Associated Chiropractic Physicians

Experienced, gentle back & neck care from our family ... to yours!

TO THE

New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:
A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:
The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:
You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

STEP SIX:
Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

STEP SEVEN:
An estimation of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of you problem has been obtained.

STEP EIGHT:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

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First Name:_____ **Last Name:**_____

Preferred method of communication for patient reminders *(Check one):* ☐ Email ☐ Phone ☐ Mail

Preferred Language: _____

Smoking Status (Check one): ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Height: _____ ***Weight:*** _____

Race (Check one): ☐ American Indian or Alaska Native ☐ Asian / Black or African American ☐ White(Caucasian)

☐ Native Hawaiian or Pacific Islander ☐ Other ☐ I Decline to Answer

Ethnicity (Check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

Are you currently taking any medications? *(Please include regularly used over the counter medications)*

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)	Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? ☐ NO ☐ YES

List: _____

_____

☐ ***I choose to decline receipt of my clinical summary after every visit*** *(<u>These summaries are often blank as a result of the nature and frequency of chiropractic care.</u>)*

Patient Signature: _____ Date: _____

For office use only:

Blood Pressure: _____ / _____ Pulse: _____

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
SOCIAL SECURITY NUMBER:	GENDER:
MARITIAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:

ABOUT YOUR SPOUSE

SPOUSE NAME:	
SPOUSE EMPLOYER:	
EMPLOYER ADDRESS:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:

HEALTH HABITS

DO YOU DRINK ALCOHOL? ❑ YES ❑ NO

DO YOU DRINK COFFEE, TEA OR SODA? ❑ YES ❑ NO

DO YOU EXERCISE REGULARLY? ❑ YES ❑ NO

DO YOU WEAR: ❑ HEEL LIFTS ❑ INNER SOLES ❑ ARCH SUPPORTS

WERE YOU AWARE THAT...

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?

❑ YES ❑ NO

THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?

❑ YES ❑ NO

CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?

❑ YES ❑ NO

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY):

❑ NEWSPAPER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ MAILING

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:

❑ JOB ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY

❑ CHRONIC DISCOMFORT ❑ OTHER

PLEASE EXPLAIN:

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER?

❑ YES ❑ NO

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:

❑ GOTTEN WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:

❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES

PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE? ❑ YES ❑ NO

PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

Associated Chiropractic Physicians

1320 Kenwood Ave. Duluth, MN 55811

ADULT MEMBER HEALTH RECORD

Past and Present Health Conditions

Past	Present	Condition
❑	❑	Headaches
❑	❑	Neck Pain
❑	❑	Upper Back Pain
❑	❑	Mid Back Pain
❑	❑	Low Back Pain
❑	❑	Shoulder Pain
❑	❑	Elbow/Upper Arm Pain
❑	❑	Wrist Pain
❑	❑	Hand Pain
❑	❑	Hip/Upper Leg Pain
❑	❑	Knee/Lower Leg Pain
❑	❑	Ankle/Foot Pain
❑	❑	Jaw Pain
❑	❑	Joint Swelling/Stiffness
❑	❑	Arthritis
❑	❑	Rheumatoid Arthritis
❑	❑	General Fatigue
❑	❑	Muscular Incoordination
❑	❑	Visual Disturbances
❑	❑	Dizziness
❑	❑	Smoking/Tobacco Use
❑	❑	Drug/Alcohol Dependence
❑	❑	Allergies
❑	❑	Depression
❑	❑	Systemic Lupus
❑	❑	Epilepsy
❑	❑	Dermatitis/Eczema/Rash

Past	Present	Condition
❑	❑	High Blood Pressure
❑	❑	Heart Attack
❑	❑	Chest Pains
❑	❑	Stroke
❑	❑	Angina
❑	❑	Kidney Stones
❑	❑	Kidney Disorders
❑	❑	Bladder Infection
❑	❑	Painful Urination
❑	❑	Loss of Bladder Control
❑	❑	Prostate Problems
❑	❑	Abnormal Weight Gain/Loss
❑	❑	Loss of Appetite
❑	❑	Abdominal Pain
❑	❑	Ulcer
❑	❑	Hepatitis
❑	❑	Liver/Gall Bladder Disorder
❑	❑	Cancer
❑	❑	Tumor
❑	❑	Asthma
❑	❑	Chronic Sinusitis
❑	❑	HIV/AIDS
		Females Only
❑	❑	Birth Control Pills
❑	❑	Hormonal Replacement
❑	❑	Pregnancy
		Other
❑	❑	_____
❑	❑	_____

Indicate if an Immediate Family Member Has Had any of the Following:

❑Arthritis ❑Heart Problems ❑Diabetes ❑Cancer ❑_____

List all the Surgical Procedures You Have Had and Times You Have Been Hospitalized:

_____

_____

_____

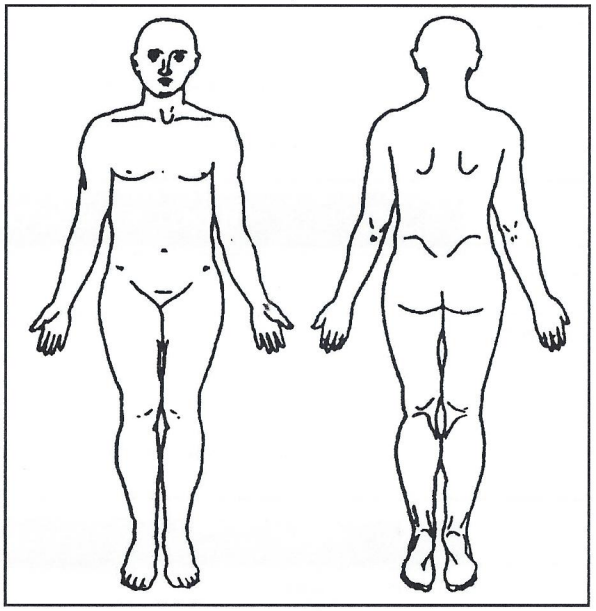
_____

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. ***Please check the type of care desired*** so that we may be guided by your wishes whenever possible.

- ❑ ***Relief care:*** Symptomatic relief of pain or discomfort.
- ❑ ***Corrective care:*** Correcting and relieving the cause of the problem as well as the symptom.
- ❑ ***Comprehensive care:*** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ❑ ***I want the Doctor to select the type of care appropriate for my condition.***

Please outline on this diagram the area of your discomfort:



Doctor's Additional Comments

Patient Signature: _____

Doctor's Signature: _____ Date: _____

AUTHORIZATIONS AND RELEASES

Consent for Treatment

I, the undersigned, hereby authorize Dr._____ and whomever he/she may designate as his/her assistant (s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained. Chiropractic care has been proven to be very effective, however it is not unusual to be sore after your first few corrective adjustments. Although rare, it is possible to suffer from other side effects including muscle spasms, stiffness, rib fracture, headache, dizziness and stroke. All questions regarding the objective to my care in the office have been answered to my complete satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

I also understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. Collection cost, filing and attorney's fees will be added to cash balances exceeding 90 days old. **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, any fees for professional services rendered me will be immediately due and payable.**

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Associated Chiropractic Physicians, the entirety of benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Attorney Representation and Projection of Balance

I, the undersigned patient am directing my Attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance, I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s), and certify that all insurance information given to this clinic is correct and complete.

Pregnancy Release - *FEMALES ONLY*

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. ***Date of last menstrual cycle:*** _____ ☐ ***I AM PREGNANT***

Patient Name (Print): _____ Relationship to Patient: _____

Signature: _____ Date: _____

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NECK DISABILITY INDEX

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 *Unbearable pain*

Please read: This questionnaire has been designed to give the doctor information on how your neck pain has affected your ability to manage in everyday life. Please answer every question, and circle only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1 – Pain Intensity
0. I have no pain at the moment.
1. The pain is mild at the moment.
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 severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I can look after myself 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 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.

Section 3 – 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 lifting heavy weights off the floor, but I can if they are conveniently positioned, e.g. on the table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Reading
0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I cannot read as much as I want because of severe pain in my neck.
5. I cannot read at all.

Section 5 – Headache
0. I have no headache 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 most of the time.

Section 6 – Concentration
0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

Section 7 – Work
0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can 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.

Section 8 – Driving
0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my car at all.

Section 9 – 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).

Section 10 - Recreation
0. I am able to engage in all recreational activities with no pain in my neck.
1. I am able to engage in all recreational activities with some pain in my neck.
2. I am able to engage in most, but not all recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of my neck pain.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.

TOTAL_____

Print name _____ Signature _____ Date

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain	0	1	2	3	4	5	6	7	8	9	10	*Unbearable pain*

Please read: This questionnaire has been designed to give the doctor information on how your back pain has affected your ability to manage in everyday life. Please answer every question, and circle only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1 – 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 severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would 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 increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase 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.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain walking.
1. I have some pain walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only 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 ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on 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 ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – 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 nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect 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.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but 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.

TOTAL_____

Print Name _____ Signature _____