Chiropractic Little Rock
Dr. William Carbary, DC PA
Patient Information Form

Name:_____**SS#:**_____

Address:_____**City/State/Zip:**_____

Home Phone: _____**Cell Phone:** _____ **Fax number:** _____

Date of Birth:_____ **Age:**_____**E-Mail address:** _____

(Chiropractic Little Rock will be using email to keep in touch with patients. We never rent or sell your email addresses, and it will always be kept private. Providing this information constitutes your permission for Chiropractic Little Rock to contact you regarding information via mail, e-mail, fax, or phone.)

Occupation:_____**Employer:**_____

Marital Status: S M D W Spouse Name:_____

Spouse Occupation:_____ **Number of Children/Ages:**_____

Referred By: (Friend) (Relative) (Google) (Yellow Pages) (Sign) (Other:_____)

Which one of our patient's should we thank for referring you?_____

Primary Care physician (PCP): _____

PCP Address: _____

PCP Phone: _____

Insurance Information/Method of Payment

- **Cash**
- **Check**
- **Credit Card**

Insurance Company:_____**Claim Representative:**_____

Policy#_____**Group#**_____**Claim#**_____

I hereby authorize Chiropractic Little Rock (Dr. William Carbary, DC) to release health care or other information to process insurance claims. I hereby authorize payment for health care services to the aforementioned provider/health care facility.

Patient, Parent or Guardian Signature_____**Date**_____

Symptoms and Present State of Health

Previous years of unnoticed and or unattended damage to the nervous system and spine may show up as acute or chronic symptoms.

Present Complaint/Reason for Seeking Care in this Office:

Major_____

Pain or Problem started on_____

Pains are: O Sharp O Dull/ Ache O Constant O Intermittent O Other_____

Does this pain shoot, radiate, or travel in your body? Where?_____

Are you experiencing numbness or tingling in any area of your body? Where?_____

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day?_____

Is this condition interfering with work?_____ Sleep?_____Routine?_____Other?_____

Is this condition progressively getting worse?_____

Other Doctors seen for this condition_____

Any home remedies? _____

Please Circle a measurement of pain on the scale:

(No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Please mark any of the following that you are presently experiencing or have experienced in the past. Check appropriate circles and put a pa (for "past") or a pr (for "present") after symptom.

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste

Have you ever smoked? Yes or No Currently Smoking? Yes or No

If yes, frequency used? _____

List any medications you currently take (prescription and over-the-counter):

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

Have you ever had surgery/been under anesthesia? YES NO
If YES, please list operations/procedures:

1. _____ When?_____
2. _____ When?_____
3. _____ When?_____

Is there a family History of:	Heart Disease	Arthritis	Cancer	Diabetes
Father's side	O	O	O	O
Mother's side	O	O	O	O

Other: _____

Females Only – Date last of Menstrual Period:_____ Are you possibly Pregnant?:YES/NO

This page and next page relate to how your health related condition is affecting your day to day life. If an area does not apply to you, or you do not want to answer the question, don't answer or put a NA next to the topic.

I. Driving

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

II. Lifting

1. I can **lift** heavy weights without causing extra pain.
2. Pain prevents me from **lifting** heavy weights off the floor but I can manage if they are conveniently positioned for example on a table.
3. Pain prevents me from **lifting** heavy weights but I can manage light to medium weights if they are conveniently positioned.
4. I can **lift** only very light weights.
5. I cannot **lift** or carry anything at all.

III. Reading

1. I can **read** as much as I want to with no pain in my neck.
2. I can **read** as much as I want to with slight pain in my neck.
3. I can **read** as much as I want to with moderate pain in my neck.
4. I cannot **read** as much as I want to because of moderate pain in my neck.
5. I cannot **read** as much as I want to because of severe pain in my neck
6. I cannot **read** at all.

IV. Sex Life

1. My **sex life** is normal and causes no extra pain.
2. My **sex life** is normal but causes some extra pain.
3. My **sex life** is nearly normal but is very painful.
4. My **sex life** is severely restricted by pain.
5. My **sex life** is nearly absent because of pain.
6. Pain prevents any **sex life** at all.

V. Sitting

1. I can **sit** in any chair as long as I like.
2. I can only **sit** in my favorite chair as long as I like.
3. Pain prevents me **sitting** more than 1 hour.
4. Pain prevents me from **sitting** more than 0.5 hours.
5. Pain prevents me from **sitting** more than 10 minutes.
6. Pain prevents me from **sitting** at all.

VI. Sleeping

1. Pain does not prevent me from **sleeping** well.
2. I can **sleep** well only by using tablets.
3. Even when I take tablets I have less than 6 hours **sleep**.
4. Even when I take tablets I have less than 4 hours **sleep**.
5. Even when I take tablets I have less than 2 hours of **sleep**.
6. Pain prevents me from **sleeping** at all.

VII. Walking

1. Pain does not prevent me **walking** any distance.
2. Pain prevents me **walking** more than 1 mile.
3. Pain prevents me **walking** more than 0.5 miles.
4. Pain prevents me **walking** more than 0.25 miles.
5. I can only **walk** using a stick or crutches.
6. I am in bed most of the time and have to **crawl** to the toilet

VIII. Work

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

About Your Care

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (**Neurological Defense Pattern**). This care often reduces or eliminates the symptoms; then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me, or my child, with chiropractic care.

Patient, Parent or Guardian Signature_____Date_____

If you would like to have your spouse and/or children checked for structural dysfunction, check the box below and they/he/she can receive a complimentary examination within 2 wks of your starting care. This exam is at no cost to you and does not obligate them to receive future care.

☐ **Yes, I would like my family member(s) checked in the next two weeks**

Informed Consent for Chiropractic Care

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 one instance per one million and one per two million cervical spine neck adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, 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 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 deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____

(Date)

_____

(Print Name)

_____

(Signature)

_____

(Parent or legal guardian signature)

_____

Witness signature (office staff)