New Patient Case History- Dr. Della M. Schmid, PLLC

Name: ______________________________ **Date:** ______________________________

Address: ____

City: ______________________ State: ______________________ Zip: __________

Home Phone: _____-______-______ Work Phone: _____-_____-_______ Cell Phone: _____-_____-________

What number do you prefer calls? ☐ Home ☐ Work ☐ Cell

How do you want appointment reminders sent? ☐ Text ☐ Email

Preferred Language: ____

Email Address: ____

Date of Birth: ____

Gender/Identity: ☐ Male ☐ Female ☐ Other ☐ Not Disclosed

Marital Status: ☐ Single ☐ Married ☐ Other

Dominant Hand: ☐ Right ☐ Left

Occupation: ____

Employer: ______________________ Address: ______________________________

List your hobbies: ____

Emergency contact: ______________________________ Phone: ____________________

How did you hear about our office? ☐ Doctor ☐ Website ☐ Insurance ☐ Online Search ☐ Social Media

☐ Patient: ____________________ Other: ____________________

Have you ever had Chiropractic care? ☐ Yes ☐ No

Where? ____

Why? ____

When was your last visit? ____

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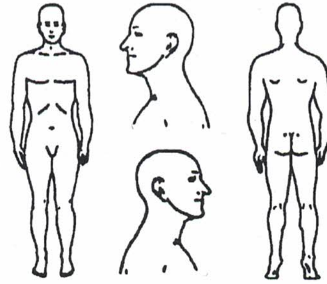
Name: ______________________________ **Date:** ______________________________

PLEASE MARK YOUR SYMPTOMS ON THE PICTURE

A = Ache
N = Numbness
T = Tingling
S = Stiffness
O = Other:______________



Height:__________ Weight:__________

1. **MAJOR COMPLAINT**? ______________________________ ☐ Left ☐ Right ☐ Both

Date began? ____________ **How?** ______________________________

Rate your pain: No pain: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Worst

Symptoms: ☐ None ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable

Describe your symptoms: ☐Sharp ☐Dull Ache ☐Numb ☐Burning ☐Shooting ☐Tingling ☐Tightness ☐Throbbing ☐Other ☐Radiating to: __________

Symptoms Frequency: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Goals: ☐ Become pain free ☐ Explanation of my condition ☐ Learn self-care ☐ Reduce symptoms ☐ Resume normal activity

What makes your pain better? ☐ Chiropractic ☐ Heat ☐ Ice ☐ Massage ☐ Medication ☐ Sleep/Rest ☐ Stretching ☐ Nothing ☐ Other: __________

What aggravates your condition? ______________________________

Is your condition changing? ☐Getting Better ☐Getting Worse ☐Not Changing

Have you had this condition in the past? ☐ Yes ☐ No **Treated by:** ______________ **Date:** __________ **XR / MRI / CT dates:** __________

2. **OTHER COMPLAINT**? ______________________________ ☐ Left ☐ Right ☐ Both

Date began? ____________ **How?** ______________________________

Rate your pain: No pain: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Worst

Symptoms: ☐ None ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable

Describe your symptoms: ☐Sharp ☐Dull Ache ☐Numb ☐Burning ☐Shooting ☐Tingling ☐Tightness ☐Throbbing ☐Other ☐Radiating to: __________

Symptoms Frequency: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Goals: ☐ Become pain free ☐ Explanation of my condition ☐ Learn self-care ☐ Reduce symptoms ☐ Resume normal activity

What makes your pain better? ☐ Chiropractic ☐ Heat ☐ Ice ☐ Massage ☐ Medication ☐ Sleep/Rest ☐ Stretching ☐ Nothing ☐ Other: __________

What aggravates your condition? ______________________________

Is your condition changing? ☐Getting Better ☐Getting Worse ☐Not Changing

Have you had this condition in the past? ☐ Yes ☐ No **Treated by:** ______________ **Date:** __________ **XR / MRI / CT dates:** ________

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Name:______________________________________ **Date:**____________________________

ALLERGIES				
☐ Animals	☐ Dust	☐ Latex	☐ Poison Ivy	☐ X-Ray Dye
☐ Bee Stings	☐ Gluten	☐ Molds	☐ Ragweed / Pollen	☐ Other:
☐ Dairy Products	☐ Grasses	☐ Peanuts / Tree Nuts	☐ Seasonal Allergies	

SURGERIES					
☐ Abdominal:	☐ Bladder	☐ Dermatology	☐ Gynecological	☐ Knee	☐ Shoulder
☐ Ankle	☐ Brain	☐ EENT	☐ Hand / Wrist	☐ Lumbar:	☐ Thyroid
☐ Appendix	☐ Caesarian Section	☐ Foot	☐ Heart:	☐ Lumpectomy / Mastectomy	☐ Tonsillectomy
☐ Arm	☐ Carpal Tunnel	☐ Gall Bladder	☐ Hip	☐ Neck:	Other:
☐ Back:	☐ Dental	☐ Gastrointestinal	☐ Hysterectomy	☐ Pacemaker	

MEDICAL HISTORY					
☐ ADD/ADHD	☐ Concussion	☐ GERD	☐ Joint Injury / Pain:	☐ Nausea / Vomiting – Persistent	☐ Shingles
☐ Alcoholism	☐ Constipation	☐ Gout	☐ Kidney	☐ Neck Pain	☐ Shoulder Pain
☐ Anemia	☐ COPD	☐ Gynecological/ Obstetrical: ____________	☐ Knee Pain	☐ Neurological Disorder: ____________	☐ Sinusitis
☐ Aneurysm	☐ Dental	☐ Hand Pain	☐ Leg Cramps	☐ Night Sweats	☐ Skin Disease
☐ Ankle Edema / Pain	☐ Depression	☐ Head Trauma	☐ Leg Pain	☐ Numbness / Tingling	☐ Sleeping Difficulty
☐ Anxiety	☐ Diabetes	☐ Headaches – Frequent	☐ Liver Disease	☐ Orthotics	☐ Stroke / TIA
☐ Appetite Loss	☐ Diarrhea	☐ Hearing Problems	☐ Low Back Pain	☐ Osteoporosis	☐ Swallowing Difficulty
☐ Arm Pain	☐ Diverticulitis	☐ Heart Attack	☐ Low Blood Pressure	☐ Pacemaker	☐ Thyroid Disease
☐ Arteriosclerosis	☐ Dizziness	☐ Heart Disease	☐ Lyme Disease	☐ Palpitations	☐ Tinnitus
☐ Arthritis Type:	☐ Eating Disorder	☐ Hepatitis	☐ Memory Loss	☐ Pneumonia	☐ TMJ / Jaw Pain
☐ Asthma	☐ Elbow Pain	☐ Hernia	☐ Meningitis	☐ Poor Posture	☐ Tremors
☐ Autoimmune Disorder	☐ Epilepsy	☐ High Blood Pressure	☐ Menopause	☐ Prostate Disease	☐ Upper Back Pain
☐ Bladder	☐ Eye/Vision Problems	☐ High Cholesterol	☐ Menstrual Problems	☐ Psoriatic Arthritis	☐ Urinary Frequency
☐ Bone Fracture	☐ Fainting	☐ Hip Pain	☐ Mental Illness	☐ Rheumatoid Arthritis	☐ Vertigo
☐ Breast Cancer	☐ Fatigue - Chronic	☐ IBS/Crohn's/Colitis	☐ Migraines	☐ Sciatica	☐ Weakness-Arms / Legs
☐ Cancer:__________	☐ Foot Pain	☐ Incontinence	☐ Muscle Spasm / Pain	☐ Scoliosis	☐ Weight Loss
☐ Carpel Tunnel	☐ Gall Bladder	☐ Increased Stress	☐ Muscle Weakness	☐ Seizure	☐ Wrist Pain
☐ Chest Pain	☐ GI Disorder	☐ Other:			

MEDICATION ALLERGIES	CURRENT MEDICATIONS	Reason for taking:
1.	1.	
2.	2.	
3.	3.	
4.	4.	

FAMILY HISTORY							
	Father	Mother	Siblings		Father	Mother	Siblings
Arthritis	☐	☐	☐	Heart Disease	☐	☐	☐
Back Pain	☐	☐	☐	Neurological Problems	☐	☐	☐
Cancer	☐	☐	☐	Parkinson's Disease	☐	☐	☐
Diabetes	☐	☐	☐	Stroke	☐	☐	☐
Migraine / Headache	☐	☐	☐	Osteoporosis	☐	☐	☐
High Blood Pressure	☐	☐	☐	Other:	☐	☐	☐

INJURIES		
Car Accident? Yes: Date____________ / No	Work injury? Yes: Date______________ / No	Other trauma? Yes: Date______________ / No

OTHER INFORMATION					
☐ Smoke # per day_______ ☐ Former Smoker	☐ Alcoholic Drinks Per day_______	☐ Drink caffeine Per day_______	☐ Exercise Type:__________ How often:_________	Primary Care Doctor: _______________ Date Last physical_________	**WOMEN ONLY:** ☐ Pregnant ☐ Breastfeeding Date last cycle:___________

Neck Disability Index

Patient Name____ **Date**____________

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment. (0)
- ❑ The pain is very mild at the moment. (1)
- ❑ The pain is moderate at the moment. (2)
- ❑ The pain is fairly severe at the moment. (3)
- ❑ The pain is very severe at the moment. (4)
- ❑ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

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

Section 3 – Lifting

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

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck. (0)
- ❑ I can read as much as I want to with slight pain in my neck. (1)
- ❑ I can read as much as I want with moderate pain in my neck. (2)
- ❑ I cannot read as much as I want because of moderate pain in my neck. (3)
- ❑ I can hardly read at all because of severe pain in my neck. (4)
- ❑ I cannot read at all. (5)

Section 5 – Headaches

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

Section 6 – Concentration

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

Section 7 – Work

- ❑ I can do as much work as I want to. (0)
- ❑ I can do my usual work, but no more. (1)
- ❑ I can do most of my usual work, but no more. (2)
- ❑ I cannot do my usual work. (3)
- ❑ I can hardly do any work at all. (4)
- ❑ I cannot do any work at all. (5)

Section 8 – Driving

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

Section 9 – Sleeping

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

Section 10 – Recreation

- ❑ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ❑ I am able to engage in all my recreation activities, with some pain in my neck. (1)
- ❑ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ❑ I can hardly do any recreation activities because of pain in my neck. (4)
- ❑ I cannot do any recreation activities at all. (5)

________________________ ________

Patient's Signature **Date**

Revised Oswestry Low Back Pain Questionnaire

Revised Oswestry

PLEASE READ: This questionnaire is designed to enable your health care provider to understand how much your **low back pain** has affected your ability to manage everyday activities. Answer each section by circling the **ONE** choice that most applies to you. We realize you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 – Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

Section 2 – Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing and dressing even though it causes some pain.
C Washing and dressing increase the pain but I manage not to change my way of doing it.
D Washing and dressing increase the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do *some* washing and dressing without help
F Because of the pain I am unable to do *any* washing and dressing without help.

Section 3 – Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

Section 4 – Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

A I can sit in any chair as long as I like without pain
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than 1 hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

Section 6 – Standing

A I can stand as long as I like without pain.
B I have some pain while standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain straight away.

Section 7 – Sleeping

A I get no pain in bed.
B I get pain in bed but it does not prevent me from sleeping well.
C Because of pain my normal night's sleep is reduced by less than 1/4.
D Because of pain my normal night's sleep is reduced by less than 1/2.
E Because of pain my normal night's sleep is reduced by less than 3/4.
F Pain prevents me from sleeping at all.

Section 8 – Social Life

A My social life is normal and gives me no pain.
B My social life is normal but increases the degree of pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

Section 9 – Traveling

A I get no pain while traveling.
B I have some pain while traveling but none of my usual forms of travel make it any worse.
C I have extra pain while traveling but it does not compel me to seek alternate forms of travel.
D I get extra pain while traveling that compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Name (Print):	Signature:	Date:
Comments:		Oswestry #

Dr. Della M. Schmid, PLLC

Patient Name: ____________________

Statement of Financial Responsibility

I understand I am financially responsible for any balance, as well as fees associated with collection of any balance, due for services rendered at this office. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefit payment to Dr. Della M. Schmid, PLLC. I understand that if I suspend or terminate my treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that if my insurance company does not cover services rendered by this office that I am responsible for payment of any non-covered services. I am also responsible for payment of services that my insurance company requires a referral for, and I did not receive one prior to my first treatment.

Wellness Care Policy

Under my insurance plan, I am also financially responsible for all non-covered services that are determined to be Wellness Care (maintenance). Wellness Care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive Wellness Care once maximum benefit from treatment has been reached. If, during Wellness Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered wellness and may then be covered by your health plan. As your provider, we will submit a request for insurance coverage of your active care.

Telehealth Services Consent

Telehealth services involve the use of electronic communications to enable health care providers to deliver health care services to patients using interactive video and audio communications. 1. The laws that protect the confidentiality of my personal information also apply to telehealth. 2. I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment. 3. The same standard of care that would apply to an in-person visit also applies to telehealth. 4. My health care information may be shared with other individuals for scheduling and billing purposes. 5. There are certain risks associated with telehealth, including delays in treatment occurring due to deficiencies or failures of equipment, interruptions of service or other technical difficulties, or the breach of privacy of personal health information caused by failure of security protocols. 6. Certain technical failures may necessitate the rescheduling of my appointment or the continuation of my visit by alternative means. 7. I am responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telehealth visit, and I understand that health plan payment policies for telehealth visits may be different from policies for in-person visits. 8. This document will become a part of my health record. I hereby give my informed consent for the use of telehealth services in my health care. I have personally read this form (or had it explained to me) and fully understand and agree to its contents. My questions about telehealth services have been answered to my satisfaction, and the risks, benefits, and alternatives to telehealth services have been shared with me in a language I understand. I am located in and will remain in the state of Connecticut during my telehealth encounter(s).

Patient/Parent/Legal Guardian Signature: ____________________ Date: __________

A copy of this signature is as valid as the original.

Insurance Information

1. Primary Insurance Company: ____________ Telephone: __________

   I.D. #: ____________ Group #: ____________

   Policyholder (Name): ____________________

   If insured is not the patient, please complete the following on the policyholder:

   Employer: ____________________

   Birthdate: __________

   Do you have Secondary Health Insurance? Yes No

2. Secondary Insurance Company: ____________ Telephone: __________

   I.D. #: ____________ Group #: ____________

   Policyholder (Name): ____________________

   Employer: ____________________

   Birthdate: __________

Personal Injury/MVA: Attorney's Name: ____________ Telephone: __________