



**Personal Information**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female

Parents: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Parents Cell: \_\_\_\_\_

Email address for educational info & clinic announcements: \_\_\_\_\_  
We maintain full confidentiality of this information

Race (circle one): American Indian or Alaska native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_  
Physician Friend Family Newspaper Radio Health Fair Health Talk

**Health History**

Hospitalizations (other than birth) YES NO  
If Yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Birth Weight: \_\_\_\_\_ Current Weight: \_\_\_\_\_  
Birth Length: \_\_\_\_\_ Current Length: \_\_\_\_\_

If in diapers, how many diapers per day are:  
Wet \_\_\_\_\_ Dirty \_\_\_\_\_

APGAR Score: (if known) \_\_\_\_\_

Current medications? \_\_\_\_\_

Hours of sleep per night: \_\_\_\_\_

Any antibiotics since birth? YES NO  
If so, how many? \_\_\_\_\_

**MOM:**  
Any problems during pregnancy? \_\_\_\_\_  
Any problems during delivery? \_\_\_\_\_

At what age did the child walk? \_\_\_\_\_  
At what age did the child crawl? \_\_\_\_\_

Immunization History: \_\_\_\_\_  
\_\_\_\_\_

History of: (please circle any that apply)  
ear infections colic jaundice  
cyanosis congenital abnormalities

Has your child been exposed to any toxins? YES NO

Please list sports or leisure activities your child is involved in:  
\_\_\_\_\_

Medical Pediatrician: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Purpose: \_\_\_\_\_

CONFIDENTIAL

CHILDREN (0-12) HEALTH HISTORY

**What medication/vitamins are you currently taking?** (please include regularly used over the counter medications)

Medication/Vitamin Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

**Do you have any medication allergies?**

Medication	Reaction	Onset Date	Additional Comments

**I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

## Eating Habits

Does your child eat a balanced diet? YES NO

How much water per day does your child drink? \_\_\_\_\_

## Clinical Information

What is the nature of today's visit? \_\_\_\_\_

How long has this concerned you? \_\_\_\_\_

How would you rate your concern over this issue? (1 to 10 scale) \_\_\_\_\_

Would you consider your child to be developing at a normal rate? YES NO

Have you noticed any developmental issues with your child?

colic breathing problems sleep disturbance allergic reactions chronic infections

colds sore throats ear infections/aches fevers asthma tonsillitis allergies

bed-wetting infections pains falls stomach-aches cyanosis congenital abnormalities

other: \_\_\_\_\_

## Billing Information

Please check any and all insurance coverage that may be applicable in this case

Who will be responsible for your bill?    Self    Spouse    Parent-Guardian    Other

Major Medical     Worker's Compensation     Medicare     Auto Accident     Other

Name of insurance company \_\_\_\_\_

Name of insured (card holder) \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Insured's (card holder's) Social Security Number \_\_\_\_\_

We will make every effort to help you receive the maximum benefit from your insurance. However, **please remember that your insurance is a contract between you and the insurance company.** We urge you to contact your insurance company to find out *your* benefits.

## A note from the doctor

Dear Parents (Guardian):

Welcome and thank you for the opportunity to serve your family's health needs. It's most important to understand that chiropractic is not a treatment for disease. Its purpose is to remove spinal nerve stress disorder (known clinically as a "subluxation") - a serious and often painless condition many children (and adults) have in their bodies. Spinal nerve stress disorder can interfere with the proper function of the nervous system, can weaken internal organs and organ systems, lower resistance, reduce healing potential and set the stage for sickness and disorders of all kinds. Chiropractic adjustments are the primary treatment for this condition.

When a chiropractic adjustment frees the nervous system from spinal stress syndrome/disorder, the healing power of the body can become more pronounced: the immune system functions more efficiently, resistance to disease increases, and your child's body can function more efficiently. Your child may respond more efficiently to internal and external environmental stresses such as germs, changes in temperature, humidity, toxins, pollen and all the other stresses with which he/she comes in contact with.

So although children with diseases are often brought to the chiropractor, the chiropractic adjustment is not treating their diseases, but is instead freeing them of spinal nerve stress disorder, thus permitting their body's natural healing potential to function at its full human potential.



Dr. Jonah McCandless  
Clinic Director  
Chiropractic Physician

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# OSWESTRY-LOW BACK

This questionnaire is designed to enable our doctors to understand how much your low back pain has affected your ability to manage your everyday activities.

PLEASE CHECK  ONE ANSWER IN EACH SECTION THAT MOST APPLIES

Name \_\_\_\_\_

## 1. PAIN INTENSITY

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

## 2. PERSONAL CARE

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

## 3. LIFTING

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

## 4. WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than 1/4 mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk while using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

## 5. SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

## 6. STANDING

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 1/2 hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

## 7. SLEEPING

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours' sleep.
- Because of pain I have less than 4 hours' sleep.
- Because of pain I have less than 2 hours' sleep.
- Pain prevents me from sleeping at all.

## 8. SOCIAL LIFE

- My social life is normal and causes me no extra pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sport, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of the pain.

## 9. SEX LIFE

- My sex life is normal and causes me no extra pain.
- My sex life is normal, but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

## 10. TRAVELING

- I can travel anywhere without pain.
- I can travel anywhere but I gives extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treat-

CONFIDENTIAL

OSWESTRY PAIN DISABILITY INDEX QUESTIONNAIRE

Patient or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



# NECK PAIN

This questionnaire is designed to enable our doctors to understand how much your neck pain has affected your ability to manage your everyday activities.

PLEASE CHECK  **ONE** ANSWER IN EACH SECTION THAT MOST APPLIES

Name \_\_\_\_\_

## 1. PAIN INTENSITY

- No pain at the moment
- Very mild at the moment
- Moderate at the moment
- Fairly severe at the moment
- Very severe at the moment
- Worst imaginable at the moment

## 2. PERSONAL CARE

- Normal without extra pain
- Normal with extra pain
- Painful and I'm slow / careful
- Manage most of my personal care with some help
- Need help every day in most aspects of self care
- Do not get dressed, wash with difficulty & stay in bed

## 3. LIFTING

- Lift heavy weights, without extra pain
- Lift heavy weights, with extra pain
- Lift heavy items from a table, but not the floor
- Lift moderate items from a table, but not the floor
- Lift very light weights
- Cannot lift or carry anything

## 4. READING

- As much as I want with no pain
- As much as I want with slight pain
- As much as I want with moderate pain
- Moderate pain prevents reading as much as I want
- Sever pain prevents reading as much as I want
- Cannot read at all

## 5. HEADACHES

- No headaches
- Slight headaches infrequently
- Moderate headaches infrequently
- Moderate headaches frequently
- Sever headaches frequently
- Constant headaches

## 6. CONCENTRATION

- Fully concentrate with no difficulty
- Fully concentrate with slight difficulty
- Fair degree of difficulty concentrating
- Lot of difficulty concentrating
- Extreme difficulty concentrating
- Cannot concentrate at all

## 7. WORK

- Work as much as I want
- Can do usual work, but no more
- Can do most of my usual work, but no more
- Cannot do my usual work
- Can hardly do any work at all
- Cannot do any work

## 8. DRIVING

- Drive without pain
- Drive as long as I want with slight pain
- Drive as long as I want with moderate pain
- Cannot drive as long as I want due to moderate pain
- Hardly drive at all due to severe pain
- Cannot drive at all

## 9. SLEEPING

- No trouble sleeping
- Sleep is mildly disturbed (less than 1 hour sleepless)
- Sleep is mildly disturbed (1-2 hours sleepless)
- Sleep is moderately disturbed (2-3 hours sleepless)
- Sleep is greatly disturbed (3-5 hours sleepless)
- Sleep is completely disturbed (5-7 hours sleepless)

## 10. RECREATION

- Can do all recreational activities with no pain
- Can do all recreational activities with some pain
- Can do most recreational activities with some pain
- Can do a few recreational activities with some pain
- Can hardly do any recreational activities
- Cannot do any recreational activities

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONFIDENTIAL**

**NECK PAIN DISABILITY INDEX QUESTIONNAIRE**



## INFORMED CONSENT FOR CHIROPRACTIC CARE

### WHAT TYPE OF CARE ARE YOU SEEKING?

- WELLNESS:** Improving overall general health in the absence of acute symptoms.
- NUTRITIONAL THERAPY:** Promoting optimal health through education, goal setting, supplement recommendations and active lifestyle.
- CORRECTIVE:** Restoring underlying problems while improving symptoms and decreasing pain.
- MASSAGE THERAPY:** Enhance function, aid in the healing process, and promote relaxation and well-being.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care.

The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at McCandless Chiropractic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor(s) at McCandless Chiropractic deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

\_\_\_\_\_  
 Patient Name (printed)                      Patient Name (signature)                      Date

\_\_\_\_\_  
 Legal Guardian Signature                      Relationship to patient                      Date

\_\_\_\_\_  
 Witness Signature (office staff)                      Date

**McCandless Chiropractic LLC (Bel-Ray Wellness Center)**

**Acknowledgement of Receipt of  
Notice of Privacy Practices**

*This form will be retained in your medical record.*

**NOTICE TO PATIENT**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of McCandless Chiropractic LLC (Bel-Ray Wellness Center).

\_\_\_\_\_  
*Patient's Signature or that of Legal Representative*

\_\_\_\_\_  
*Printed Name of Patient or that of Legal Representative*

\_\_\_\_\_  
*Today's Date*

\_\_\_\_\_  
*If Legal Representative, Indicate Relationship*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement
- Communications barriers prohibited obtaining the acknowledgement
- Other (please specify): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Employee Name*

\_\_\_\_\_  
*Today's Date*



## X-RAY CONSENT FORM

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

During your examination, the doctor may decide that x-rays will be needed in order to help further diagnose your condition and determine the correct treatment. Our clinic requires the patient's or legal guardian's consent before any x-ray procedure is performed.

**Please choose ONE:**

\_\_\_\_\_ I understand that my doctor may need x-rays in order to better diagnose my condition and I give permission of all needed diagnostic tests.

\_\_\_\_\_ I understand that my condition may require my doctor to take x-rays to further diagnose my condition. I choose **NOT** to have any x-rays at this time and release my doctor of all liabilities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FEMALES ONLY:**

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam.

With those factors in mind, I am advising my doctor that:

I am pregnant \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ I'm not sure

My menstrual period is late \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ I'm not sure

I have an IUD \_\_\_\_\_ Yes \_\_\_\_\_ No

I have had a tubal ligation \_\_\_\_\_ Yes \_\_\_\_\_ No

I have had a hysterectomy \_\_\_\_\_ Yes \_\_\_\_\_ No

I have irregular menstrual periods \_\_\_\_\_ Yes \_\_\_\_\_ No

I have begun menopause \_\_\_\_\_ Yes \_\_\_\_\_ No

My last menstrual period began \_\_\_\_\_

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if my doctor deems it necessary.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Making Remembering Your Appointment Easier

McCandless Chiropractic will now be sending out reminders for your appointment via text or email.

Choose ONE of the following:

Reminder Text      *Carrier:* \_\_\_\_\_ *Cell #:* \_\_\_\_\_

Reminder Email      *Email:* \_\_\_\_\_

You will have a choice when you would like to receive your reminder before your appointment.

Choose ONE of the following:

- |                                     |                                     |                                  |                                 |
|-------------------------------------|-------------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> 5 minutes  | <input type="checkbox"/> 30 minutes | <input type="checkbox"/> 2 hours | <input type="checkbox"/> 2 days |
| <input type="checkbox"/> 10 minutes | <input type="checkbox"/> 45 minutes | <input type="checkbox"/> 4 hours | <input type="checkbox"/> 1 week |
| <input type="checkbox"/> 15 minutes | <input type="checkbox"/> 1 hour     | <input type="checkbox"/> 1 day   |                                 |

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_