GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print) ____________________ DATE: ____________

AGE ____________ DATE OF BIRTH ____________ OCCUPATION ____________

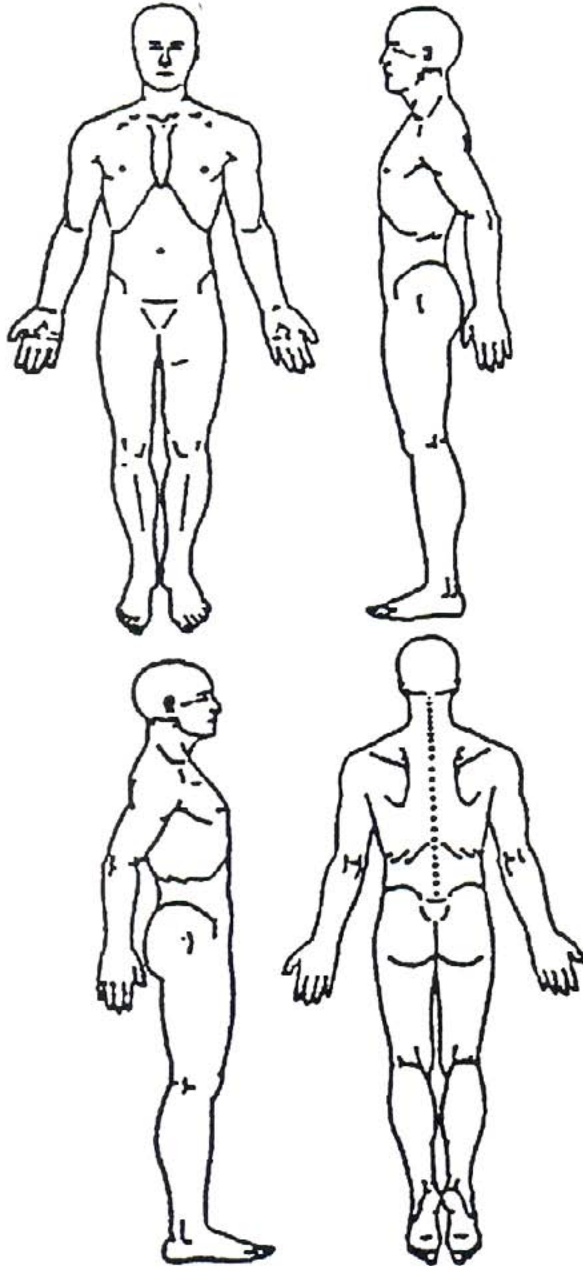
HOW LONG HAVE YOU HAD THIS PAIN?________YEARS________MONTHS________WEEKS ________

IS THIS YOUR FIRST EPISODE OF PAIN ________ YES________NO________

USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW

KEY:

A-ACHE | B-BURNING | N-NUMBNESS
P-PINS & NEEDLES | S-STABBING | O-OTHER



ARWA CHIROPRACTIC

OVER PLEASE

For Doctor's Use:
Chief complaint (other than neck or low back pain): ____________________

____

(For neck conditions use the Neck Pain Disability Index Questionnaire for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire)

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NEW PATIENT FORM

Date: mm / dd / 20

Name:

Address: Street
City St Zip

SSN:
Marital Status:
Gender: F M

Age:
Height: ' "
Weight: lbs
Shoe Size:

Home Phone: ( )
Cell Phone: ( )
Work Phone: ( )
Email:

Birth Date: / /

Emergency Contact: ( )
Name Phone

May we Friend you on Facebook? YES NO

Referred by:
Reason for visit:
How long have you had this condition?
Is it getting worse?
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?

Does it affect your:
Sleep YES NO
Work YES NO
Other YES NO
Describe

Are you under the care of a physician now? YES NO Physician Name: Phone #: ( )
Other concurrent therapies? YES NO If YES describe:

Family Medical History

- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Cancer (Describe)
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Stroke

Your Past Medical History

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (Your own Birth)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke

Surgery (list)

Thyroid Disorders

Major Trauma (list)

- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other (Specify)

Your Diet

Appetite ☐ Low ☐ High

☐ Coffee ☐ Soft Drinks ☐ Artificial Sweetener ☐ Sugar ☐ Salty Food

Thirst for water?
glasses per day ______ 8 oz glasses

Average daily menu

Morning	Snack	Noon	Snack	Evening

Drug List: list all drugs taken in the last two months including over-the-counter drugs, vitamins and supplements

Name	Dosage	Frequency	Reason

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Your Lifestyle

- [ ] Alcohol Use
- [ ] Tobacco
- [ ] Marijuana
- [ ] Illegal Drugs
- [ ] Stress
- [ ] Occupational Hazards

Regular Exercise
Type ______ Frequency ______
Type ______ Frequency ______

General Symptoms

- [ ] Poor Appetite
- [ ] Heavy Appetite
- [ ] Strongly like cold drinks
- [ ] Strongly like hot drinks
- [ ] Recent weight loss/gain
- [ ] Poor Sleep
- [ ] Heavy Sleep
- [ ] Dream-Disturbed Sleep
- [ ] Fatigue
- [ ] Lack of Strength
- [ ] Bodily Heaviness
- [ ] Cold Hands or Feet
- [ ] Poor Circulation
- [ ] Shortness of Breath
- [ ] Fever
- [ ] Chills
- [ ] Night Sweats
- [ ] Sweat Easily
- [ ] Muscle Cramps
- [ ] Vertigo or Dizziness
- [ ] Bleed or Bruise easily
- [ ] Peculiar Taste (Describe)
- [ ] ______

Head, Eyes, Ears, Nose, Throat

- [ ] Glasses
- [ ] Eye Strain
- [ ] Eye Pain
- [ ] Red Eyes
- [ ] Itchy Eyes
- [ ] Spots in Eyes
- [ ] Poor Vision
- [ ] Blurred Vision
- [ ] Night Blindness
- [ ] Glaucoma
- [ ] Cataracts
- [ ] Teeth Problems
- [ ] Grinding Teeth
- [ ] TMJ
- [ ] Facial Pain
- [ ] Gum Problems
- [ ] Sores on lips or tongue
- [ ] Dry Mouth
- [ ] Excessive Salivation
- [ ] Sinus Problems
- [ ] Recurring Sore Throat
- [ ] Swollen Glands
- [ ] Lumps in Throat
- [ ] Enlarged Thyroid
- [ ] Nose Bleeds
- [ ] Ringing in Ears
- [ ] Poor Hearing
- [ ] Earaches
- [ ] Headaches
- [ ] Migraines
- [ ] Concussion
- [ ] Excessive Phlegm
- [ ] Color of Phlegm
- [ ] Other head or neck problems (Describe) ______

Respiratory

- [ ] Difficulty Breathing When Lying Down
- [ ] Shortness of breath
- [ ] Tight Chest
- [ ] Asthma/Wheezing
- [ ] Cough (please circle)
  Wet or Dry
  Thick or Thin

Color of Phlegm: ______

- [ ] Coughing Blood
- [ ] Pneumonia

Cardiovascular

- [ ] High Blood Pressure
- [ ] Blood Clots
- [ ] Low Blood Pressure
- [ ] Fainting
- [ ] Chest Pain
- [ ] Difficulty Breathing
- [ ] Tachycardia
- [ ] Heart Palpitations
- [ ] Phlebitis
- [ ] Irregular Heart Beat

Gastrointestinal

- [ ] Nausea
- [ ] Vomiting
- [ ] Acid Regurgitation
- [ ] Gas
- [ ] Hiccup
- [ ] Bloating
- [ ] Bad Breath
- [ ] Diarrhea
- [ ] Constipation
- [ ] Laxative Use
- [ ] Black Stools
- [ ] Bloody Stools
- [ ] Mucous in Stools
- [ ] Intestinal Pain or cramping

Bowel Movements
Frequency: ______ times per day Texture/Form: ______
Color: ______ Odor: ______

Musculoskeletal

- [ ] Neck/Shoulder Pain
- [ ] Muscle Pain
- [ ] Upper Back Pain
- [ ] Low Back Pain
- [ ] Joint Pain
- [ ] Rib Pain
- [ ] Limited Range of Motion
- [ ] Limited Use
- [ ] Other (Describe) ______

Skin and Hair

- [ ] Rashes
- [ ] Hives
- [ ] Ulcerations
- [ ] Eczema
- [ ] Psoriasis
- [ ] Acne
- [ ] Dandruff
- [ ] Itching
- [ ] Hair Loss
- [ ] Change in Hair/Skin Texture
- [ ] Fungal Infections
- [ ] Other Hair or Skin Problems ______

Neuropsychological

- [ ] Seizures
- [ ] Numbness
- [ ] Tics
- [ ] Poor Memory
- [ ] Depression
- [ ] Anxiety
- [ ] Irritability
- [ ] Easily Stressed
- [ ] Abuse Survivor
- [ ] Considered/Attempted Suicide
- [ ] Seeing a Therapist
- [ ] Other (Describe) ______

Genito-Urinary

- [ ] Pain on Urination
- [ ] Frequent Urination
- [ ] Urgent Urination
- [ ] Blood in Urine
- [ ] Unable to Hold Urine
- [ ] Incomplete Urination
- [ ] Venereal Disease
- [ ] Bedwetting
- [ ] Wake to Urinate
- [ ] Increased Libido
- [ ] Decreased Libido
- [ ] Kidney Stone
- [ ] Impotence
- [ ] Premature Ejaculation
- [ ] Nocturnal Emission

Gynecology

- [ ] Age Menses began
- [ ] Length of Cycle (Day 1 to Day 1)
- [ ] Duration of Flow
- [ ] Irregular Periods
- [ ] Painful Periods
- [ ] PMS
- [ ] Vaginal Discharge
- [ ] Color: ______
- [ ] Vaginal Sores
- [ ] Vaginal Odor
- [ ] Clots
- [ ] Breast Lumps

Pregnancies: ______
Live Births: ______
Premature Births: ______
Age at Menopause: ______

Date of last PAP ______
Date Last Period Began ______

Other:
______

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ASSIGNMENT OF BENEFITS AND PAYMENTS

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

All payments are expected at the time of service or as already agreed upon by an authorized payment plan. Balance unpaid 90 days after services are rendered become the patient's responsibility and will be considered delinquent. Payments may apply to balances including but not limited to co-pays, deductibles, co-insurance and services or charges not paid by insurance for any reason.

Your personal balance may not exceed $100. If for any reason your check or credit card gets declined there will be a charge of $25 applied to your balance. If your balance is overdue 90 days there will be a late fee charge of $25 added to your balance. If for any reason you need to cancel an appointment, we kindly request a 24hr notice prior to your appointment. A less than 24hr notice will result in a $25 charge.

I authorize payment for services rendered to me or my dependents to be paid directly to Arwa Chiropractic P.C. from my insurance company, my attorney, or any other party who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled. I understand that all charges incurred are the personal responsibility of the patient/guarantor. Commercial insurance is filed as a courtesy to the patient, and managed care insurance is filed with contracted carrier. The patient/guarantor is responsible for all residual balances including but not limited to co-pays, deductibles, co-insurance and services or charges not paid by insurance for any reason, after consideration of contractual adjustments.

In the event any insurance company, attorney, or other person obligated by contractual agreement to make payment to me for your service charges, refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against such company, attorney, or person and authorize you to prosecute said action either in my name or your name or for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account.

I hereby direct my attorney not to interfere with or claim any lien upon, any medical payment benefits to which I may be entitled from either my health insurance or medical payment sources. And if any said medical payment checks include my attorney's name, I direct my attorney to sign his name to these checks for the benefit of the medical provider herein.

In the event that this account goes into default and our office turns it over to our outside collections agency/attorney for collections, it is accepted and agreed that thirty percent (30%) of the principal amount of the balance due will be added as collection/attorney fees.

It is also agreed and accepted that in the event that a lawsuit is filed, you, the patient will be liable for any and all court costs expended whether judgment has been entered or not.

ASSIGNMENT OF BENEFITS AND PAYMENTS

I ______________________________ (Print Name) authorize Arwa Chiropractic P.C. and it's physicians to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment including disability related information to any third party payer (including Medicare), or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

SIGNATURE: ______________________________ DATE: ______ / ______ / ______