Katherine E. Bruce, DC

Bruce Chiropractic

118 E Main St., Lancaster, OH 43130 Phone
(740)422-8484 Fax (740) 422-8486

Patient Registration

Patient Name: **Date:**

(First) (Middle) (Last)

Sex: ◯ Male ◯ Female **Date of Birth:** **Social Security #:**

Street Address:

City: **State:** **Zip Code:**

Home Phone: **Cell Phone:** **Email:**

Cell Carrier: (ATT, Verizon, etc.) **Work Phone:**

Best phone # to reach you during business hours: ◯ Home ◯ Cell ◯ Work

Marital Status: ◯ Single ◯ Married (years) ◯ Widowed ◯ Separated ◯ Divorced

Language: ◯ English ◯ Spanish ◯ Other:

Race: ◯ Native Hawaiian or other Pacific ◯ White or Caucasian
◯ American Indian or Alaska Native ◯ Black or African American

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic or Latino

Occupation: **Employer:**

Employer's Address:

Employer's Phone #:

Spouse: **Address:** (If differ than above)

Spouse Phone #: **Spouse Employer:**

Emergency Contact: **Relationship:**

Phone Number (s):

Family Doctor: **Referring Doctor:**

How did you hear about our office?

Do you seek help for: ☐ Back Pain ☐ Neck Pain ☐ Headache ☐ Other:

HIPPA Practice's Requirements

This Practice:

a) Is required by federal law to maintain the privacy of your PHI and to provide you with Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI
b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use of release of your PHI that which is provided for under federal law
c) Is required to abide by the terms of the Privacy Notice
d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains
e) Will distribute any revised Privacy Notice to you prior to implementation
f) Will not retaliate against you for filing a complaint

Effective Date: 04/14/2003

Patient Acknowledgment: By subscribing my name below, I acknowledge receipt of my copy of this Notice, and my understanding and agreement to its terms.

Signed: **Date:**

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Billing Assignment

Patient Name: **Date:**

Injury/Accident Information

Is your condition due to an accident? ◯ Yes ◯ No **Date of Accident/Injury:**

Type of Accident: ◯ Auto ◯ Work ◯ Other:

Have you made a report of your accident: ☐ Auto Insurance ☐ Employer ☐ Work Comp ☐ Other:

Attorney Name (If applicable):

BWC Claim #: **Insurance Company:**

Insurance Information:

Primary:

Who is responsible for this account? ◯ Self ◯ Spouse ◯ Dependent ◯ Parents ◯ Other:

Subscriber/Guarantor Name: (if not self) **Social Security #:**

Relationship to patient: **Date of Birth:**

Address: **Phone #:**

Employer: **Employer Address:**

Insurance Company: **ID #:** **Group #:**

Secondary:

Who is responsible for this account? ◯ Self ◯ Spouse ◯ Dependent ◯ Parents ◯ Other:

Subscriber/Guarantor Name: (if not self) **Social Security #:**

Relationship to patient: **Date of Birth:**

Address: **Phone #:**

Employer: **Employer Address:**

Employer: **Employer Address:**

Insurance Company: **ID #:** **Group #:**

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance company/companies. I assign directly to The Chiropractic Group 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: **Relationship:** **Date:**

By signing below, I acknowledge that The Chiropractic Group has informed me that payment for services and supplies may be denied under my health insurance plan, if applicable. I agree that if denied as medically not necessary, not authorized/no referral on file, exceed benefit limits or any other reason, including non-insured, I accept full responsibility to pay The Chiropractic Group for services or supplies received.

Signed: **Date:**

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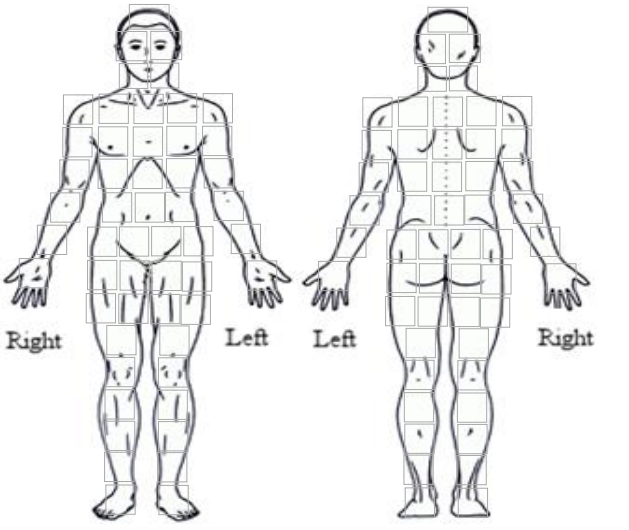
Name:

Date: _____

1. SELECT/MARK on the picture where your complaint is.



What is your estimated:

Height: _____ ft. ___ in. Weight: _____

2. Describe your **primary** complaint? _____

3. What does it affect the most (ex: walking, sleep, work, recreation)? _____

4. When did it start? _____

5. How did it start? _____

6. Describe the pain/symptoms (sharp, ache, sore, throbbing, numbness, weakness, stiffness, toothache, etc.):

_____

7. Does the pain/symptom radiate? ◯ Yes ◯ No _____

8. (Select one) How bad is it? ◯ **None** ◯ **Minimal** ◯ **Mild** ◯ **Moderate** ◯ **Severe**

9. (Select one) Pain is present: ◯ **Constantly** (100-76%) ◯ **Frequently** (75-51%) ◯ **Occasionally** (50-26%) ◯ **Intermittently** (25-1%) ◯ **None** (0%)

10. (Select one) degree of pain (0=none, 10=severe) ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

11. (Select one) Pain is: ◯ **Improving** ◯ **Not Changing** ◯ **Worsening**

12. Are there any other symptoms related to your primary complaint? ◯ Yes ◯ No _____

13. What aggravates the pain? _____

14. What relieves the pain? _____

15. List other **Doctors,Tests and Treatments:** _____

16. Previous episodes? _____

17. Additional complaints: _____

---------- Office Use ----------

BP _____ Pulse _____ Temp _____

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NAME: _____ DATE: _____

ALLERGIES

Environmental:

Medication:

Food:

FAMILY HISTORY

Mark conditions that are in your **IMMEDIATE** family.

- ☐ Allergies
- ☐ Back Problems
- ☐ Cancer
- ☐ Nervous System Disease
- ☐ Headaches Heart Disease
- ☐ High Blood Pressure
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Strokes

Other

SOCIAL HISTORY

Smoking: ◯ Never Smoked ◯ Current Smoker ◯ Past Smoker

Alcohol Use: ◯ None ◯ Casual ◯ Moderate ◯ Heavy

Caffeine Use: ◯ None ◯ < 3 cups/day ◯ 3-6 cups/day ◯ >6 cups/day

Drug Use: ◯ None ◯ Recreational ◯ Addicted

Exercise Habits: ◯ Never ◯ Daily ◯ Weekly

☐ Sporadic Walk ☐ Run/Jog ☐ Resistance/Weights
☐ Aerobics ☐ Yoga ☐ Stretch

OCCUPATIONAL HISTORY

Occupation:

Physical Demands: ◯ Low ◯ Moderate ◯ Heavy

Past Medical History (Please list any current or prior health problems):

General health problems: ☐ None / _____
Addiction or drug abuse problems: ☐ None / _____
Neurological/Psychological problems: ☐ None / _____
Spinal/Spinal Cord problems: ☐ None / _____
Musculoskeletal problems: ☐ None / _____
Heart problems: ☐ None / _____
Vascular/Circulatory problems: ☐ None / _____
Eye/Ear/Nose/Throat problems: ☐ None / _____
Breathing/Respiratory problems: ☐ None / _____
Stomach/Colon/Digestive problems: ☐ None / _____
Genital/Urinary problems: ☐ None / _____
Endocrine/Diabetic/Hormone problems: ☐ None / _____
Immune system problems: ☐ None / _____
Bleeding/Blood problems: ☐ None / _____
Previous/current infections: ☐ None / _____
Tumors/Cancer problems: ☐ None / _____

MEDICATIONS

List:

SURGERIES

List:

HOSPITALIZATIONS

List:

BONE/JOINT PROBLEMS and INJURIES:

List:

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NAME: _____ DATE: _____

Have you recently experienced any of the following:

○ Yes ○ No: Chills		○ Yes ○ No: Bowel incontinence		○ Yes ○ No: Loss of strength	
○ Yes ○ No: Fatigue		○ Yes ○ No: Blood in stool		○ Yes ○ No: Tingling/numbness	
○ Yes ○ No: Fever		○ Yes ○ No: Bladder incontinence		○ Yes ○ No: Little interest or pleasure in doing things	
○ Yes ○ No: Night sweats		○ Yes ○ No: Muscle aches			
○ Yes ○ No: Weight gain		○ Yes ○ No: Painful joints		○ Yes ○ No: Depressed mood	
○ Yes ○ No: Weight loss		○ Yes ○ No: Pain/cramping in legs after exertion		○ Yes ○ No: Difficulty sleeping	
○ Yes ○ No: Chest pain					
○ Yes ○ No: Shortness of breath		○ Yes ○ No: Ulcerations of feet			

In order to properly assess your condition and accurately grade your response to treatment, we must understand how much your neck and/or back problem(s) have affected your ability to manage everyday activities (ADLs).
For each section below, please select the one number which most closely describes your condition right now.

Pain Intensity:
- ○ 0 No pain
- ○ 1 Mild Pain
- ○ 2 Moderate Pain
- ○ 3 Severe Pain
- ○ 4 Worst Possible Pain

Sleeping:
- ○ 0 Perfect Sleep
- ○ 1 Mildly Disturbed Sleep
- ○ 2 Moderately Disturbed Sleep
- ○ 3 Greatly Disturbed Sleep
- ○ 4 Totally Disturbed Sleep

Personal Care (washing, dressing, etc.):
- ○ 0 No pain, no restrictions
- ○ 1 Mild pain, no restrictions
- ○ 2 Moderate pain, need to go slowly
- ○ 3 Moderate pain, need some assistance
- ○ 4 Severe pain, need 100% assistance

Travel (driving, etc):
- ○ 0 No pain on long trips
- ○ 1 Mild pain on long trips
- ○ 2 Moderate pain on long trips
- ○ 3 Moderate pain on short trips
- ○ 4 Severe pain on short trips

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

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

Recreation:
- ○ 0 Can do all activities
- ○ 1 Can do most activities
- ○ 2 Can do some activities
- ○ 3 Can do few activities
- ○ 4 Cannot do any activities

Lifting:
- ○ 0 No pain with heavy weight
- ○ 1 Increased pain with heavy weight
- ○ 2 Increased pain with moderate weight
- ○ 3 Increased pain with light weight
- ○ 4 Increased pain with any weight

Walking:
- ○ 0 No pain; any distance
- ○ 1 Increased pain after 1 mile
- ○ 2 Increased pain after ½ mile
- ○ 3 Increased pain after ¼ mile
- ○ 4 Increased pain with all walking

Standing :
- ○ 0 No pain after several hours
- ○ 1 Increased pain after several hours
- ○ 2 Increased pain after 1 hour
- ○ 3 Increased pain after ½ hour
- ○ 4 Increased pain with any standing

Patient Signature:_____ Date: _____

Raw Score: _____ Percent Impairment: _____ Dr. Initials: _____