# PATIENT INTRODUCTION (HEALTH INSURANCE)


## Hokokian Chiropractic

**1543 W. Shaw Ave, Fresno, Ca 93711**

Office: (559) 230-1102 Fax: (559) 230-1105


**Today's Date:** _____

| | | |
|---|---|---|
| **Last Name:** | **MI:** | **First Name:** |
| Home Address: | City: | State: Zip: |
| Date Birth: Age: | Tel. Home: | Tel. Work: |
| Height: Weight: | Cell Number: | |
| Employer's Name: | Social Security No/ID No.: | |
| Occupation: | Marital Status (Circle): Single, Married, Divorced, Widowed | |
| Email Address: | | |

## MEDICAL INSURANCE INFORMATION

| | |
|---|---|
| Does your health insurance plan cover Chiropractic treatment? | ☐ Yes, ☐ No If yes, we need a copy of the card |
| If yes, indicate Insurance Company Name (Need copy of card). | Insurance Name: _____<br>Address: _____<br>Telephone: |
| Are you the insured person or dependent (wife/husband/child)? | ☐ Insured, ☐ Dependent |
| If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number/ID No, and the company/business name of the insured employer in order to do billing. | Name of Insured Person: _____<br>Social Security Number: _____<br>Insured Date of Birth: _____<br>Name of Insured Employer:_____ |
| What is your co-payment amount for each visit? | Amount: $ Percentage: % |
| Do you have a health insurance deductible for chiropractic? | ☐ Yes, ☐ No Have you met deductible yet?<br>What is your deductible $ _____ |
| If known, what are your chiropractic health insurance benefits annually? | Number visits per year #_____. Amount per year: $_____ |

**IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT CO-PAYMENT OR DEDUCTIBLE PAYMENT AT THE CONCLUSION OF EACH TREATMENT. OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES AS A COURTESY. ANY OUTSTANDING BALANCE CAN BE SUBJECT TO AN 18% ANNUALLY OR 1 ½ % PER MONTH INTEREST.**

| | |
|---|---|
| Patient Signature and Date | I authorize and direct payment of medical benefits to the undersigned doctor for services/procedures or supplies described in the CMS-1500 form. I authorize the release of any medical or other information necessary to process this claim. |

I further authorize undersigned doctor to use my name in the "Signature on File" in all future billings (sections 12 and 13 in CMS-1500 forms). I am a responsible party and agree to pay for any outstanding bills for services-supplies incurred in this office. I acknowledge that it is my responsibility to pay any deductible, co-pay, co-insurance, and/or any other balances not paid by my medical insurance carrier at the conclusion of each treatment.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) require that all health care providers comply with patient privacy and security laws (45 CFR 160, 164). Patient confidentiality and privacy/security applies to any **protected health information (PHI).** This notice explains how a patient's protected health information (PHI) may be used and what said office's responsibilities are regarding my privacy rights and protected health information. Indicate whether you are the parent or a legal guardian of the patient or minor. If you want to discuss anything privately that you do not want to be overheard by other persons in the doctor's office, please inform the staff before you see the doctor so a private room can be arranged. Please sign and date below.

| | |
|---|---|
| Patient Signature and Date | By signing this form, I acknowledge that this office has presented me with a copy of their HIPAA privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall. |

☐ **LEGAL GUARDIAN/PARENT NAME/RELATIONSHIP:** _____

| | |
|---|---|
| Patient Name: | Date: |

# GENERAL HEALTH HISTORY (Page1)
# HOKOKIAN CHIROPRACTIC

**1543 W. Shaw Ave, Fresno, Ca 93711**
Office: (559) 230-1102 Fax: (559) 230-1105

**DESCRIBE THE REASON(S) WHY YOU HAVE COME TO OUR OFFICE (Symptoms/Injury). Print Clearly**

*Check only those conditions that apply to you and indicate if you have had in the past or presently have.*

| YES | GENERAL QUESTIONS | PAST | PRESENT |
|---|---|---|---|
| ☐ | History of poor healing or told that you have a healing disorder? | ☐ | ☐ |
| ☐ | Smoke cigarettes or use tobacco products? | ☐ | ☐ |
| ☐ | Diabetes, hypoglycemia, thyroid, kidney, liver disease, or other endocrine-metabolic disorder? | ☐ | ☐ |
| ☐ | Heart attack, heart disease or have a heart pacemaker or neck or chest shunt? | ☐ | ☐ |
| ☐ | History of infectious diseases such as AIDS, Tuberculosis, Meningitis, Hepatitis, etc.? | ☐ | ☐ |
| ☐ | Do you have difficulties or intolerance to heat packs or ice packs on your skin? | ☐ | ☐ |
| ☐ | Do you have problems with dizziness, blacking out, balance, fainting, or tripping? | ☐ | ☐ |
| ☐ | Epilepsy-Seizure-Convulsion history or any other neurological disease? | ☐ | ☐ |
| ☐ | History of multiple sclerosis, lupus, psoriasis, paralysis, or disease affecting nerves? | ☐ | ☐ |
| ☐ | Cancer history or cancer treatment or surgery of any type? | ☐ | ☐ |
| ☐ | Stroke history (Indicate any suspected mild strokes or transient ischemic attacks)? | ☐ | ☐ |
| ☐ | Have you ever been hospitalized? Why/When: | ☐ | ☐ |
| ☐ | Blood clots, bleeding or vascular disorder, or told you have an abdominal or brain aneurysm? | ☐ | ☐ |
| ☐ | Hypertension or high blood pressure? If yes, name of MD seeing: | ☐ | ☐ |
| ☐ | Autoimmune disease, digestive or intestinal disease, or respiratory diseases, etc? | ☐ | ☐ |
| ☐ | **Do you have any type of chest or breast implants presently (males & females)?** | N/A | ☐ |
| ☐ | **Women only**: Check box to left if there any chance that you are currently pregnant | | |

**If you checked yes, please describe:**

## HAVE YOU HAD PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN?

☐ **NO. (Check box if you have no prior history of previous injury or pain)** If yes, please describe below:

## HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?

☐ **NO. (Check box if you have never had any broken bones in the past).** If yes, please describe below:

## HAVE YOU HAD ANY PREVIOUS SURGERIES?

☐ **NO. (Check box if you never had any surgical procedure).** If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen), please describe type and when:

Patient Name: Date:

# GENERAL HEALTH HISTORY (Page 2)
# HOKOKIAN CHIROPRACTIC

**1543 W. Shaw Ave, Fresno, Ca 93711**
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☐ No, ☐ Yes **Do you have a family history** of high blood pressure, stroke, heart attacks, scoliosis, spina bifida, genetic conditions of the spine, rheumatoid arthritis, other forms of joint or spine arthritis, herniated discs in the spine, spinal cord disease, brain disease, nerve disease, blood vessel aneurysms, or other diseases?

| If yes, please describe: |
|---|
| |

☐ No, ☐ Yes **Have you ever been to a Chiropractor before for any condition?**
If yes, Chiropractor's Name/City: _____ Year: _____
List Problem(s) that the Chiropractor treated you for: _____
_____

| | |
|---|---|
| Indicate when you have your last physical examination by a medical doctor and please indicate his/her name? | Doctor:<br>Date: |

☐ No, ☐ Yes Do **you have any problems laying face down on an examination table** (tender breasts, chest or breast surgical implants, ports, etc? If yes, why: _____

## MEDICATION HISTORY (PRESCRIBED AND OVER-THE-COUNTER)

☐ No, ☐ Yes **Are you taking any medications currently?** In yes, list all medications that you are taking:

| |
|---|
| |
| |
| |

☐ No, ☐ Yes**. Have you taken any pain medications today? If yes, describe: _____**

## FOOD OR MEDICATION ALLERGY HISTORY

☐ No, ☐ Yes. Do you have allergies to any medications, foods, shellfish, seafood, etc? If yes, List:

| |
|---|
| |
| |

## DESCRIBE YOUR TYPICAL EXERCISE ROUTINE CURRENTLY

| | |
|---|---|
| Describe what types of exercise you perform: | |
| How often to do you regularly exercise? | |

## SYMPTOM OR COMPLAINT ONSET

**☐ Suddenly, ☐ Gradually. Check box indicating if your current symptoms developed gradually or suddenly.**

## HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Excessive fatigue-malaise | ☐ | Bowel or bladder disorders | ☐ | Night pain or night time sweats |
| ☐ | Weight loss | ☐ | Ovarian pain | ☐ | Abdominal pain |
| ☐ | Low grade fever | ☐ | Kidney pain/painful urination | ☐ | Balance problems |

| YES | NO | SLEEPING PATTERNS |
|---|---|---|
| ☐ | ☐ | Do you sleep poorly at night? |
| ☐ | ☐ | Do you sleep on your stomach? |
| ☐ | ☐ | Do you consistently feel extremely tired when you wake up in the morning? |

| Patient Name: | Date: |
|---|---|

Form 1010

# GENERAL HEALTH HISTORY (Page 3)
# HOKOKIAN CHIROPRACTIC

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*Please print clearly. Check all boxes that apply to you and describe your "YES" responses. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.*

| YES | NO | GENERAL SPINE HISTORY (HEAD, NECK, BACK, SACRUM, AND PELVIS) |
|---|---|---|
| ☐ | ☐ | Have you been told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae? |
| ☐ | ☐ | Told that you have a bulging/herniated disc or disc degeneration in the spine? |
| ☐ | ☐ | Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis in your spine or joints? |
| ☐ | ☐ | Told you have arthritis, degeneration, or rheumatoid arthritis in your spine or joints? |
| ☐ | ☐ | Have you had a previous head injury in the past (e.g., blow or fall)? |
| ☐ | ☐ | Have you injured your neck, back, sacrum or pelvis in the past? |
| ☐ | ☐ | Have you ever had an injection into your discs or spine (facet joints) in your back, sacrum or neck? |
| ☐ | ☐ | Do you have a stomach, intestinal, digestive, malabsorption disorder (wheat allergy, etc.), muscle disease, prostate, ovarian, or uterine problem, condition or disease that could be affecting your back? |

| **If yes, describe and provide dates:** |
|---|
| |
| |

## NECK PAIN AND/OR INJURY HISTORY

| | |
|---|---|
| Describe your neck pain location (left side, right side, middle of your neck or on both sides). | |
| When did your neck pain begin and/or injury occur? | Date required: |
| Describe how or why your pain began (mechanism). Describe any neck injury (what happened)? | |
| Describe all aggravating physical activities/motions. What makes your neck or referring arm pain worse? | |
| Describe any relieving physical activities. What activities lessen your neck/arm symptoms? | |
| Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc). | |
| Describe any symptoms that originate from your neck that radiate to your head/shoulders/arms/hands. | |
| How frequent are your pain/symptoms (Percent)? | |
| How severe are your pain/symptoms (Zero-to-10)? | |
| List all doctors you have seen for your neck before. | |

| YES | NO | NECK REGION HISTORY CONTINUED |
|---|---|---|
| ☐ | ☐ | Do you get dizzy when you look up or twist your head? If yes, how often: |
| ☐ | ☐ | Do you black out, lose your balance or get a headache when you look up or twist your head? |
| ☐ | ☐ | Do you feel your neck pain sends pain downwards between your shoulders or to the front of your chest? |
| ☐ | ☐ | Have you had a new type of headache or an unusually severe headache recently? |
| ☐ | ☐ | Have you noticed your head leaning or tilting to one side recently? |

Patient Name: Date:

# GENERAL HEALTH HISTORY (Page 4)
# HOKOKIAN CHIROPRACTIC

**1543 W. Shaw Ave, Fresno, Ca 93711**
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| | |
|---|---|
| Describe your pain location (middle back, lower back, sacrum and if located in the front/side/back of body) | |
| When did your pain begin and/or injury occur? | Date required: |
| Describe how or why your pain began (mechanism). Describe any injury (what happened)? | |
| Describe all aggravating physical activities/motions. What makes your back or referring leg pain worse? | |
| Describe any relieving physical activities. What activities lessen your back or leg symptoms? | |
| Describe any symptoms that originate from your back that radiate to your chest, hips, legs, or feet. | |
| Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc). | |
| How frequent are your pain/symptoms (Percent)? | |
| How severe are your pain/symptoms (Zero-to-10)? | |
| List all doctors you have seen for your back before. | |

| YES | NO | THORACIC AND LOW BACK REGION HISTORY CONTINUED |
|---|---|---|
| ☐ | ☐ | Do you have pain that shoots or radiates outward along your rib cage? |
| ☐ | ☐ | Does your middle back or chest wall pain intensify when you take in a deep breath or cough? |
| ☐ | ☐ | Do you have a tight band-like feeling sometimes around your chest? |
| ☐ | ☐ | Do you recently have any associated unusual indigestion, chest pressure, or pain down your left arm? |
| ☐ | ☐ | When you move your neck around, does your middle back pain or chest pain increase? |
| ☐ | ☐ | When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get worse? |
| ☐ | ☐ | Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distance that is relieved by resting or sitting down? This pain resumes after walking for same distance. |
| ☐ | ☐ | Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting. |
| ☐ | ☐ | Does either leg or foot drag on the floor when you walk? |
| ☐ | ☐ | Do you have a lot of leg cramps at night recently? |
| ☐ | ☐ | Have you recently had any urinary or bowel incontinence or had difficulty urinating? |
| ☐ | ☐ | Do your feet feel cold recently? If yes, indicate which foot or if both feet: |
| ☐ | ☐ | Have you recently noticed that either of your legs occasionally gives out on you when you walk? |
| ☐ | ☐ | Does one or both of your legs feel weak recently? |
| ☐ | ☐ | Has your anal-rectal region been completely numb? |

Please print clearly

| **If yes, describe and indicate dates:** |
|---|
| |
| |

Patient Name:

Date:

Form 1010

# EXTREMITY PAIN OR INJURY QUESTIONAIRE
# HOKOKIAN CHIROPRACTIC

**1543 W. Shaw Ave, Fresno, Ca 93711**
Office: (559) 230-1102 Fax: (559) 230-1105

*Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with. Please print clearly.*

## SHOULDER, ARM, ELBOW, WRIST AND HAND REGION

| | |
|---|---|
| Describe pain location (left, right, middle, front, and back, top). Example: top of shoulder joint/inside left elbow) | |
| When did your pain begin and/or injury occur? | Date required: |
| Describe how or why your pain began (mechanism). Describe any injury (what happened)? | |
| Describe all aggravating physical activities/motions. What makes your shoulder-arm symptoms worse? | |
| Describe any relieving physical activities/motions. What lessens your shoulder-arm pain-symptoms? | |
| If present, describe which fingers or part of your hand you have any pain, numbness, or tingling. | |
| Describe how your symptoms feel (examples: dull, sharp, ache, sore, pain, numbness, tingling, stiff, etc). | |
| How frequent are your pain/symptoms (Percent)? | |
| How severe are your pain/symptoms (Zero-to-10)? | |

## HIP, LEG, KNEE, ANKLE AND FOOT REGION

| | |
|---|---|
| Describe your pain location (left, right, middle, front, back). Example: front of hip/outer calf area. | |
| When did your pain begin and/or injury occur? | Date required: |
| Describe how or why your pain began (mechanism). Describe any injury (what happened)? | |
| Describe all aggravating physical activities/motions: What makes your hip-leg pain-symptoms worse? | |
| Describe any relieving physical activities: What lessens your hip-leg symptoms-pain? | |
| If present, describe which toes or part of your leg/foot you have any pain, numbness, or tingling. | |
| Describe how your symptoms feel (examples: dull, sharp, ache, numbness/tingling, stiff, etc). | |
| How frequent are your pain/symptoms (Percent)? | |
| How severe are your pain/symptoms (Zero-to-10)? | |
| List all doctors you have seen for your hip, leg, knee, ankle, and foot before. | |

Patient Name:

Date:

# HEADACHE-MIGRAINE QUESTIONNAIRE
# HOKOKIAN CHIROPRACTIC

**1543 W. Shaw Ave, Fresno, Ca 93711**
Office: (559) 230-1102 Fax: (559) 230-1105

*Please answer the following sections that apply to you. If some of the questions are unclear to you, skip ahead to the next question. Your doctor will be going over this questionnaire with you during your consultation, and you can clarify your answers at that time.*

**1. If your headaches/migraines have begun recently, can you think of some event or cause that may have started your pain?** ☐ YES, ☐ NO If yes, what: _____

**2. If your headaches/migraines have been bothering you for more than six months, can you describe what you think is causing them or making them worse?** ☐ YES, ☐ NO If yes, describe:_____

_____

**3. Circle how intense your typical headaches/migraines are recently? (Use 0-10 intensity)**

| Pain Intensity | None | Mild Discomfort/Annoyance | Moderate Hurts/Sore/Bearable Sensation | Severe Sharp/Intense/Unbearable |
|---|---|---|---|---|

| Headache (circle) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|

**4. Recently, would you describe the frequency and severity of your headaches-migraines as being the same as usual, a little worse than usual, or a type of headache that is entirely new/unusual:**_____

**5. WHEN DO YOU USUALLY GET YOUR HEADACHES-MIGRAINES?**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Morning | ☐ | End of week | ☐ | After napping or oversleeping |
| ☐ | Afternoon | ☐ | Bright light causes them | ☐ | After drinking alcohol |
| ☐ | Evening | ☐ | During or after having sex | ☐ | Before menstrual cycle |
| ☐ | During sleep | ☐ | During emotional stress | ☐ | During menstrual cycle |
| ☐ | During weekends | ☐ | After emotional stress | ☐ | After menstrual cycle |
| ☐ | Beginning of week | ☐ | During physical exertion | ☐ | After bending your head downwards |
| ☐ | Middle of week | ☐ | After not eating several hours | ☐ | No pattern |

**6. WHAT USUALLY HELPS YOUR HEADACHES-MIGRAINES?**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Sleeping | ☐ | Improving posture | ☐ | Drinking coffee |
| ☐ | Rest | ☐ | Dark quiet room | ☐ | Muscle massage |
| ☐ | Eating | ☐ | Medications | ☐ | Cold packs |
| ☐ | Spinal adjustments | ☐ | Nothing helps | ☐ | Other: |

**7. DESCRIBE HOW YOUR HEADACHE-MIGRAINE USUALLY FEELS:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Pounding | ☐ | Burning | ☐ | Pressure |
| ☐ | Constant pain | ☐ | Aching | ☐ | Exploding |
| ☐ | Throbbing * | ☐ | Sharp-Piercing | ☐ | Dullness |

**8. WHERE DOES MOST OF YOUR HEADACHE PAIN FOCUS?**(Check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Entire head area | ☐ | Front of head | ☐ | Left side of head |
| ☐ | Back of head near neck area | ☐ | Eye region | ☐ | Right side of head |
| ☐ | Top of head | ☐ | No pattern | ☐ | Both sides of head |

**9. IF YOUR HEAD PAIN RADIATES, WHERE DO YOUR HEADAHCE-MIGRAINES START?**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Neck area | ☐ | Front of head | ☐ | Near eyes |
| ☐ | Back of head | ☐ | Side of head | ☐ | Other: |

| Patient Name: | Date: |
|---|---|

# HEADACHE-MIGRAINE FORM (Page 2)

HOKOKIAN CHIROPRACTIC

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Recently, how many headaches/migraines do you usually have in a month? ____ Times a month
Recently, how many hours does a typical headache/migraine last for you? ____ Hours
On average, how many pills do you take every month for headaches? ____ Number pills per month

**10.** ☐ YES, ☐ NO Have you seen other Doctors for your headaches-migraines? Please list and describe treatment and if it helped. Also indicate if you have had any brain scans, laboratory tests, or other diagnostic tests done to evaluate your headaches. _____

_____

What have your previous doctors told you were the cause(s) for your headaches?

**11. MEDICATIONS:** *Please write in all medications that you have taken recently for any condition.*

| |
|---|
| |
| |
| |

**12. HEADACHE-MIGRAINE HISTORY** (Check any of the following that apply to you):

| | |
|---|---|
| ☐ | Family history of headaches or migraines |
| ☐ | History of motion sickness as a child |
| ☐ | Headaches-migraines associated with shortness of breath or excessive exhaustion |
| ☐ | Headaches-migraines associated with numbness of face and/or tongue |
| ☐ | Headaches-migraines associated with arm or leg weakness |
| ☐ | You usually know your headache is starting soon by various symptoms such as visual or sensory feelings |
| ☐ | You see lights/spots in your vision 5-50 minutes before headache-migraine pain begins |
| ☐ | You are very sensitive to light or sound during or after headache-migraine |
| ☐ | You presently or recently had a fever. This fever began just before your headaches started or during headache. |
| ☐ | You had a rash, chills, fever, headache, and joint pain/swelling 2 weeks prior to your headaches starting. |
| ☐ | Physical exertion makes your headache-migraine worse (climbing stairs, sex, lifting, etc) |
| ☐ | Headaches start 3-4 hours after eating and/or your headaches improve after you eat |
| ☐ | Jaw pain before or during headache |
| ☐ | Muscles in neck and shoulders are tight/stiff or sore prior to headache |
| ☐ | Headaches-migraines get worse when you have sustained poor posture |
| ☐ | Headaches-migraines begin or get worse when you rotate or twist your head and/or neck |
| ☐ | You get dizzy or black out when headaches-migraines occur |
| ☐ | Get tearing, face flushing, or nasal discharge during headache-migraine |
| ☐ | History of sinus infection, allergies, deviated septum, or other nasal disorders |
| ☐ | You bruise easily, sometimes finding bruises on your thighs or legs and you can't recall any injury to your leg. |
| ☐ | History of neck or head injury |
| ☐ | You eat or drink substances having caffeine (coffee, chocolate, or tea). I drink _____ number of cups per day. |
| ☐ | Your body usually feels cold |
| ☐ | Thyroid problems currently or in past |
| ☐ | You do not feel rested after sleeping |

Patient Name: Date:

# SYMPTOM INTENSITY AND FREQUENCY FORM


## HOKOKIAN CHIROPRACTIC

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PATIENT: _____ DATE: _____

*For SECTION 1, describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels currently present. A zero (0) indicates that no symptoms exists. 1-3 pain level is a minimum level and indicates that your pain is an annoyance only. A 4 pain is a slight level or where pain doing an activity begins to cause some disability. A 5-7 pain is moderate in severity and has to restrict or limit your activity ability to a significant degree. An 8-10 pain level is severe and indicates that your pain intensity is to the point where you have complete inability to perform some tasks. For SECTION 2, describe how frequently you have symptoms such as pain, numbness, and tingling in the respected areas. Please pay attention to the headache portion.*

## SECTION 1. CURRENT PAIN INTENSITY LEVELS

Circle the box following the area of pain that best indicates your overall average-usual pain severity today.

| Pain Intensity | None | **MINIMAL** Discomfort/Ache/Stiff | | | **SLIGHT-TO-MODERATE** Hurts/Sore/Bearable Sensation | | | | **SEVERE** Sharp/Intense Pain | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Headache | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Neck Pain/Soreness | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Arm/Hand Symptoms | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Mid Back Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Low back Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Leg/Foot Symptoms | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## SECTION 2. CURRENT PAIN FREQUENCY LEVELS

*Circle the box following the area of pain that best indicates the average percentage of time you have pain today.*

| Pain Frequency | None | Occasional | | | Intermittent | | | Frequent | | Constant | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Neck pain/soreness | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| Arm/Hand Symptoms | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| Mid-back Pain | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| Low Back Pain | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| Leg/Foot Symptoms | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

## SECTION 3. CURRENT HEADACHE FREQUENCY & DURATION

*During the past week or since the accident/injury if applicable (if less than one week) indicate how frequently you have had headaches and/or migraines. Be sure to indicate how long each headache typically lasts.*

A. How frequently do you have headaches/migraines?

- ☐ No headaches
- ☐ 1-2 times a month
- ☐ 3-4 times a month
- ☐ Once a week
- ☐ 2-3 times a week
- ☐ 4-5 times a week
- ☐ Almost daily
- ☐ Daily
- ☐ All the time

B. How many hours does your typical headache/migraine last? _____ Hours?

Patient Name: Date:

# PAIN INTENSITY INSTRUCTION SHEET

**HOKOKIAN CHIROPRACTIC · 1543 W. SHAW AVE · FRESNO, CA. 93711**
**OFFICE (559)230-1102 · FAX (599) 230-1105**

**PATIENT:** *Be certain to read the following pain categories and indicate which level best represents how severe your current pain level is relative to your ability to perform activity. If you do not understand these instructions be sure to ask the Doctor.*

| **Pain Intensity** | None | **MILD** | | | **MODERATE** | | | | **SEVERE** | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **PAIN LEVEL** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

| | | | | |
|---|---|---|---|---|
| PAIN LEVEL AND THE EFFECT THAT PAIN HAS ON YOUR ABILITY TO PERFORM ACTIVITY | No Pain | Annoying Pain Level Only.<br><br>Able to Perform All Home, Work, Sport, and Recreational Activities.<br><br>No Restrictions | Pain Levels Now Cause You to Slow Down.<br><br>You Are Able to Do Activities at Home and Work, But They Take You Longer to Do or You Need to Take Breaks.<br><br>Unable to Do More Demanding Activities. | Pain Levels Must Prohibit Your Ability to Perform Several Activities.<br><br>You Must have Some Inability to Do Easier Activities.<br><br>Must Have Some Difficulty Sleeping. |
| HOW DOES THE PAIN FEEL? | No Pain | Ache, Dull Soreness, Stiffness | Hurting Pain, Very Sore, Limited Motion | Sharp Pain, Stabbing Pain, Jabbing Pain |
| LEVEL | **** | MILD | MODERATE | SEVERE |

## A LEVEL 10 PAIN IS UBEARABLE AND IS SIMILAR TO THE MOST SEVERE PAIN YOU HAVE EVER HAD!

**A 10 level pain is unbearable and equates to having the most severe pain you have ever had, such as a toothache, burn, or kidney stone type of pain!**

# INFORMED CONSENT

**HOKOKIAN CHIROPRACTIC · 1543 W. SHAW AVE · FRESNO, CA. 93711**
**OFFICE (559)230-1102 · FAX (599) 230-1105**

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself, (or on the patient names below, for whom I am legally responsible) by **Dr. John H. Hokokian, D.C.,** and/or other licensed doctors of the chiropractic who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for **Dr. John H. Hokokian, D.C.,** whether or not their names are listed on this form.

I understand and consent to the following procedures (checked below):

| | | | |
|---|---|---|---|
| Examination ☐ | Mobilization ☐ | Ultrasound ☐ | Muscle Stimulation ☐ |
| X-rays ☐ | Traction ☐ | Adjustments ☐ | |

I have had an opportunity to discuss with **Dr. John H. Hokokian, D.C.,** the various types of treatment, including neck and spinal/extremity adjustments that have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustments and other chiropractic procedures, and understand that, there are some uncommon potential serious risks to chiropractic adjustments and procedures, including, but not limited to, sprains, fractures, disc injuries, dislocations, nerve injuries, and strokes specifically from neck adjustments. I understand and have had the opportunity ask about risks and benefits the proposed treatment and of other alternative types of treatment for my condition.

I have had the opportunity to read this form understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

**PATIENT NAME (PRINT) _____DATE:_____**

**X_____**
**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

**(If signing for a MINOR)**
**NAME: _____RELATIONSHIP:_____**

OFFICE/WITNESS SIGNATURE: _____ DATE: _____