Patient Name: _____ Date: _____

# Application for Patient Care

**PRIMARY COMPLAINTS: Please list in order of most severe (#1) to least severe (#4).** *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.*

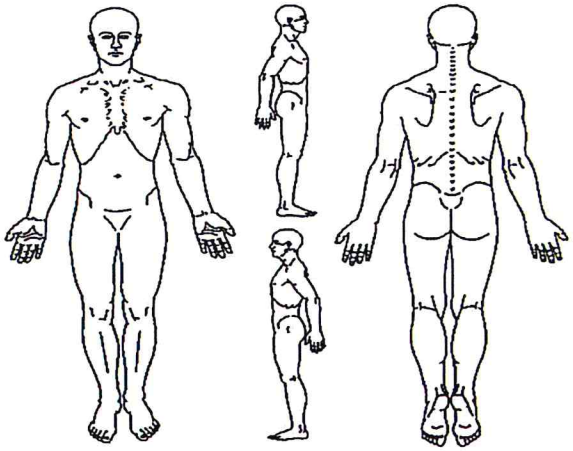
MOST SEVERE ◄——————————————► LEAST SEVERE

| You have the following complaints (WRITE-IN) | 1. | 2. | 3. | 4. |
|---|---|---|---|---|
| Circle the word that best describes this complaint. | Sharp dull achy throbbing numb shooting other | Sharp dull achy throbbing numb shooting other | Sharp dull achy throbbing numb shooting other | Sharp dull achy throbbing numb shooting other |
| How often do you feel this complaint? | Constant Daily Weekly "Off and On" | Constant Daily Weekly "Off and On" | Constant Daily Weekly "Off and On" | Constant Daily Weekly "Off and On" |
| How long have you had this complaint? | ____ Days / Weeks / Months / Years | ____ Days / Weeks / Months / Years | ____ Days / Weeks / Months / Years | ____ Days / Weeks / Months / Years |
| Is it getting better, worse, or staying the same? | Better Worse Same | Better Worse Same | Better Worse Same | Better Worse Same |
| What makes it better, if anything? | | | | |
| What makes it worse, if anything? | | | | |
| On a scale of 0 – 10, rate your discomfort. *(0 = no pain, 10 = excruciating)* | **Circle response** 0 1 2 3 4 5 6 7 8 9 10 | **Circle response** 0 1 2 3 4 5 6 7 8 9 10 | **Circle response** 0 1 2 3 4 5 6 7 8 9 10 | **Circle response** 0 1 2 3 4 5 6 7 8 9 10 |
| How have you taken care of this in the past? Has that worked for you? | | | | |
| Circle the ways this issue is affecting your life. *(all that apply)* | job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity | job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity | job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity | job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity |
| Improving this issue in my life would improve my quality of life by: *(Circle best response)* | 10-20% 30-40% 50-60% 70-80% 90% 100% | 10-20% 30-40% 50-60% 70-80% 90% 100% | 10-20% 30-40% 50-60% 70-80% 90% 100% | 10-20% 30-40% 50-60% 70-80% 90% 100% |

## PATIENT HEALTH HISTORY

***Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:***

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Loss of Taste
- ❑ Nervousness
- ❑ Jaw Problems
- ❑ Loss of Smell
- ❑ Blurred/Double Vision
- ❑ Mood Changes
- ❑ Foot Trouble
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weigh Change
- ❑ Loss of Memory
- ❑ Cold Extremities
- ❑ Sleeping Difficulties
- ❑ Bowel/Bladder Changes
- ❑ Constipation/Diarrhea
- ❑ Swollen Joints
- ❑ Trouble Concentrating
- ❑ Loss of Balance
- ❑ Nausea
- ❑ Night Pain
- ❑ Fatigue
- ❑ Fever
- ❑ Tension
- ❑ Chest Pain
- ❑ Asthma
- ❑ Cold Sweats
- ❑ Dizziness
- ❑ Fainting



## PATIENT HEALTH HISTORY continued.... *Please check if you have ever had any of the following:*

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure: High or Low (circle)
- ❑ Breast Lump
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Colon Trouble
- ❑ Contacts/Glasses
- ❑ Depression
- ❑ Diabetes
- ❑ Dry Skin
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Fractures
- ❑ Gall Bladder
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hormone/Gland Problems
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Measles
- ❑ Menopausal Prob.
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mouth Sores or Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexual Difficulty
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ TMJ Pain
- ❑ Tonsillitis
- ❑ Tremors
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other: _____

_____

_____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any and all medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

**ALLERGIES: (Please place a check mark next to any known allergy that you have.)**

___ Milk ___Eggs ___Peanuts ___Almonds ___Cashews ___Walnuts ___ Fish ___ Shellfish ___Soy ___Wheat ___ Gluten ___Penicillin ___Sulfa Drugs ___Tetracycline ___Codeine ___NSAIDS ___Phenytoin ___Carbamazepine ___Mildew ___Mold ___ Dust ___Fungus ___Mites ___Tree Pollen ___Grass Pollen ___Weed Pollen ___Insects ___Dog Dander ___Cat Dander ___Latex ___Other Animal Dander ___ OTHER: _____ *(please fill in)*

~~Please list any supplements you are currently taking (vitamins/herbs/minerals):~~ _____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease_____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach Do you use a cervical pillow? ❑ Yes ❑ No

What is your daily/weekly intake of the following: Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes _____ pks/day

**I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.**

**Signature (X)** _____ **Date**_____

# Allergy, Food & Chemical Sensitivity Survey

Gender: M / F Height: Feet _____Inches _____ Weight: _____lbs.

***Please complete the following allergy, food and chemical sensitivity questionnaire. Score each symptom based upon your experiences over the last 90 days. Circle appropriate number 0-5 according to severity.***

***0=No Problem at All***
***1=Extremely Mild Symptoms***
***2=Mild to Moderate Symptoms Occasionally***
***3=Moderate Symptoms Frequently***
***4=Moderate to Severe Symptoms***
***5=Very Severe Symptoms***

**Digestive Symptoms**
0 1 2 3 4 5 Stomach Pains or Cramping
0 1 2 3 4 5 Constipation
0 1 2 3 4 5 Diarrhea
0 1 2 3 4 5 Reflux or Heartburn
0 1 2 3 4 5 Bloating
0 1 2 3 4 5 Gas
0 1 2 3 4 5 Nausea or Vomiting

**Weight**
0 1 2 3 4 5 Inability to Lose Weight
0 1 2 3 4 5 Food Cravings
0 1 2 3 4 5 Binge Eating
0 1 2 3 4 5 Water Retention

**Sinus/Respiratory**
0 1 2 3 4 5 Stuffy or Runny Nose
0 1 2 3 4 5 Asthma
0 1 2 3 4 5 Chest Congestion
0 1 2 3 4 5 Chronic Cough
0 1 2 3 4 5 Wheezing
0 1 2 3 4 5 Frequent Sneezing or Nasal Discharge

**Head/Ears**
0 1 2 3 4 5 Migraines
0 1 2 3 4 5 Headaches
0 1 2 3 4 5 Earaches
0 1 2 3 4 5 Sinus or Ear Infections
0 1 2 3 4 5 Ringing in Ears

**Eyes/Throat**
0 1 2 3 4 5 Itchy Eyes
0 1 2 3 4 5 Watery Eyes
0 1 2 3 4 5 Sore Throats or Colds
0 1 2 3 4 5 Persistent Canker Sores

**Emotional/Mental**
0 1 2 3 4 5 Depression
0 1 2 3 4 5 Anxiety
0 1 2 3 4 5 Mood Swings
0 1 2 3 4 5 Irritability
0 1 2 3 4 5 Poor Concentration/Memory

**Energy**
0 1 2 3 4 5 Fatigue
0 1 2 3 4 5 Hyperactivity
0 1 2 3 4 5 Lethargy
0 1 2 3 4 5 Restlessness
0 1 2 3 4 5 Insomnia

**Skin Disorders**
0 1 2 3 4 5 Eczema
0 1 2 3 4 5 Dermatitis
0 1 2 3 4 5 Excessive Sweating
0 1 2 3 4 5 Rashes
0 1 2 3 4 5 Hives

**Other Symptoms:**
0 1 2 3 4 5 Joint Pain
0 1 2 3 4 5 Arthritis
0 1 2 3 4 5 Irregular Heartbeat
0 1 2 3 4 5 Chest Pains
0 1 2 3 4 5 Muscle Aches

Please list any symptoms not mentioned above:

_____

_____

**TOTAL SCORE: _____**

## TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the x-rays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

*I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to 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 this amount.*

I, _____ have read and fully understand the above statements.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

**FOR MINORS:** I, _____ being the parent or legal guardian of _____,
*(Print Guardian Name)* *(Print Minor's Name)*
have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

_____ _____
(SIGNATURE) (DATE)

**X-ray Questionnaire: For women only** Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual period: _____

☐ There is a possibility that I a may be pregnant at this time ☐ Yes, I am definitely pregnant
☐ No, I am definitely not pregnant at this time ☐ I request that x-ray films not be taken because:

_____ _____
Patient's Signature Date

## NEUROLOGICAL/MRI/VASCULAR PATIENT QUESTIONNAIRE

1. Weakness, numbness or burning in your shoulder, arms or hands? NO YES
2. Do your hands or arms fall asleep regularly? NO YES
3. Reduced feeling (sensation) or swelling in your hands or arms? NO YES
4. Loss of handgrip strength? NO YES
5. Weakness, numbness or burning in your buttocks, legs or feet? NO YES
6. Do our legs or feet fall asleep regularly? NO YES
7. Reduced feeling (sensation) or swelling in your legs, feet? NO YES
8. Cold Hands/Feet? NO YES
9. Have you had an MRI? NO YES

If yes to MRI, When? Who ordered it? What was it ordered for?

_____
_____
_____

## PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

SS#: _____-_____-_____ Age: _____ DOB: __ __ /__ __ /__ __ Male / Female

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

Occupation: _____ Employer: _____

Type of Tasks Performed/Common Movements: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name: _____ # of Children? _____ Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker Preferred Language: _____

**Race (Circle one)**: American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

## ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies) : ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Physical Therapy ☐ Chiropractic Care ☐ or Pain Management ☐? Last Visit: _____

## REFERRALS

How Did You Hear About This Office? ☐ Existing Patient: _____ ☐ Walk-In/Drive-By

☐ Ins. Co _____ ☐ Internet: _____

☐ Attorney: _____ ☐ Community Event: _____

☐ Doctor: _____ ☐ Other: _____

## INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

***Assignment and Release*** **Method of payment for today's charges: ___Cash ___Check ___Visa / MC**

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Yucha Medical Pain Management & Chiropractic Rehabilitation, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

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 care.)

**SIGNATURE (X)** _____ **DATE** _____

# PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient Yucha Medical Pain Management & Chiropractic Rehabilitation, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: DR. RANDY YUCHA. If you would like further information about our privacy policies and practices please contact: DR. RANDY YUCHA.

This notice is effective as of June 21, 2016. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

| _____ | _____ | _____ |
|---|---|---|
| *Name (Print)* | *Signature* | *Date* |

# Neck Index

Form N1-100

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.

## 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.

## 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).

## 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.

## 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.

## 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.

## 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.

## 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.

## 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.

## 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

Form BI100

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.

## 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.

## 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.

## 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.

## 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.

## 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.

## 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.

## 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.

## 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.

## 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* _____

YUCHA
MEDICAL PAIN MANAGEMENT & CHIROPRACTIC REHABILITATION

Due to the **HIPAA Compliance Privacy Laws of the federal government,** it is mandatory that we ask you to review and answer the following questions:

Name:_____ Home Phone:_____ Cell:_____

May we leave messages/detailed medical information on voicemail at either of these phone numbers:

Home: Yes_____ No_____ Cell: Yes_____ No_____

May we contact you at work: Yes_____ No_____ Work Number:_____

May we leave a message for you at work: Yes_____ No_____

Do you authorize us to discuss your personal health information with any particular person (family or otherwise):

This could include general, imaging or billing information: Yes_____ No_____

If yes, please complete:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

I hereby authorize Yucha Medical Pain Management & Chiropractic Rehab physicians and staff to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from any other health care providers, laboratories, imaging facilities, or other institutions.

***THIS AUTHORIZATION REMAINS IN EFFECT UNTIL REVOKED***

I have reviewed the aforementioned information and provide my consent regarding any and all issues as stated above. I have reviewed the Yucha Medical Pain Management & Chiropractic Rehab HIPAA PRIVACY POLICY. A copy of the policy will be provided to me upon request.

Patient Signature:_____ Date:_____

If not signed by patient, relationship to patient:_____

Witnessed by:_____

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CHIROPRACTIC REHABILITATION

# Authorization to Receive Automatic Appointment Reminders

Complete this form and sign below to give Yucha Medical Pain Management & Chiropractic Rehabilitation permission to send automatic appointment reminders by email or cell phone text message.

Patient Name: _____

**Mark all that apply:**

_____ **Text Message Option**

Yucha Medical Pain Management & Chiropractic Rehabilitation may send cell phone text messages to confirm my upcoming appointment/s. Text messages should be sent to:

_____

*(text messaging rates may apply)*

_____ **Email Option**

Yucha Medical Pain Management & Chiropractic Rehabilitation may send emails to confirm my up coming appointment/s. Emails should be sent to:

_____

_____ **OPT OUT**

Do not send me appointment reminders

_____ _____

Signature Date