Chiro 1st PATIENT INFORMATION
PERSONAL INJURY

File #_____**Name** (First) _____ (Middle)_____ Last_____

Address _____ City _____ State _____ Zip _____

Age _____ **DOB** _____ Sex _____ Status: S M W D # Child _____ **SSN**_____

Home Phone_____ Cellular Phone_____ Email _____

Occupation_____ Employer_____ Work Phone_____

Spouse's Name_____ **DOB** _____ Employer_____ **SSN**_____

INSURANCE INFORMATION

Your Ins. Co _____ Policy# _____Agent's Name _____Phone_____

Responsible Party's Name _____Insurance Co _____Phone_____

Agent's Name _____ Phone_____

Policy Holders Name _____ Policy# _____

ATTORNEY INFORMATION

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ❑ Yes ❑ No Name(s) _____

NATURE OF ACCIDENT:

Day of Accident _____**Date** of Accident _____ **Time** of Accident _____

Were you : ❑ Driver ❑ Passenger ❑ Front Seat ❑ Back Seat_____

Number of people in your vehicle? _____ Were you wearing seat belts? ❑ Yes ❑ No

What direction were you headed? ❑ North ❑ East ❑ South ❑ West

On (name of street) _____

What direction was the other vehicle headed? ❑ North ❑ East ❑ South ❑ West_____

Were you struck from: ❑ Behind ❑ Front ❑ Left side ❑ Right side_____

Approximate speed of your car _____ mph Other car _____mph

Were you knocked unconscious? ❑ Yes ❑ No If yes for how long? _____

Were police notified? ❑ Yes ❑ No

In your own words, please describe accident: _____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? ❑ Yes ❑ No If yes, please describe in detail:

_____

Please describe how you felt:

a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident: _____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

What are your PRESENT complaints and symptoms?

Do you have any congenital (from birth) factors which relate to this problem? ❑ Yes ❑ No If yes, please describe:

Do you have any previous illnesses, which relate to this case? ❑ Yes ❑ No If yes, please describe:

Where were you taken after the accident?

Have you been treated by another doctor since the accident? ❑ Yes ❑ No If yes, please list doctor's name and address:

Since this injury occurred, are your symptoms: ❑ improving ❑ Getting Worse ❑ Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

❑ Headache	❑ Irritability	❑ Numbness in Toes	❑ Face Flushed	❑ Feet Cold
❑ Neck Pain	❑ Chest Pain	❑ Shortness of Breath	❑ Buzzing in Ears	❑ Hands Cold
❑ Neck Stiff	❑ Dizziness	❑ Fatigue	❑ Loss of Balance	❑ Stomach Upset
❑ Sleeping Problems	❑ Head Seems Too Heavy	❑ Depression	❑ Fainting	❑ Constipation
❑ Back Pain	❑ Pins & Needles in Arms	❑ Lights Bother Eyes	❑ Loss of Smell	❑ Cold Sweats
❑ Nervousness	❑ Pins & Needles in Legs	❑ Loss of Memory	❑ Loss of Taste	❑ Fever
❑ Tension	❑ Numbness in Fingers	❑ Ears Ring	❑ Diarrhea	❑

Symptoms other than above

Have you lost time from work as a result of this accident? ❑ Yes ❑ No If yes, please complete this question.

a. Last Day Worked:
b. Type of Employment:
c. Present Salary:
d. Are you being compensated for time lost from work? ❑ yes ❑ No If yes, please state type of compensation you are receiving:

Do you notice any activity restrictions as a result of this injury? ❑ Yes ❑ No If yes, please describe, in detail:

Have you ever been involved in an accident before? ❑ Yes ❑ No If yes, please describe, including date(s) and types(s) of accidents, as well as injury(ies) received.

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If this doctor/therapist is a contracted provider for my managed care plan, I understand I am responsible for all co-payments, deductibles and any non-covered services. I also understand and agree to pay all co pays, deductibles and fees for non-covered services as agreed upon per the financial agreement with Chiro 1st Chiropractic. I understand that if I terminate my care and treatment, any balance for co-payments or deductibles will be immediately due and payable. If advanced payment is made and patient terminates care prior to completing the treatment schedule, no refunds will be made if there is any account balance. I understand and agree that if my financial responsibilities are submitted to an outside company such as a collection agency for non-payment, I am responsible for all additional collection fees, court fees, attorney fees, and any other fees involved.
I (we) authorize the doctor/therapist and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to prove any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of an consequences thereof. I agree that a photo static copy of this agreement shall serve as the original.
I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor/therapist as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photo copy of this agreement shall serve as the original.

Patient/Guardian Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE AND AUTHORIZATON DESCRIBES: HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. HOW OUR OFFICE FUNCTIONS AND YOUR INFORMED CONSENT FOR YOUR HEALTH CARE. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Chiro 1st, we may use or disclose personal and health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary for further diagnosis, assessment or treatment.
2. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).
3. Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you. This could include birthday, new patient, thank you, or referral cards. Occasionally we may hang photos of our patient's on our patient board as well.

It is also the procedure of Chiro 1st that our office utilizes electronic billing for claims submission. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency.
3. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
4. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
5. If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive your chiropractic or medical care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Julian at 317-898-5800. Further information about privacy policies and practices can be attained at the number provided.

This office utilizes an "open" spinal manipulation, rehabilitation and physical therapy environment for ongoing patient care. "Open" spinal manipulation, rehabilitation and physical therapy involve several patients being seen in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within an earshot of other patients and staff.

This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be in an "open" spinal manipulation, rehabilitation and physical therapy environment, other arrangements will be made for you. This notice is effective the date it was signed. This notice, and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created.

I understand that if I am accepted as a patient by a physician at Chiro 1st, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

My signature acknowledges that I have received a copy of this privacy notice and have read and understood the financial arrangements of this facility. I acknowledge that I have reviewed the Notice of Privacy Practices of Chiro 1st.
(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Medical Information Release Form

Release of Information

[ ] I authorize the release of information including the diagnosis, records;
Examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child (ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*) _____ between (*time*) _____

Assignment of Benefits

I certify that I (or my dependent) have insurance coverage and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. 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, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other therapy procedures to be performed on myself or on (child under 18) _____ by the doctor. I also consent to the procedures performed by his trained staff assistants under direct instruction and supervision.

I have had an opportunity to discuss with the doctor or other office personnel the nature and purpose of chiropractic adjustments and other therapy procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee to results has been made to, nor relied upon by, me, and I wish to rely on the doctor to exercise judgment during the course of the procedures which he feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic procedures is very low, anyone undergoing chiropractic adjustments, physical therapy services or joint manipulation procedures should know of possible complications, which have been alleged. These include, but are not limited to; burns, fractures, disc injuries, strokes, dislocations, sprains, increase or worsening of symptoms and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had the opportunity to ask questions about its' contents, and by signing below, acknowledge my understanding of its contents.

Date: _____

Patient Name: _____

Patient Signature: _____

Relationship or Authority if not signed by patient: _____

Patient Counseled by use of the following

____Discussion

____Other (Specify) _____

Signature of Doctor or Representative: _____

NECK DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing,Dressing,etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration/

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

Name _____ Date _____

Score _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ*: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 - Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 - Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain. D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minute without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one than one quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Name _____ Date _____

Score _____