Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Chiropractic Partners
3319 Durham-Chapel Hill Blvd.
Durham, NC 27707
Phone: (919) 383-9890

NEW PATIENT INTAKE

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____/_____/_____ Age _____ SSN# _____ - _____ - _____

Gender: ☐ Male ☐ Female Email: _____

How did you hear about our office? _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

CURRENT MEDICATIONS

Name of Medication	Start Date	Name of Medication	Start Date
◊ _____	_____	◊ _____	_____
◊ _____	_____	◊ _____	_____
◊ _____	_____	◊ _____	_____
◊ _____	_____	◊ _____	_____

ALLERGIES

◊ _____	◊ _____
◊ _____	◊ _____
◊ _____	◊ _____

COORDINATED CARE

For the purposes of coordinating care, we recommend that we send records to your primary physician.

Physician: _____ Facility: _____

Patient Signature: _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

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

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

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

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

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

Lifting

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

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/20(

Patient Name _____ Date _____

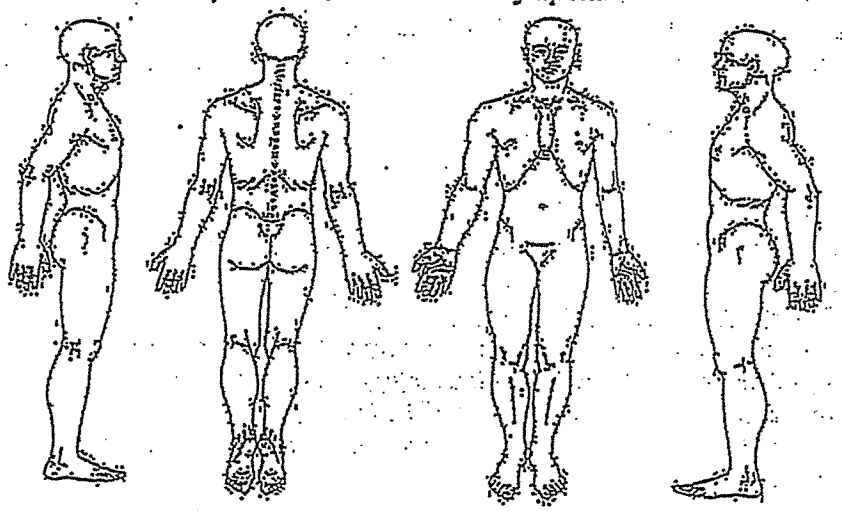
1. Describe your symptoms _____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?
① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?
① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms
None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)
① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)
① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...
① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?
① No One ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?
① Xrays date: _____ ③ CT Scan date: _____
② MRI date: _____ ④ Other date: _____

9. Have you had similar symptoms in the past?
① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
① This Office ③ Medical Doctor ⑤ Other
② Other Chiropractor ④ Physical Therapist

10. What is your occupation?
① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?
① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ Date _____

Patient Name: _____ Date: _____

MEDICAL CONDITIONS

- ☐ Hypertension
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Easy Bruising/Bleeding
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Blood Clots
- ☐ Bowel Problems
- ☐ Constipation
- ☐ Nausea/Vomiting
- ☐ Poor Appetite
- ☐ Bloody Stools
- ☐ Gout
- ☐ Arthritis
- ☐ Swelling of Legs
- ☐ Dizziness/Vertigo
- ☐ Difficulty Swallowing
- ☐ Skin Disease
- ☐ Immune Disorder
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Fevers/Chills/Sweats
- ☐ Aneurysm
- ☐ Weight Loss/Gain
- ☐ Difficulty Sleeping
- ☐ Head Injury
- ☐ Osteoporosis
- ☐ Broken bones
- ☐ Shortness of Breath
- ☐ Numbness
- ☐ Balance Issues

Other: _____

SURGERIES (Please list type of surgery and approximate date)

◊ _____ ◊ _____
◊ _____ ◊ _____
◊ _____ ◊ _____

FAMILY HISTORY

	Parent	*Sibling*		*Parent*	*Sibling*		*Parent*	*Sibling*
• Arthritis	☐	☐	• Cancer	☐	☐	• Psychiatric	☐	☐
• Cholesterol	☐	☐	• Diabetes	☐	☐	• Stroke	☐	☐
• Heart Problems	☐	☐	• Hypertension	☐	☐	• Thyroid	☐	☐

SUBSTANCE USE

	Present	*Past*		*Present*	*Past*		*Present*	*Past*
• Alcohol	☐	☐	• Tobacco	☐	☐	• Heroin	☐	☐
• Opioids	☐	☐	• Marijuana	☐	☐	• Cocaine	☐	☐
• Barbituates	☐	☐	• Amphetamines	☐	☐	• Other _____		

FINANCIAL POLICY FOR OFFICE OF DR. MICHAEL KRASNOV

COMPLIMENTARY CONSULTATION (circle one) YES/NO

I only wish to have a complimentary consultation and do not wish to receive any other services.

COMMERCIAL INSURANCE

We will file your insurance; however it is your responsibility to understand your insurance plan. Although we verify benefits as a service to you, we cannot guarantee your insurance will pay according to the benefits quoted to us and therefore there are **no guarantees of payment** from your insurance company. Unless otherwise prohibited, **any balance not paid by your insurance company within 90 days of our billing date is your responsibility.**

Payment of deductible, coinsurance, copays, and any non-covered services, based on the information provided to us by your insurer, is due and payable **at the time of service.**

PERSONAL INJURY

If your condition is due to a motor vehicle accident, we retain the right to file **ANY** available insurance, such as Medpay or health insurance. You will be responsible for any non-covered balance. If you retain an attorney or if there is a liable insurance company, we will wait to receive payment from them for up to one year from completion of treatment. **Any balance is immediately due and payable** under the following conditions: 1) you terminate care without your doctor's approval, 2) you fall to notify us that you are no longer represented by the attorney we have on record, 3) you receive payments in whole or in part for our services from a third party including Med Pay, and do not promptly use it to settle any balance due, of 4) you fail to cooperate with our efforts to receive third party reimbursement. Until we can verify your insurance coverage and/or legal representation, you may be asked to pay for your services in full.

WORKER'S COMPENSATION INJURY

Almost all employers carry industrial insurance to cover treatment of your Worker's Comp Injury. There is no out of pocket expense to the patient on **APPROVED** job-related injury claims; however we must receive from your employer and/or employer's insurance carrier approval prior to your examination and treatment for this direct billing. Patient without prior approval are required to pay for their services at the time of service. Any payments made by the patient prior to approval are reimbursed after this office receives payment from the insurance carrier.

MEDICARE

Medicare **only pays for spinal manipulation** and only if they consider it medically necessary. They do not cover any other services. Other services not covered by Medicare include but are not limited to examinations, x-rays and therapies.

SIGNATURE (Medicare patients only): _____ Date: _____

CASH

If you do not wish us to file any type of insurance, and you pay us in full at the time of service, you will be set up as a "cash" patient. This entitles you to a discount off our regular rates. If you have insurance and ask us not to file your insurance, you can change your mind in the future, but past visits will not be filed.

THERE IS A $25 RETURNED CHECK FEE FOR ALL RETURNED CHECKS

We request the courtesy of 24-hour advance notice if you are unable to keep your appointment. Failure to do so on a repeated basis may result in the loss of scheduling privileges.

I understand the above information and agree to pay any amount not covered by my insurance carrier or liable party, unless otherwise prohibited. I agree to pay any cost associated with collecting payments over 30 days past due. This includes any late fees, interest, attorney's fees, and court cost.

All durable medical equipment, supplements, other supplies which may not be covered by my insurance plan must be paid for upon receipt. Returns cannot be accepted on any supplies or products that are not in new condition. Pillows can not be returned if the packaging is opened. Returns must be made within 14 days of purchase. Refunds for items paid by check will be issued after the check clears.

PRINTED NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

Chiropractic Partners
RESTORING HEALTH AND WELLNESS

Chiropractic Partners
Dr. Michael Krasnov, DC, CCSP, CCEP
Dr. Alex Allard, DC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand them. I understand that this form will be placed in my patient chart and maintained for 7 years.

_____ _____
Patient Name (print) Date

_____
Parent, Guardian, or Patient's Legal Representative

_____
Signature

Please list below the names and relationship of people to whom you authorize us to release personal health information (PHI).

◊ _____ ◊ _____

◊ _____ ◊ _____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapeutic modalities and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with other Chiropractic Partners Offices.

I have had an opportunity to discuss with the office or clinic personnel, the nature and purpose of chiropractic adjustments, and other procedures. I understand that results are not guaranteed.

I understand and am informed that as with the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but not limited to, 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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

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 form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment.

To be completed by patient:

_____
Printed Name

_____
Signature

_____
Date

To be completed by patient's representative, if necessary (e.g. if patient is a minor or is mentally impaired):

_____
Printed Name of Patient's Representative

_____
Signature of Patient's Representative

_____
Date