ZMOOS CHIROPRACTIC CENTER PLC

4045 River Ridge Dr. NE | Cedar Rapids, IA 52402 | (319) 395-9598 (319) 395-9660 fax | www.drzmoos.com est. 1946

Date:_____

Name_____Home Ph_____

SS#_____Address_____

City_____Zip Code_____

Age_____Birth Date_____Married (Y) (N) # of Children_____

Occupation_____Employer_____

Work Ph_____Cell Ph_____ Spouse's Name_____

Spouse's Date of Birth_____Nearest Relative_____

Address_____Phone Number_____

Patient's Email Address_____

Referred by _____Date of Last Physical_____

Purpose of Today's Appointment_____

Other Drs. seen for this condition_____

Have You Been Treated For Any Heath Condition By A Physician In The Last Year? (Y) (N)
Describe _____

Primary Care Physician_____ Send Notes? Yes ❒ No ❒

Primary Care Physician Address_____

Is this injury the result of a work injury or auto accident? Yes ❒ No ❒

PAYMENT IS EXPECTED AT TIME OF VISIT: ❒ CASH ❒ CHECK ❒ CREDIT CARD

Name of Person Responsible for Payment_____

Are You Insured (Y) (N) Name of Insurance Company_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carried and myself. I also understand that Zmoos Chiropractic Center, PLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Zmoos Chiropractic Center, PLC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

ATTENTION MEDICARE PATIENTS: MEDICARE WILL ONLY COVER 80% OF AN ADJUSTMENT, THEY WILL NOT COVER ANY ADDITIONAL SERVICES!

Patient's Signature_____ Date_____

Guardian or Spouse Signature_____ Date_____

PLEASE FILL OUT THE BACK OF THIS FORM

Please check the appropriate box for any of the following symptoms, which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O = OCCASIONAL F = FREQUENT C = CONSTANT

O F C

Muscle / Joint

- ❒ ❒ ❑ Athritis
- ❒ ❒ ❑ Bursitis
- ❒ ❒ ❑ Foot trouble
- ❒ ❒ ❑ Hernia
- ❒ ❒ ❑ Low back pain
- ❒ ❒ ❑ Lumbago
- ❒ ❒ ❑ Neck pain
- ❒ ❒ ❑ Stiffness
- ❒ ❒ ❑ Pain between shoulders

General

- ❒ ❒ ❑ Allergy
- ❒ ❒ ❑ Chills
- ❒ ❒ ❑ Convulsions
- ❒ ❒ ❑ Dizziness
- ❒ ❒ ❑ Fainting
- ❒ ❒ ❑ Fatigue
- ❒ ❒ ❑ Fever
- ❒ ❒ ❑ Headache
- ❒ ❒ ❑ Loss of sleep
- ❒ ❒ ❑ Loss of weight
- ❒ ❒ ❑ Nervousness
- ❒ ❒ ❑ Neuralgia
- ❒ ❒ ❑ Numbness
- ❒ ❒ ❑ Sweats
- ❒ ❒ ❑ Tremors

Cardiovascular

- ❒ ❒ ❑ Hardening of arteries
- ❒ ❒ ❑ High blood pressure
- ❒ ❒ ❑ Low blood pressure
- ❒ ❒ ❑ Pain over heart
- ❒ ❒ ❑ Poor circulation
- ❒ ❒ ❑ Rapid heartbeat
- ❒ ❒ ❑ Slow heartbeat
- ❒ ❒ ❑ Swelling of ankles

Genitourinary

- ❒ ❒ ❑ Bed wetting
- ❒ ❒ ❑ Blood in urine
- ❒ ❒ ❑ Frequent urination
- ❒ ❒ ❑ Lack of kidney control
- ❒ ❒ ❑ Kidney infection
- ❒ ❒ ❑ Painful urination
- ❒ ❒ ❑ Prostate trouble
- ❒ ❒ ❑ Pus in urine

HEIGHT_____

WEIGHT_____

O F C

Eye, Ear, Nose and Throat

- ❒ ❒ ❑ Asthma
- ❒ ❒ ❑ Colds
- ❒ ❒ ❑ Crossed eyes
- ❒ ❒ ❑ Deafness
- ❒ ❒ ❑ Dental decay
- ❒ ❒ ❑ Earache
- ❒ ❒ ❑ Ear discharge
- ❒ ❒ ❑ Ear noise
- ❒ ❒ ❑ Enlarged glands
- ❒ ❒ ❑ Enlarged thyroid
- ❒ ❒ ❑ Eye pain
- ❒ ❒ ❑ Failing vision
- ❒ ❒ ❑ Far sightedness
- ❒ ❒ ❑ Gum trouble
- ❒ ❒ ❑ Hay fever
- ❒ ❒ ❑ Hoarseness
- ❒ ❒ ❑ Nasal obstruction
- ❒ ❒ ❑ Near sightedness
- ❒ ❒ ❑ Nose bleeds
- ❒ ❒ ❑ Sinus infection
- ❒ ❒ ❑ Sore throat
- ❒ ❒ ❑ Tonsillitis

Gastrointestinal

- ❒ ❒ ❑ Belching or gas
- ❒ ❒ ❑ Colitis
- ❒ ❒ ❑ Colon trouble
- ❒ ❒ ❑ Constipation
- ❒ ❒ ❑ Diarrhea
- ❒ ❒ ❑ Difficult digestion
- ❒ ❒ ❑ Bloated abdomen
- ❒ ❒ ❑ Excessive hunger
- ❒ ❒ ❑ Gallbladder trouble
- ❒ ❒ ❑ Hemorrhoids
- ❒ ❒ ❑ Intestinal worms
- ❒ ❒ ❑ Jaundice
- ❒ ❒ ❑ Liver trouble
- ❒ ❒ ❑ Nausea
- ❒ ❒ ❑ Pain over stomach
- ❒ ❒ ❑ Poor appetite
- ❒ ❒ ❑ Vomiting
- ❒ ❒ ❑ Vomiting of blood

O F C

Skin

- ❒ ❒ ❑ Boils
- ❒ ❒ ❑ Bruise easily
- ❒ ❒ ❑ Dryness
- ❒ ❒ ❑ Hives or allergy
- ❒ ❒ ❑ Itching
- ❒ ❒ ❑ Skin eruption (rash)
- ❒ ❒ ❑ Varicose veins

Pain or numbness in

- ❒ ❒ ❑ Shoulders
- ❒ ❒ ❑ Arms
- ❒ ❒ ❑ Elbows
- ❒ ❒ ❑ Hands
- ❒ ❒ ❑ Hips
- ❒ ❒ ❑ Legs
- ❒ ❒ ❑ Knees
- ❒ ❒ ❑ Feet
- ❒ ❒ ❑ Painful tailbone
- ❒ ❒ ❑ Poor posture
- ❒ ❒ ❑ Sciatica
- ❒ ❒ ❑ Spinal curvature
- ❒ ❒ ❑ Swollen joints

Respiratory

- ❒ ❒ ❑ Chest pain
- ❒ ❒ ❑ Chronic cough
- ❒ ❒ ❑ Difficult breathing
- ❒ ❒ ❑ Spitting up blood
- ❒ ❒ ❑ Spitting up phlegm
- ❒ ❒ ❑ Wheezing

Women only

- ❒ ❒ ❑ Congested breasts
- ❒ ❒ ❑ Cramps or backache
- ❒ ❒ ❑ Excess menstrual flow
- ❒ ❒ ❑ Hot flashes
- ❒ ❒ ❑ Irregular cycle
- ❒ ❒ ❑ Lumps in breast
- ❒ ❒ ❑ Menopause
- ❒ ❒ ❑ Painful menstruation
- ❒ ❒ ❑ Vaginal discharge

Are you pregnant ☐ Yes ☐ No

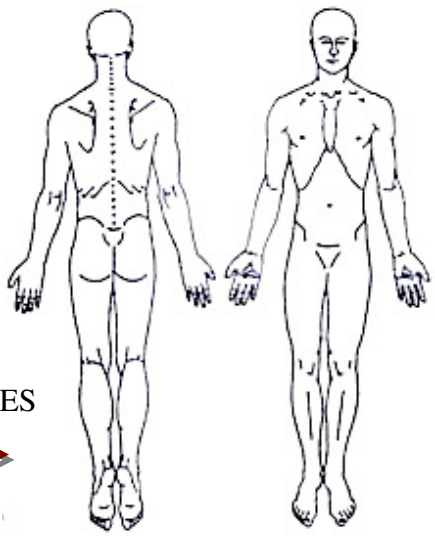
If yes, how long_____mo

Number of children_____

Check any of the following conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES



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Name:_____ Date:____-____-20__

What is your ***preferred*** communication preference? (*check one*):

- ☐ home phone_____
- ☐ work phone_____
- ☐ cell phone_____
- ☐ fax_____
- ☐ emergency contact : name and phone number
- ☐ in person only
- ☐ do not contact
- ☐ text message_____

Race (*check one*):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other native Pacific Islander
- ☐ White
- ☐ Mixed 2 or more
- ☐ Patient chooses NOT to identify

Ethnicity (*check one*):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient chooses NOT to identify

Preferred language: _____

Email: _____

Emergency Contact:

Name: _____ Relationship_____

Home #_____ Cell #_____

Work #_____ext_____

Approximate Height:_____ft _____in Weight _____lbs

Smoking status: Have you ever smoked? ☐ Yes ☐ No

If Yes, did you quit ☐recently, ☐several years ago, or ☐currently smoking?
If you currently smoke, how many days a week____ and packs a day_____ do you smoke?

Medications : Please see front desk

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
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 off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score