CHIROPRACTIC 1ST NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient Name: ______________________________

____

Date: ______________________________

Address: ______________________________

____

Birthdate: ____________________

SS Number: ____________________

Sex: ☐ M ☐ F Age: ____________

Employer/School: ______________________________

Occupation: ______________________________

Employer/School Address: ____________________

____

Employer/School Phone Number:

____

Spouse's Name: ______________________________

Whom may we thank for referring you?

____

INSURANCE INFORMATION

Responsible for this account: ____________________

Relationship to Patient: ____________________

Insurance Co.: ______________________________

Group #: ______________________________

ID #: ______________________________

Assignment & Release:

I certify that I, and/or my dependent(s), have insurance coverage with the above-listed insurance company and assign directly to Chiropractic 1st all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named office may use my health care information and may disclose such information to the above-named insurance company and their agents for obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X: ______________________________

CONTACT INFORMATION

Cell: ____________________ Home: ____________________

Email: ______________________________

Emergency Contact:

Name: ____________________ Relationship: ____________________

Cell: ____________________ Home: ____________________

ACCIDENT INFORMATION

Is condition due to an accident: Yes ☐ No ☐

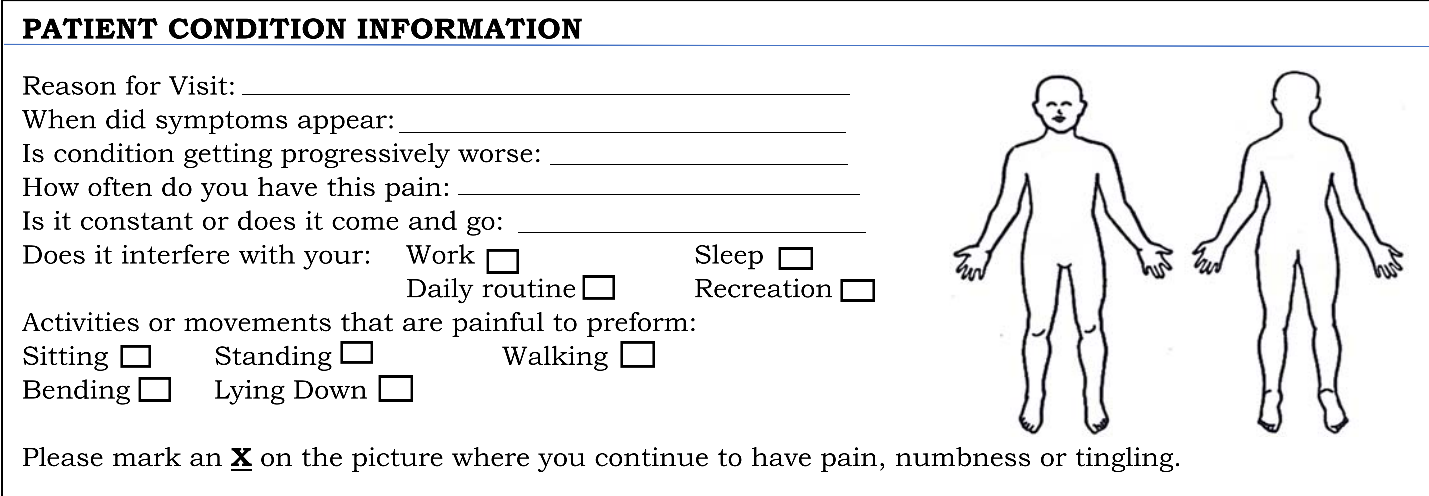
Date of Accident: ______________________________

Type of Accident:

Auto ☐ Work ☐ Home ☐

To whom have you made a report of your accident:

____



PATIENT CONDITION INFORMATION

Reason for Visit: ______________________________

When did symptoms appear: ______________________________

Is condition getting progressively worse: ____________________

How often do you have this pain: ______________________________

Is it constant or does it come and go: ____________________

Does it interfere with your: Work ☐ Sleep ☐ Daily routine ☐ Recreation ☐

Activities or movements that are painful to preform:

Sitting ☐ Standing ☐ Walking ☐

Bending ☐ Lying Down ☐

Please mark an **X** on the picture where you continue to have pain, numbness or tingling.

CHIROPRACTIC 1ST NEW PATIENT INFORMATION

REVIEW OF SYSTEMS

Are you currently experiencing any of the following?

Constitutional:
Fever
Chills
Sudden Weight Loss
Sudden Weight Gain
Extreme Fatigue

Eyes:
Diplopia
Pain
Discharge
Changes in Vision

Ears:
Drainage
Pain
Difficulty hearing
Hearing loss

Nose:
Nose Bleed
Dry Nose
Sinus Pain

Throat
Sore throat
Voice changes
Difficulty Swallowing

Mouth
Ulcers
Mouth pain
Lesions

Cardiovascular:
Chest Pain
Shortness of Breath
Exercise Induced Asthma
Palpitations
History of Heart Attack

Respiratory
Shortness of Breath
Chest Pain
Coughing up Blood
Cough
Asthma

Gastrointestinal
Abdominal Pain
Nausea
Vomiting
Diarrhea
Constipation
Gerd
Bleeding

Gastro-Urinary
Painful/Difficult Urination
Change in Frequency
Blood in Urine
Pain in Groin w/ Urination
Excessive Urination at Night

Skin
Rash
Wounds
Bites

Neurological
Seizure
Dizziness or Fainting
Numbness
Tingling
Weakness

Psychological
Depression
Change in Appetite
Sleep
Lack of Positive Emotion
Disinterest in Sex
Thoughts of Suicide
Anxiety

Endocrine
Excessive Appetite
Excessive Thirst
Excessive Urination
Dry Skin
Severe Change in Weight
Diabetes
High Cholesterol

Heme/Lymph
Pale Skin Tone
Kernels
Infections
Weakness

Please list the following:

Medications:

____
____
____
____

Previous Hospitalizations

____
____
____
____

Surgeries

____
____
____
____

Patient's Name____ Number__________ Date________________

NECK DISABILITY INDEX

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 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.
☐ 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.

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

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ 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, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (___ Sections x 10) = __________ %ADL______

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments____________________________________
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

CHIROPRACTIC 1ST NEW PATIENT INFORMATION

Patient's Name________________________________ Number____________ Date________________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only 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 can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ 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, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 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 one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 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 one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ____________ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

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

Section 8 – Social Life

- ☐ My social life is normal and gives 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. dancing.
- ☐ 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 pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

CHIROPRACTIC 1ST NEW PATIENT INFORMATION

Informed Consent for Chiropractic Care

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from; latent pathological defects, illnesses or deformities which would otherwise not come to the specialized, non-duplication health care service. Your doctor of chiropractic is licensed in a special proactive and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Chiropractic 1st, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read HIPAA NOICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time following the PA State Medical Record Fee Schedule. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has to right to refuse treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I understand that if I am accepted as a patient by a physician at Chiropractic 1st, I am authorizing then to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Signature: ______________________________ Date: ______________________

CHIROPRACTIC 1ST NEW PATIENT INFORMATION

Clinic Policies

Thank you for choosing Chiropractic 1st as your health care provider. We are committed to the success of your treatment. The following is statement of our policies which we require you to read and sign prior to any treatment or examination. All patients must complete our Patient Information, Health Information, and Policy and Coverage forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHERWISE ARRANGED WITH OUR FINANCIAL DEPARTMENT. WE ACCEPT CASH, CHECK, CREDIT AND DEBIT CARDS. WE OFFER AN EXTENDED PAYMENT PLAN WHERE NECESSARY AND A FINANCIAL AGREEMENT IS SIGNED.

Regarding Insurance: We accept most insurance plans and will confirm benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed to you, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services presented by said payment, in full at the time of service.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of the contract. Payment for treatment rendered is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you provide us with the information necessary to do so.

Note: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable or necessary under your insurance program. Specifically, most insurance plans do not provide coverage for maintenance care. If you are unsure as to the nature of the treatment you are receiving, please ask your doctor.

Update Examinations/Progress Reports: We are required by your insurance to measure your progress every 6-7 visits or as stated necessary by the doctor. The examinations are required for authorization purposes, to provide medical necessity, and to monitor patient progress through their treatment plan.

Financial Policy: Patients with credit cards on file in our system give us the right to obtain payment from that card at time of service. Placing a card on file as form of payment also gives our clinic permission to run said card for any payment not obtained at time of service or for any balances accrued due to lack of payment, misquotation of benefits or denial from your insurance company after 30 days.

Non-Covered Services: Your treatment may involve services that are not covered under your health benefit plan. You have the right to deny receipt of these services. If you elect to receive any or all recommended services, you will be fully responsible for payment of these services.

Adult Patients: Adult patients are responsible for full payment at time of service.

Minor Patients: The adult accompanying a minor is responsible for full payment at the time of service. Children 16 years of age or older are permitted to attend their appointments on their own, however a credit/debit card must be placed on file for payment to be obtained at time of service.

Financial Arrangements: Where necessary, based on your financial circumstances, we will permit you to make payment that will permit you to meet the obligations detailed on your insurance benefit contract and this policy. Strict adherence to the financial agreement that you make is required. You must relay any change in financial circumstance to our financial department immediately. Past due balances that cannot be handled in house will be referred to the Credit Bureau of Lancaster County Inc., for collection. Where this is necessary, you agree to be additionally responsible for any costs and attorney fees related to the collection of unpaid accounts. You will receive 2 reminder letters in a matter of 30 days. Lastly, you will receive a FINAL NOTICE letter within 60 days. If, at that time, you do not pay the balance in full or make payment arrangements with our billing department you will be sent to collections.

CHIROPRACTIC 1ST NEW PATIENT INFORMATION

Acknowledgement of Special Promotion:

I acknowledge that the discount with (coupon/referral card/other: ______________________________) is a social promotion at Chiropractic 1st designated to allow me to receive care only at Chiropractic 1st. As such, I understand that Chiropractic 1st reserves the right to bill my insurance company for any balance of the visit. Promotions within Chiropractic 1st excludes any patients, the cost for which are covered by Medicare, Worker's Compensation, Personal Injury or Auto Insurance health care plans.

____ ______________________

Signature of Patient or Responsible Party/Guardian Date

____ ______________________

Signature of Staff Witness Date

Release of HIPPA Privacy: This clinic is concerned about the privacy of your individually identifiable health information and has enacted policy and procedure to protect your privacy as required by the Health Insurance Portability and Accountability Ad of 1996. A notice of this clinic's privacy practices is posted in the clinic or can be obtained from a staff member. I acknowledge that I have received Notice of Privacy Practices for protected health information.

____ ______________________

Signature of Patient/Personal Representative Date

____

Name of Patient

Massage Cancellation Policy

In order for Chiropractic 1st to function efficiently and effectively, cancellations for massage appointments must be made 24 hours prior to the scheduled time.

Failure to cancel a scheduled massage appointment within the required time will result in a $50 cancellation fee to be charged to your patient account.

This fee will also be charged for missed massage appointments. Exceptions will be made at the discretion of the doctor and office staff.

Three (3) cancelled/missed appointments will result in termination of advanced scheduling for massage appointments. Patient will only be allowed to make appointments on the day of.

____ ______________________

Patient Signature Date

____ ______________________

Staff Signature (Witness) Date