APPLICATION FOR TREATMENT / SELECT TYPE OF ACCOUNT/ AUTHORIZATION AND ASSIGNMENT

Name - Last:__________________ First:_____________ Middle:___

Date of Birth:________________________________ Male / Female

Name of Spouse (or Parent if Minor): __________________________

Street Address: ____

City, State and Zip Code: ___________________________________

Mailing Address (if different): ______________________________

E-mail Address: ____

Home Phone: ________________ Work Phone: _________________

Best Number to Call: ___________ Best Time to Call: ___________

Circle One: Married Single Widowed Divorced # of Children:____

Social Security #: ______________ Drivers License #:____________

Employer:_____________________ Occupation:________________

Employer Address: ____

Employer Phone #:________________ Supervisor:_______________

Have you had chiropractic care before? YES NO When?_________

Have you ever been a patient at this office? YES NO

Whom may we thank for referring you? _________________________

SELECT TYPE OF ACCOUNT (CHECK ONE):

_____ **Discount Plan-**I will not file any insurance and I will pay in full at time of service and receive a **25% discount** from all our usual and customary services, supplies excluded. Under this plan, no statement can be provided to any 3rd party, including health insurance companies, liability adjusters, med-pay adjusters, or attorneys.

_____ **Insurance**-I will pay my deductible, co-payments, and/or co-insurance in full for services rendered each visit.

_____ **Personal Injury**-I have been injured in an accident. I will my claim to my med-pay, liability, attorney (if applicable), and health insurance (if applicable). Credit will be granted up to the limit of the med-pay policy or as indicated by office manager. The office is **not** required to accept contracted reduced fees under a liability situation.

My auto insurance name:_______________________________

The other driver's insurance name:________________________

My health insurance is: ________________________________

My attorney's name: ___________________________________

_____ **Worker's Compensation**-I was hurt at work and have been authorized by my employer and their insurance carrier for chiropractic treatment at this office.

_____ **Medicare**-I will pay my deductible and co-insurance in full for services rendered each visit. Medicare only covers chiropractic adjustments. I will pay for all non-covered services in full such as the initial examination and maintenance adjustments.

_____ **Medicaid-**Medicaid only pays for the adjustments. I will pay for all non-covered services in dull such as the initial examination.

TYPE OF CARE YOU ARE REQUESTING (CHECK ONE):

_______ **WELLNESS CARE** (Available to people with no symptoms and no chronic injury who desire periodic care for themselves and their family. This maintains the spine and nervous system, and prevents avoidable illnesses. Recommended also for infants and children.)

_______ **INITIAL INTENSIVE CARE** (For people with symptoms and chronic conditions who want pain relief and initial healing.)

_______ **RELIEF CARE** (Sufficient care to produce acute symptoms relief only.)

_______ NOT SURE OF THE TYPE OF CARE I NEED.

AUTHORIZATION AND ASSIGNMENT

The undersigned hereby authorizes and directs any person, government agency, or corporation having notice of this assignment to pay to Anderson Family Chiropractic directly the amount of the indebtedness owed to Anderson Family Chiropractic in connection with services rendered to the patient. The undersigned hereby assigns to Anderson Family Chiropractic all rights, title, and interest in and to any payment or compensation in any form that the undersigned received or shall receive as a result of or arising out of the injuries sustained by the patient. This assignment is made without prejudice to any rights that the patient and the undersigned might have to compensation for injuries incurred by the patient.

I understand that I remain personally responsible for the total amounts due on my account(s) with Anderson Family Chiropractic, regardless of medically unnecessary, non-covered, or maintenance services or lack of sufficient benefits or settlements. Signing this form allows Anderson Family Chiropractic, at it's discretion, to collect payments at the time that services are rendered. If asked, I agree to make payments on my account.

I authorize Anderson Family Chiropractic to release any information, pertinent to my case, to any insurance company, government agency, adjuster, or attorney to facilitate collection under this assignment, lien, and authorization. I hereby revoke all previous authorizations given by me to stop the release of medical information. A copy of this signed authorization and lien shall be as effective as the original.

I agree that Anderson Family Chiropractic may endorse, sign my name, to any checks sent to the clinic as payment on my account.

I agree that Anderson Family Chiropractic can send appointment reminders, office news, office promotions via email from time to time.

By signing below, I fully understand all of which is on this page.

Signed (Parent/Guardian if child): ______________________ __________ Print: ____________________________ Date: ___________

Witness: ____ Print: ____________________________ Date: ___________

Patient Health History

Name: ________________________________ Date: __________________

Chiropractic or Acupuncture may sometimes help some of the following conditions, check those that apply to you:

Past	**Present**		**Past**	**Present**		**Past**	**Present**	
____	____	High Blood Pressure	____	____	Irritable Bowel	____	____	PMS/Cramps
____	____	Colic	____	____	Migraine	____	____	Heartburn/Indigestion
____	____	Sinus Problems	____	____	Depression/Anxiety	____	____	Sleep Disturbances
____	____	Asthma	____	____	Belching/Gas	____	____	Ear Infections
____	____	Tinnitus	____	____	Poor Vision	____	____	Bed Wetting
____	____	Reflux/Ulcers	____	____	Seizures	____	____	Dizziness/Ear Ringing

Please check other conditions/symptoms which apply to you, please read carefully:

Past	**Present**		**Past**	**Present**		**Past**	**Present**	
____	____	Vertigo/Unsteadiness	____	____	Double Vision	____	____	Giddiness/Confusion
____	____	Diabetes	____	____	Frequent Urination	____	____	Loss of Bowel Control
____	____	Prostate Problems	____	____	Bloody Urination	____	____	Osteoporosis
____	____	Pacemaker	____	____	Painful Urination	____	____	Chest Pain
____	____	Stroke	____	____	Rheumatoid Arthritis	____	____	Cancer Where: ______
____	____	Abnormal Wt. Loss	____	____	Heart Disease	____	____	Fainting/Drop Attacks
____	____	Anemia	____	____	Night Pain	____	____	Perm. Disability Rating
____	____	Bleeding Disorders	____	____	Easily Bruised	List Your Rating: ______________		

Do you have a family history of: ___ Diabetes _________ Heart Disease ____ Cancer ___ Kidney Disease

Do you take vitamins? _______ No _______ Yes Please List: ______________________________

How much do you exercise? _______ None _______ Moderate _________ Daily Type: ________________

Do you smoke? _______ No _______ Yes How Much: ________________________

Do you drink alcohol?_______ No _______ Yes How Much: ________________________

Do you drink coffee/tea/caffeinated drinks? __ No _______ Yes How Much: ________________________

Case History

Account Number: _______________ Name: ____________________________________ Date: ____________

______ I have no pain or any other symptoms and I just want to have my spine examined. (Skip to next page.)

[1]Below, **list the symptoms** you are having. Begin with the symptom that hurts or troubles you the most.	[3]Is the pain **sharp**, **dull**, **throbbing**, **numbness**, **aching**, **shooting**, **tingling**, **cramping**, **burning**, **stiffness**, etc.	[5a]Put a number on each symptom (**1-10**). **1** = "barely hurts" **10** = "the worst pain I ever had"	Is the pain **constant** or does it **come and go**.	[1a]Exactly **when** did the symptom begin?
Example: Migraine	Throbbing/Shooting	8	Comes and Goes	2/12/2010
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

[1]Do you suffer from any other condition or symptom? ________________________________

[1]I feel (circle one) **pain** / **numbness** in my: ___ Rt. Arm ___ Lt. Arm ___ Rt. Leg ___ Lt. Leg ___ Head

[1]How far down the arm or leg does the pain go? ________________________________

____

____

[4]In general, since my condition began, it is getting: _____ Better _____ Worse _____ Same

[2]How often do you experience your problem per day? ____ 79-100% ____ 51-75% ____ 26-50% ____ 0-25%

[5b6]How much has pain interfered work/activities? ___ extreme ___ a lot ___ moderately ___ a little ___ not at all

[1b]This was caused by: ____ Auto Accident ____ On the Job ____ Unknown ____ Other Date: ____________

[1b]Describe further what caused your symptoms: ________________________________

____

____

What activity, position, or time of day seems to make your symptoms **worse**? ____________________

____

____

What activity, position, or time of day seems to make your symptoms **better**? ____________________

____

____

List all the doctors you have seen for **this episode of this condition**:

	Doctor or Clinic Name	**Location**	**Date Last Seen**
1.			
2.			
3.			
4.			

Other than this episode, have you had a condition like this before: _______ No ______ Yes Results: ______
If yes, list all the doctors you have seen for previous episodes:

Doctor or Clinic Name	Location	Date Last Seen
1.		
2.		
3.		

List all the doctors you have seen for **any condition within the last year**:

Doctor or Clinic Name	Location	Condition	Date Last Seen
1.			
2.			

List all medications you are currently taking (including birth control pills and over-the-counter medications):

Medication	For What Condition?
1.	
2.	
3.	
4.	

[7]In general would you say your overall health right now is (circle one): Excellent Very Good Good Fair Poor

[10]What is your occupation? ____ Professional/Executive ____ White Collar/Secretarial ____ Tradesperson
____ Laborer ___ Homemaker ____ FT Student ____ Retired ____ Other

[10a]What is your work status? ___ full time ___ part time ___ self employed ___ unemployed ___ off work
other

List any falls or injuries you had as a child? ______________________________

List any hobbies that strain your spine (for example, golf, bowling, needlepoint, horseback riding, reading in bed, long period in front of computer): ______________________________

List any accidents, falls, auto accidents, etc. that occurred throughout your life that could have contributed to your condition: ______________________________

List all your lifetime surgeries you have had:

Type of Surgery	Date	Surgeon

Is there any chance that you could be pregnant? ___ No ______ Yes
Have you ever been to a chiropractor before? _____ No ______ Yes Doctor's Name: ________________
Location: ______________________ Date: ____________ Condition? ______________

REVISED 10/06/2010

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.

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.

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).

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.

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.

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.

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.

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.

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.

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

Back Index

ACN Group, Inc. Form BI-100

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

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your back 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 The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

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

Back Index Score