Patient Application Form

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in research based spinal and postural rehabilitation that helps our patients recover their optimal health; often where many other systems have failed. Because of this, we may not accept you as a patient until you are absolutely certain we know what is causing your condition, can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations, as well as make certain your healing will be our TOP PRIORITY. Thank you again for applying as a patient in our clinic.

Directions:
1. Please TYPE in all the Blue Areas on your computer
2. Print Out Paperwork and Sign in proper areas.
3. Fill out Pain Drawing
4. Fill out Functional Rating Index
5. Bring in your paperwork with your insurance card.

_____

Patient Name

_____

Date Completed

584 N. Sunrise Ave. Suite 130 Roseville, CA 95661 ph: 916.781.2600 fax: 916.781.2765

TwinCreeksHealth.com RosevilleFibromyalgia.com RosevilleBackCenter.com RosevilleInjuryCenter.com

Patient Information

Name:_____ Age: _____ Gender: M◯ F◯
Home Address: _____ Hm Ph: _____
City, State, Zip: _____ Cell _____
Email Address: _____ Marital Status:S◯M◯D◯W◯
Birth Date: _____ Social Security #: _____ - _____ - _____
Occupation: _____ Employer Name:_____
Spouse's Name: _____ Spouse's Contact #: _____

Purpose For This Visit

Reason for this visit: _____
If your symptoms are the result of an auto accident or work related injury, please inform the front desk.
Please use the general symptoms chart on the next page to provide a detailed notion of your symptoms.

When did these symptoms begin? _____ Are they getting worse? ◯YES ◯ NO
Are they:☐Constant ☐Intermittent ☐Activity - Related
Describe: _____
Do they interfere with: ☐Work ☐Sleep ☐Hobbies ☐Daily Routine
Explain:_____
What activities aggravate your symptoms? _____
Is there anything that relieves your symptoms? ◯YES ◯NO
If Yes, Please Explain: _____
Have you experienced these symptoms before? ◯YES ◯ NO
If Yes, Please Explain: _____
Have you been treated for this before? ◯YES ◯NO
When were you last treated _____ Who did you see? _____
What treatment was performed?_____
How did you respond? _____

Who may we thank for referring you to our office? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Twin Creeks Health will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Twin Creeks Health will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature _____ Date _____

Guardian Signature Authorizing Care _____ Date _____

Patient Name _____ Date_____

Review Of Symptoms Please check any symptoms you have or had in the past 6 months
Patient_____ Date_____

General Health
- ☐ Weakness
- ☐ Fever
- ☐ Chills
- ☐ Weight change
- ☐ Night sweats
- ☐ Fatigue

Skin
- ☐ Rash
- ☐ Redness
- ☐ Itching
- ☐ Eczema
- ☐ Hair changes
- ☐ Nail changes
- ☐ Other

_____

Neurologic
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Other

_____

Eyes
- ☐ Normal
- ☐ Vision trouble
- ☐ Pain
- ☐ Discharge
- ☐ Other

_____

Ears
- ☐ Hearing troubles
- ☐ Ringing
- ☐ Pain
- ☐ Discharge
- ☐ Other

Nose
- ☐ Pain
- ☐ Bleeding
- ☐ Absence of smell
- ☐ Other

_____

Mouth/Throat
- ☐ Sores
- ☐ Bleeding
- ☐ Absence of taste
- ☐ Abnormal taste
- ☐ Other

_____

Heart/Lung
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Swollen extremities
- ☐ Heart murmur
- ☐ Blue extremities
- ☐ Chest pain
- ☐ Palpitations
- ☐ Other

_____

Stomach/Intestines
- ☐ Decreased appetite
- ☐ Increased appetite
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other

_____

Glandular
- ☐ Heat/cold intolerance
- ☐ Sugar in urine
- ☐ Goiter
- ☐ Tremor
- ☐ Other

_____

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss or Impairment
- ☐ Phobias
- ☐ Mood swings
- ☐ Other

_____

Women
- ☐ Irregular menstruation
- ☐ Painful menstruation
- ☐ Abnormal vaginal
- ☐ bleeding
- ☐ Abnormal breast changes (lumps, redness/itching pain, dimpling discharge)
- ☐ ANY CHANCE YOU MAY BE PREGNANT
- ☐ Take birth control?

Reproduction/Urination
- ☐ Inability to hold urine
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Impotence
- ☐ Other

_____

_____ Initial Here

Which of the following illnesses have you had (or have)?

- ☐ Arthritis
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Hay Fever
- ☐ Allergies
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Thyroid Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Trouble
- ☐ HIV/ARC (AIDS)
- ☐ Sexually Transmitted Disease

(explain)_____

- ☐ Ulcer
- ☐ Cancer
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Bone Fracture
- ☐ Dislocated Joints
- ☐ Spinal Disc Disease
- ☐ Multiple Sclerosis
- ☐ Scoliosis
- ☐ Mental/Emotional Difficulty
- ☐ Prostate Trouble
- ☐ Kidney Trouble
- ☐ Other

(explain)_____

Do You:			
Smoke?	○ No	○ Yes	How Much?_____
Drink Alcohol?	○ No	○ Yes	How Much?_____
Use Drugs?	○ No	○ Yes	How Much?_____
Exercise?	○ No	○ Yes	How Often?_____
			What Type?_____

Family History

Who in your family has had the following problems?

	Father	Mother	Brother(s)	Sister(s)	Children
Heart Trouble	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Neck Problems	☐	☐	☐	☐	☐
Back Problems	☐	☐	☐	☐	☐
Pinches Nerve	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐
Bad Posture	☐	☐	☐	☐	☐

To best of my knowledge all these statements are true and accurate:

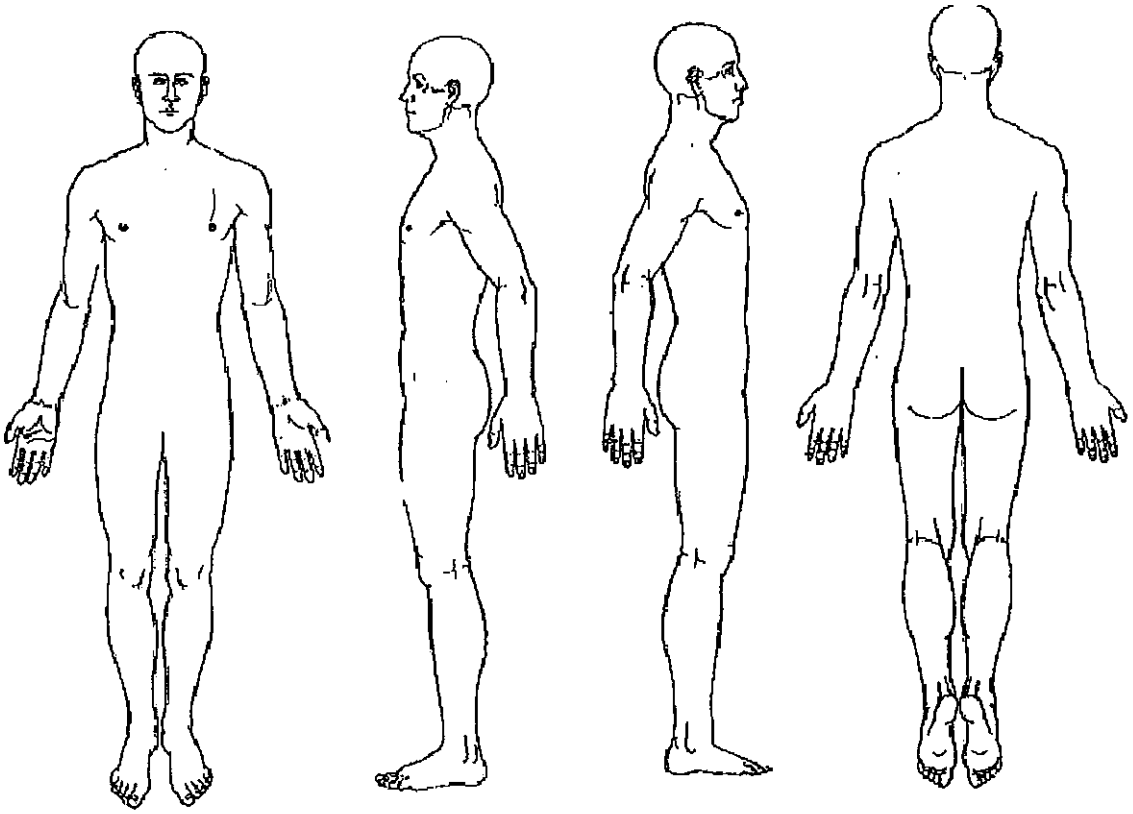
Patient Signature_____

Name_____ Date_____

PAIN DRAWING

Mark the location of your pain on the diagram with the appropriate letter to describe your pain, then rate your pain on the scale below of 0-100 with 100 being worst possible pain.

Ache = a Burning = b Numbness = n Pins and Needles = p Other = o



PAIN LINE

Pain Now No Pain _____ Worst Possible Pain
0 10 20 30 40 50 60 70 80 90 100

Average Pain No Pain _____ Worst Possible Pain
0 10 20 30 40 50 60 70 80 90 100

Worst Pain No Pain _____ Worst Possible Pain
0 10 20 30 40 50 60 70 80 90 100

ARE THESE SYMPTOMS DUE TO AUTO INJURY OR ON THE JOB INJURY?

☐ Auto ☐ Work Related ☐ None of the above

Please initial in the appropriate box.

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

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

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

FORM 501

ABOUT FINANCIAL ARRANGEMENTS FOR YOUR CHIROPRACTIC CARE

We are committed to providing you with the best possible care. If you have chiropractic coverage under your health insurance policy, we are glad to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for service is due **at the time services are rendered.** We accept cash, checks, MasterCard, Visa or CareCredit. We will be happy to bill your insurance company for their portion of your healthcare. If you choose to be billed for your co-payment will not however, be able to give you the time of service discount.

Returned checks will be charged an additional $35.00 and account balances older than 30 days will be subject to additional interest charges of 1% per month. A $35 charge may also be made for broken appointments and appointments canceled without 12 hours advance notice (excepting emergencies.)

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Please realize, however, that:

1. Your insurance coverage is a contract between you and the insurance company. When we are a preferred provider with your insurance company you understand that services and/or supplies may be determined, based on the opinion of your insurance company, to not be medically necessary or investigational and therefore not covered by your insurance company. You will then be financially responsible for those services and/or supplies.
2. Our fees generally fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all Insurance contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as chiropractic care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If problems arise, we encourage you to contact our billing office promptly for assistance in the management of your account.

If you have any questions about the above information or insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Patient's Signature _____ Date _____
Parent/Guardian Signature_____ Date_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

TWIN CREEKS CHIROPRACTIC
MICHAEL D. PUTMAN, D.C.
584 N. Sunrise Ave., Ste. 130
Roseville, CA 95661
Telephone: (916) 781-2600

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated ,with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription ·drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Date: _____

Name of Patient: _____

Signature of Patient: _____

Parent/Guardian Signature: _____

Parent/ Guardian Name Printed: _____

Doctor of Chiropractic Name: Michael Putman, DC, CMFP

Doctor of Chiropractic Name: Heather Taylor, DC

Pregnancy Release and Consent Form

Date: _____

Patient Name: _____

Patient DOB: _____

Please answer the following questions:

Are you pregnant or any chance you may be? Yes No

Are you trying to get pregnant? Yes No

Date of the start of your last period: _____

Any surgeries? List types:

_____

Please initial the line and check the box for the following that apply:

_____ I acknowledge that Twin Creeks Chiropractic may require that I have a urine and/or blood pregnancy test before I have any imaging procedures since I am 50 years of age or younger and have not had a Tubal Ligation or a Hysterectomy.

_____ I do not feel it is necessary for me to take a pregnancy test before I have any imaging procedures. I am aware of the potential medical risks due to exposure of radiation to myself and if I were pregnant, my unborn child.

_____ I will not hold Twin Creeks Chiropractic or any of the doctors or staff liable if I have any imaging procedures and find out that I am pregnant afterwards.

Your signature indicates that you have read and understand the above and accept all responsibility associated with exposure to yourself or your unborn child and have accurately answered the above statements.

Signature: _____ Date: _____