Cypher Chiropractic and Rehabilitation Center

22636 Glenn Drive Suite 204 Sterling, VA 20164 703-481-9698

--Welcome to Cypher Chiropractic and Rehab Center -- Today's Date: _____

Name _____ DOB _____ Age _____ Phone _____

(H) e-mail _____ (W) e-mail _____ Cell # _____ Work # _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Employer_____

Employer Address _____

Occupation _____ Full time or Part time? Are you currently able to work? _____

Marital Status: S M D W Spouse's Name _____ Spouse Work Phone _____

Spouse Date of Birth_____ Employer _____

Other Emergency Contact _____ Relationship _____

Phone (H) _____ (W) _____ How were you referred to our office? _____

- Have you ever had Chiropractic care before? _____ If so, please record Dr. name, phone, dates, and results:

_____

- Please describe the problem for which you have come to our office: _____

_____

- Record any treatment you have had for this (at home, hospital, Dr's. office): _____

_____

- Did you have any falls, injury, accidents, sporting event, or activity prior to current symptoms?_____

_____

Are you pregnant? _____ How many children have you had? _____ Medications_____

Vitamins _____ Any regular exercise plan?_____ Interests/hobbies_____ Have you had any surgeries? Yes / No If YES, PLEASE DESCRIBE ON BACK OF THIS FORM

INSURANCE INFORMATION

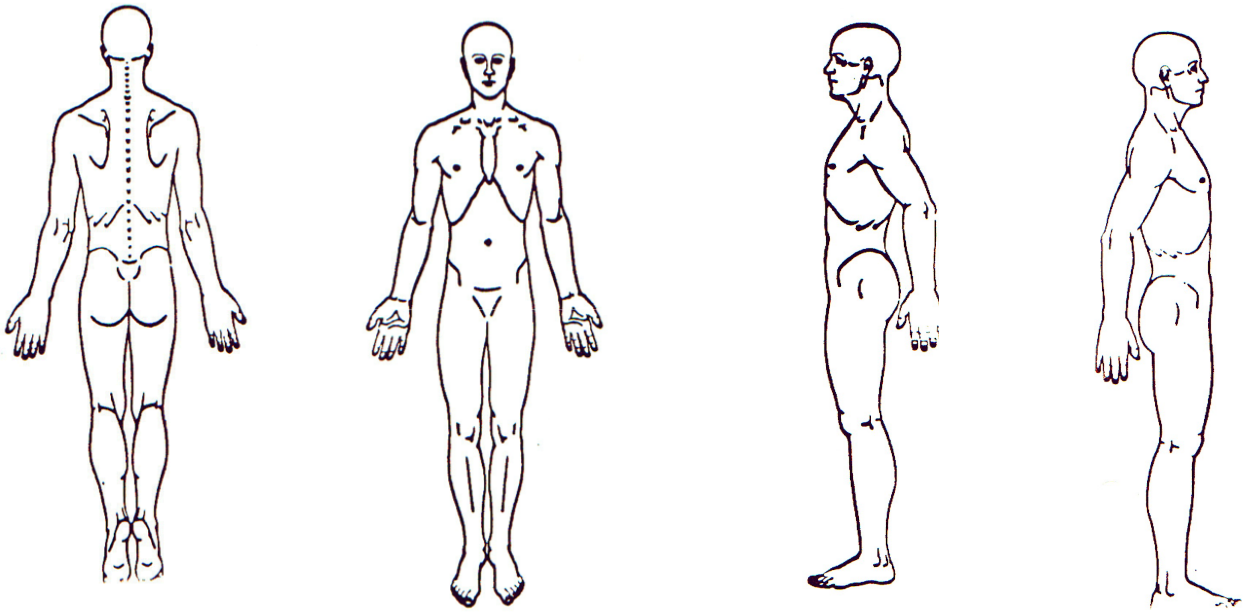
Name of Insurance Co. _____ Phone_____ Address_____
ID# _____ Name of Insured_____ Relation to you_____
Group # _____ Insured SS#_____ Insured Date of Birth _____
Name of Employer of Insured _____ Do you need a referral from primary or ins. Co?_____
SECONDARY INSURANCE CO. _____ Phone_____
Address_____ ID # _____
Name of Insured _____ Relation to you _____ Insured SS# _____ Insured Date of Birth _____

- Your Primary Care Doctor:_____ Phone # _____ City_____
- If Applicable – Referring Doctor: _____ Phone # _____ City _____
- If Applicable – Date of Accident: _____

TURN OVER TO COMPLE

INDICATE ALL AREAS OF PAIN, STIFFNESS, DISCOMFORT, NUMBNESS OR TINGLING.
SHOW PATHS OF RADIATING PAIN WITH AN ARROW

Use the key below to mark the type and location of your sensation
A= ACHE P= PINS & NEEDLES B= BURNING N= NUMBNESS S= STABBING O= OTHER



ADDITIONAL COMMENTS REGARDING YOUR SYMPTOMS: _____

_____

I am responsible for any deductible by my insurance company. Insurance co-payments are payable each visit. I am responsib for my balance. All outstanding fees for services become immediately due and payable when treatment is terminated. I am responsible for attorney/collection fees should my account be placed in collection for non-payment. Should X-rays be taken, they remain the property of Cypher Chiropractic Center. I am responsible for any referral from my primary care physician if required by my insurance plan. If you have any questions regarding the financial policy above, please talk to us now!

SIGNATURE_____DATE _____

I have been given the opportunity to review Cypher Chiropractic Center's office privacy practices
SIGNATURE_____

Please sign below for minors or students:

I, _____ am the guardian/parent for _____

Cypher Chiropractic & Rehabilitation Center
22636 Glenn Drive, Suite 204
Sterling, VA 20164
703.481.9698 Fax: 703.481.9699

Vertebrobasilar/Cerebrovascular Questionnaire

Name: _____ Date: _____

Please answer the following questions as accurately as possible.
Check the appropriate response.

- Did your neck pain/headache begin gradually? Yes _____ No _____ or
- Suddenly? Yes _____ No _____
- Have you had these symptoms before? Yes _____ No _____
- If yes, is this episode similar to _____ or different then _____ your prior episodes?
- If it is different, explain how:_____

  _____
- Have you had any dizziness? Yes _____ No _____
- Lightheadedness? Yes _____ No _____
- Have you had any trouble with your vision? Yes _____ No _____
- Have you had any trouble with your speech? Yes _____ No _____
- Have you had any trouble with your balance? Yes _____ No_____
- Have you had any trouble with your coordination? Yes _____ No _____
- Have you had any trouble with swallowing? Yes _____ No _____
- Have you had any nausea or vomiting? Yes _____ No _____
- Have you had any numbness or tingling? Yes _____ No _____

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Health History

NAME: _____ DATE:_____

Please review the listed conditions and indicate those that are current or past health problems of yourself or family members.

CONDITION	**SELF AGE ( )**	**FATHER AGE ( )**	**MOTHER AGE ( )**	**SPOUSE AGE ( )**	**BROTHERS AGE ( )**	**SISTERS AGE ( )**	**CHILDREN AGE ( )**
AIDS							
ARTHRITIS							
ASTHMA- HAY FEVER							
BACK TROUBLE							
BURSITIS							
CANCER							
CONSTIPATION							
DEPRESSION							
DIABETES							
DISC PROBLEM							
EMPHYSEMA							
EPILEPSY							
HEADACHES							
HEART DISEASE							
HIGH BLOOD PRESSURE							
HIV							
INSOMNIA							
KIDNEY DISEASE							
LIVER DISEASE ---------- MENTAL ILLNESS							
MIGRANES							
NEURITIS							
PINCHED NERVE							
SCOLIOSIS							
SINUS TROUBLE							
ULCER							
TB							
OTHER							

If any of the above family members are deceased, please list their age of death and cause.

NECK DISABILITY INDEX QUESTIONNAIRE

Patient's Name: _____ **Today's Date:** _____/_____/_____

SS# _____ **DOB**: _____/_____/_____ **Member ID #** _____

Instructions: This questionnaire has been designed to give your doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section with the ONE answer that applies best to you. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

Pain Intensity

- o I have no pain at the moment.
- o The pain is very mild at the moment.
- o The pain is moderate at the moment.
- o The pain is fairly severe at the moment.
- o The pain is very severe at the moment.
- o The pain is the worst imaginable at the moment.

Lifting

- o I can lift heavy weights without extra pain.
- o I can lift heavy weights, but it gives me extra pain.
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- o I can lift very light weights.
- o I cannot lift or carry anything at all.

Headaches

- o I have no headaches at all.
- o I have slight headaches, which come infrequently.
- o I have moderate headaches, which come infrequently.
- o I have moderate headaches, which come frequently.
- o I have severe headaches, which come frequently. I have headaches almost all the time.

Personal Care (Washing, Dressing, etc.)

- o I can look after myself normally without causing extra pain.
- o I can look after myself normally, but it causes extra pain.
- o It is painful to look after myself and I am slow and careful.
- o I need help every day in most aspects of self-care.
- o I need some help every day in most aspects of self-care.
- o I do not get dressed, I wash with difficulty and stay in bed.

Reading

- o I can read as much as I want with no pain in my neck.
- o I can read as much as I want with slight pain in my neck.
- o I can read as much as I want with moderate pain in my neck.
- o I can't read as much as I want because of moderate pain in my neck.
- o I can hardly read at all because of severe pain in my neck. I cannot read at all because of severe pain in my neck.

Concentration

- o I can concentrate fully when I want with no difficulty.
- o I can concentrate fully when I want with slight difficulty.
- o I have a fair degree of difficulty in concentrating when I want.
- o I have a lot of difficulty in concentrating when I want.
- o I have a great deal of difficulty in concentrating when I want. I cannot concentrate at all.

Work

- o I can do as much work as I want.
- o I can only do my usual work, but no more.
- o I can do most of my usual work, but no more.
- o I cannot do my usual work.
- o I can hardly do any work at all.
- o I can't do any work at all.

Sleeping

- o I have no trouble sleeping.
- o My sleep is slightly disturbed (less than 1 hr. sleepless). My sleep is mildly disturbed (1 – 2 hr's. sleepless).
- o My sleep is moderately disturbed (2 – 3 hr's. sleepless). My sleep is greatly disturbed (3 – 5 hr's. sleepless).
- o My sleep is completely disturbed (5 – 7 hr's. sleepless).

Driving

- o I can drive my car without any neck pain.
- o I can drive my car as long as I want with slight pain in my neck.
- o I can drive my car as long as I want with moderate pain in my neck.
- o I can't drive my car as long as I want because of moderate pain in my neck.
- o I can hardly drive at all because of severe pain in my neck. I can't drive my car at all.

Recreation

- o I am able to engage in all my recreational activities with no neck pain at all.
- o I am able to engage in all my recreational activities with some pain in my neck.
- o I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- o I am able to engage in a few of my usual recreational activities because of pain in my neck.
- o I can hardly do any recreational activities because of pain in my neck.
- o I can't do any recreational activities at all.

Patient's Signature: _____

REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Patient's Name: _____ Today's Date: _____/_____/_____
SS # _____ DOB: _____/_____/_____ Member ID # _____

Instructions: This questionnaire has been designed to give your doctor information as to how your low back pain has affected your ability to manage everyday life. Please answer every section and mark in each section the ONE answer that applies to you best. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most closely describes your problem.

Pain Intensity
- o The pain comes and goes and is very mild.
- o The pain is mild and does not vary much.
- o The pain comes and goes and is moderate.
- o The pain is moderate and does not vary much.
- o The pain comes and goes and is severe.
- o The pain is severe and does not vary much.

Lifting
- o I can lift heavy weights without extra pain.
- o I can lift heavy weights, but it gives me extra pain.
- o Pain prevents me from lifting heavy weights off the floor.
- o Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- o I can only lift very light weights at the most.

Sitting
- o I can sit in any chair as long as I like without pain.
- o I can only sit in my favorite chair as long as I like.
- o Pain prevents me from sitting more than one hour.
- o Pain prevents me from sitting more than ½ hour.
- o Pain prevents me from sitting more than ten minutes.
- o Pain prevents me from sitting at all.

Personal Care (Washing, Dressing, etc.)
- o I do not have to change my way of washing or dressing in order to avoid pain.
- o I do not normally change my way of washing or dressing even though it causes some pain.
- o Washing and dressing increases the pain, but I manage not to change my way of doing it.
- o Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- o Because of the pain, I am unable to do some washing and dressing without help.
- o Because of the pain, I am unable to do any washing or dressing without help.

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

Standing
- o I can stand as long as I want without pain.
- o I have some pain while standing, but it does not increase with time.
- o I cannot stand for longer than one hour without increasing pain. I cannot stand for longer than ½ hour without increasing pain.
- o I cannot stand for longer than ten minutes without increasing pain.
- o I avoid standing because it increases the pain straight away.

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

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

Social Life
- o My social life is normal and gives me no pain.
- o My social life is normal, but increases the degree of my pain.
- o Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- o Pain has restricted my social life and I do not go out very much.
- o I have hardly any social life because of the pain. I can't drive my car at all because of the pain.

Changing Degree of Pain
- o My pain is rapidly getting better.
- o My pain fluctuates, but overall is definitely getting better.
- o My pain seems to be getting better, but improvement is slow at present.
- o My pain is neither getting better nor worse.
- o My pain is gradually worsening.
- o My pain is rapidly worsening

Patient's Signature: _____