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

Section 4 – Reading
1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want to with moderate pain in my pain in my neck.
4. I cannot read as much as I want because of moderate pain in my neck.
5. I cannot read as much as I want because of severe pain in my neck.
6. I cannot read at all.

Section 5 – Headaches
1. I have no headaches at all.
2. I have slight headaches, which come infrequently.
3. I have moderate headaches, which come infrequently.
4. I have moderate headaches, which come frequently.
5. I have severe headaches, which come frequently.
6. I have headaches almost all of the time.

Section 6 – Concentration
1. I can concentrate fully when I want to with no difficulty.
2. I can concentrate fully when I want to with slight difficulty.
3. I have a fair degree of difficulty in concentrating when I want to.
4. I have a lot of difficulty in concentrating when I want to.
5. I have a great deal of difficulty in concentrating when I want to.
6. I cannot concentrate at all.

Section 7 – Work
1. I can do as much work as I wan to.
2. I can do only my usual work, but no more.
3. I can do most of my usual work, but no more.
4. I cannot do my usual work.
5. I can hardly do any work at all.
6. I cannot do any work at all.

Section 8 – Driving
1. I can drive my car without any neck pain.
2. I can drive my car as long as I want with slight pain in my neck.
3. I can drive my car as long as I want with moderate pain in my neck.
4. I cannot drive my car as long as I want because of moderate pain in my neck.
5. I can hardly drive at all because of severe pain in my neck.
6. I cannot drive my car at all.

Section 9 – Sleeping
1. I have no trouble sleeping.
2. My sleep is slightly disturbed (less than 1 hour sleepless).
3. My sleep is mildly disturbed (1-2 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless).
5. My sleep is greatly disturbed (3-5 hours sleepless).
6. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation
1. I am able to engage in all of my recreational activities, with no neck pain at all.
2. I am able to engage in all of my recreational activities, with some pain in my neck.
3. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
4. I am able to engage in a few of my usual recreational activities because of pain in my neck.
5. I can hardly do any recreational activities because of pain in my neck.
6. I cannot do any recreational activities at all.

Comments: _____

Patient's Signature: _____ Date: _____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back 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 apply to you, but PLEASE JUST CIRCLE THEONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity
1. The pain comes and goes and is very mild.
2. The pain is mild and does not vary much.
3. The pain comes and goes and is moderate.
4. The pain is moderate and does not vary much.
5. The pain comes and goes and is severe.
6. The pain is severe and does not vary much.

Section 2 – Personal Care
1. I would not have to change my way of washing or dressing in order to avoid pain.
2. I do not normally change my way of washing or dressing even though it causes some pain.
3. Washing and dressing increases the pain, but I manage not to change my way of doing it..
4. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
5. Because of the pain, I am unable to do some washing and dressing without help.
6. Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting
1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
5. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
6. I can only lift very light weights, at the most.

Section 4 – Walking
1. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than one mile.
3. Pain prevents me from walking more than ½ mile.
4. Pain prevents me from walking more than ¼ mile.
5. I can only walk while using a cane or on crutches.
6. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
1. I can sit in any chair as long as I like without pain.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than one hour.
4. Pain prevents me from sitting more than ½ hour.
5. Pain prevents me from sitting more than ten minutes.
6. Pain prevents me from sitting at all.

Section 6 – Standing
1. I can stand as long as I want without pain.
2. I have some pain while standing, but it does not increase with time.
3. I can not stand for longer than one hour without increasing pain.
4. I can not stand for longer than ½ hour, without increasing pain.
5. I can not stand for longer than ten minutes, without increasing pain.
6. I avoid standing, because it increases the pain straight away.

Section 7 – Sleeping
1. I get no pain in bed.
2. I get pain in bed, but it doesn't prevent me from sleeping well
3. Because of my pain, my normal night's sleep is reduced by less than one-quarter.
4. Because of my pain, my normal night's sleep is reduced by less than one-half.
5. Because of my pain, my normal night's sleep is reduced by less than three-quarters.
6. Pain prevents me from sleeping at all.

Section 8 – Social Life
1. My social life is normal and gives me no pain.
2. My social life is normal, but increases the degree of my pain.
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
4. Pain has restricted my social life and I do not go out very often.
5. Pain has restricted my social life to my home.
6. I have hardly any social life because of the pain.

Section 9 – Traveling
1. I get no pain while traveling.
2. I get some pain while traveling, but none of my usual forms of travel make it any worse.
3. I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
4. I get extra pain while traveling which compels me to seek alternative forms of travel.
5. Pain restricts all forms of travel.
6. Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain
1. My pain is rapidly getting better.
2. My pain fluctuates, but overall is definitely getting better.
3. My pain seems to be getting better, but improvement is slow at present.
4. My pain is neither getting better or worse.
5. My pain is gradually getting worse.
6. My pain is rapidly worsening

Comments: _____

Patient's Signature: _____ Date: _____

Design Chiropractic

Christian B. Carlstrom, D.C.
Denise T. Carlstrom, D.C.

Phone (561) 741-1316 Fax(561) 741-1375

Confidential Patient Information

Primary Complaint/Reason for appointment	Date condition started or for how long:	Have you had this before?	Injury related related?
1. _____	_____	Yes / No	Yes / No
Please circle pain scale (no pain) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 (worst pain)			
2. _____	_____	Yes / No	Yes / No
Please circle pain scale (no pain) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 (worst pain)			
3. _____	_____	Yes / No	Yes / No
Please circle pain scale (no pain) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 (worst pain)			

What other treatment options have you tried for these conditions?_____

If this is a work or auto injury, please notify the receptionist now. Work _____ Auto_____ other_____
Have you lost work from above condition(s)? ☐ Yes ☐ No If yes, give dates: from _____ to _____

All current medications: NONE or 1._____2._____3._____
Allergies to any medications: (please list medication and allergic reaction when taken): NONE or 1._____
2._____ 3._____
All previous surgeries and dates:_____
Do you smoke? ☐ Yes ☐ No Have you smoked in the past? ☐ Yes ☐ No Height_____ Weight_____
Do you exercise? ☐ Yes ☐ No If yes, how often?_____ Blood Pressure:_____/_____
Are you interested in a complimentary Body Fat/Body Composition analysis? ☐ **Yes** ☐ **No**

How is your current problem affecting your hobbies?_____

Medical Doctors consulted in the past year:
Name:_____ Date:_____ Reason:_____
Name:_____ Date:_____ Reason:_____
Chiropractic Doctors or Physical Therapists consulted in the past year:
Name:_____ Date:_____ Reason:_____
Date of last spinal x-rays:_____ How long were you under care?_____
FEMALES: Is there a possibility of you being pregnant? ☐ Yes ☐ No ☐ Unsure

Please circle the following conditions you may have had in the past or have now:

Headaches	Arthritis	Insomnia	High Blood Pressure	Digestive Problems
Migraines	Other Joint Pain	Stroke	Blood Vessel Disease	Ulcers
Neck Pain	Numbness	Vision Changes	Menstrual Cramps	Constipation
Shoulder Pain	Joint Swelling	Nose Bleeds	Irregular Periods	Urinary Problems
Arm/Hand Pain	Scoliosis	Ringing in Ears	Allergies	Kidney Problems
Mid Back Pain	Flat Feet	Earaches	Asthma	Gallbladder Problems
Low Back Pain	Dizziness	Hearing Loss	Cancer	Tuberculosis
Hip Pain	Nausea	Cough	Osteoporosis	Gout
Leg/Foot Pain	Weakness/Fatigue	Chest Pains	Diabetes	Depression
Disc Problems	Nervousness	Heart Problems	Hypoglycemia	Other_____

*****Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Your doctor will weigh your needs and desires when recommending your treatment program.***

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ **Relief Care** ☐ **Corrective Care** ☐ **Doctor will select appropriate care for condition.**

Relief Care

Relief care gets rid of symptoms or pain, but not the cause of it. Initial problem is likely to return.

Corrective Care

Corrective care differs from relief care in that the goal is to get rid of symptoms AND correct the cause of the problem.

Consent for Treatment

I hereby give my consent for the doctors and staff of Spine Design Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) such as (a scanned copy will serve as original):

- Release of information to insurance companies.
- The taking of photographs and x-rays to be used for treatment purposes.
- The performance of other diagnostic and therapeutic procedures for treatment purposes.
- I authorize assignment of my insurance benefits to be paid directly to:

Spine Design Chiropractic & Physical Therapy (Carlstrom Family Chiropractic Center, P.A.)
1102 W. Indiantown Road, Suite 11
Jupiter, FL 33458
561-741-1316

I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be IMMEDIATELY due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect these fees.

Payment Policies

1. **PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.**
   Method of payment for today's charges will be: □ Cash or □ Visa/MC □ AmEx □ Discover □ HSA/debit
   (* Please note - Credit cards will be subject to 3.5% processing fee)

2. After this first visit, you will be scheduled for a Report of Findings and the doctor will review your examination and x-ray results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate (there is no charge for this visit unless you opt into treatment at that time).

Patient's Signature:_____ Date:_____

Guardian's Signature:_____ Date:_____

Consent to Treatment of Minor Child

I hereby authorize Spine Design Chiropractic to administer treatment as they so deem necessary to my

son/daughter/other,_____ (name)

Date:_____ Signed:_____

TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal: *to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.*

Adjustment: *the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.*

Health: *a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.*

Vertebral Subluxation: *a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.*

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. **However, if during the course of chiropractic spinal exam we encounter non-chiropractic or unusual findings, we advise you.** If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate power. Our only method is specific adjusting to correct vertebral subluxations.

I _____ have read and fully understand the above statement.
(print name)

I can get questions regarding the doctor's objective pertaining to my care in this office answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
(signature) (date)

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

SPINE DESIGN CHIROPRACTIC & PHYSICAL THERAPY

I, _____ (Patient name) have read a copy of Spine Design Chiropractic's Notice of Patient Privacy Practices.

_____ _____

Signature of Patient or Parent or legal Guardian

Date

HOW OUR OFFICE WORKS...

We want to provide you with the highest level of service possible so please read the following information about how our office works.

PATIENT PRIVACY – The majority of our patient care takes place in a semi-private setting so please be aware that many of our conversations are overheard by other patients. **If you need to discuss something confidential, we will schedule a time for you to speak to the doctors in a private consultation room when the need arises.** Our adjusting room doors can be closed to provide some privacy while you are getting adjusted.

FIRST THINGS FIRST – We will complete a thorough exam and x-rays to confirm the true nature of your condition FIRST & to determine the care you will need. **All of these findings will be reported back to you at our DOCTOR'S REPORT on your very next visit!** Our goal is to correct your spinal issues and teach you how to maintain better health for a lifetime.

DOCTOR'S REPORT – We will review your exam/x-ray findings & recommendations. Attendance is required for anyone who wishes to become new patients of our practice. ***We strongly urge you to invite your spouse or significant other to attend.*** From our experience, families that support each other in restoring their health through chiropractic care get better results.

This is the only time we ask you to come at a specific time and you will be very enlightened about how to achieve and maintain optimal health naturally! **We do not charge you for this appointment. **Yes, it's that important!**

Name_____ Date_____

Signature_____