NEW PATIENT INFORMATION

Patient: ________________________________ Date:___________

Your Personal Information

Name:____ Spouse:________________

Address:_________________________ City:_____________ State:___ Zip:________

Home Phone:______________ Date of Birth:___________ SS#:______ - ___ - _______

Age:_____ Gender: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D

Employer:_____________________________________ Work Phone:______________

Type of Work Performed:____

In Case Of Emergency Notify:___________________________ Phone #:____________

Family Physician:_____________________ E-mail Address________________________

Who Should We Thank For Telling You About Our Office?_________________________

Your Current Health Concern

Primary Reason For Todayø Visit:____

Check The Severity Of Your Complaint: (Mild) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Severe)

When Did This Begin?_________________ Experienced Previously? ☐ Yes ☐ Never

Is This Condition: ☐ Job Related ☐ Auto Accident ☐ Fall or Injury ☐ Other:________

Other Doctors Seen For This Problem:____

Other Doctorø Opinions or Diagnosis: ____

Other Or Secondary Health Concerns:____________________________________

Drugs Or Medications Now Taking: ☐ Pain Killers / Muscle Relaxants ☐ Tranquilizers

☐ Blood Pressure Medicine ☐ Antibiotics

☐ Other:__________________________________

Your Past Health History

Previous Surgeries: ☐ Eyes / Ears / Nose / Throat ☐ Head/Neck ☐ Back /Spine

☐ Chest / Heart / Lungs ☐Abdominal ☐ Other:_______

Previous Fractures Or Broken Bones: ☐ Yes ☐ No Describe:_____________________

Previous Falls Or Accidents: ☐ Yes ☐ No Describe:_____________________

Previous Hospitalization: ☐ Yes ☐ No Describe:_____________________

Previous Chiropractic Care: ☐ Yes ☐ No Describe:____________________

Similar Problem In Family: ☐ Yes ☐ No Describe:_____________________

Similar Problems With Co-Workers: ☐ Yes ☐ No Describe:_____________________

Do You Workout Or Exercise? ☐ Yes ☐ No Describe:_____________________

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PLEASE COMPLETE OTHER SIDE

NEW PATIENT INFORMATION

Check Any Of The Following That May Apply To You

Health Issues:

- ☐ Scoliosis
- ☐ Lyme's Disease
- ☐ Diabetes
- ☐ High Stress
- ☐ Under Weight
- ☐ Endocrine
- ☐ Arthritis
- ☐ AIDS or ARC
- ☐ Frequent Illnesses
- ☐ Poor Diet
- ☐ Lungs
- ☐ Over Weight
- ☐ Infections
- ☐ Heart
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cancer
- ☐ Other______________________
- ☐ Sleeplessness
- ☐ Chronic Fatigue
- ☐ Genetic Disorders
- ☐ Kidney Disorders
- ☐ Polio

If Female, is there any possibility that you are pregnant? ☐Yes ☐ No

Intake Or Use:

- ☐ Alcohol
- ☐ Sleeping Pills
- ☐ Tobacco
- ☐ Birth Control Pills
- ☐ Pain Relievers
- ☐ Caffeine
- ☐Other:_____________

Check Any Problems That You May Have Had Within The Last Six Months

Muscles-Skeleton

- ☐ Low Back Pain
- ☐ Middle Back
- ☐ Neck
- ☐ Hips / Legs
- ☐ Joint Pain
- ☐ Shoulders/Arms

Circulation-Breathing

- ☐ Chest Pain
- ☐ Lungs/Breathing
- ☐ Blood Pressure
- ☐ Heart Rate
- ☐ Poor Circulation
- ☐ Coughing or Wheezing

Eye-Ear-Nose-Throat

- ☐ Eyes / Vision
- ☐ Dental / TMJ
- ☐ Throat / Voice
- ☐ Ears / Hearing
- ☐ Sinus Pain / Drainage

Nerve System

- ☐ Headaches
- ☐ Nervousness
- ☐ Numbness
- ☐ Weak Muscles
- ☐ Dizziness
- ☐ Forgetfulnes
- ☐ Depression
- ☐ Fainting
- ☐ Seizures
- ☐ Cold Hands / Feet
- ☐ Stress Reactions
- ☐ Shaking / Tremors

Digestion-Elimination

- ☐ Poor Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight Loss / Gain
- ☐ Heartburn
- ☐ Change In Stools

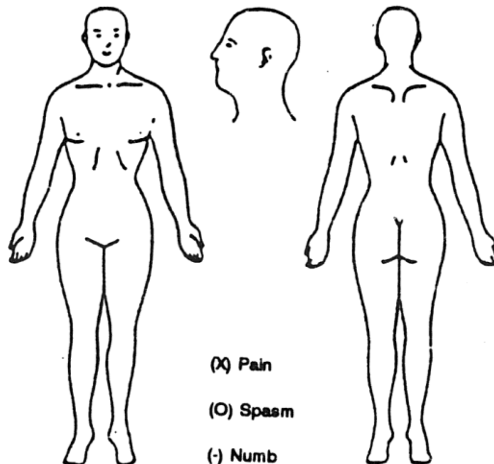
Urinary-Genitals

- ☐ Pain With Urination
- ☐ Infrequent Urination
- ☐ Frequent Urination
- ☐ Weak Stream
- ☐ Bladder Control
- ☐ Genitals

Female Only

- ☐ Menstrual Problems
- ☐ Back Pain w/ Period
- ☐ Breast Lumps/Pain
- ☐ Breast Implants

Please Mark Area Of Concern & Sign



I understand that my care in this office involves the making of judgements that are based upon the facts known by the doctor. Therfore, the above information is true and complete to the best of my knowledge

____

Patient's Signature:

TUCKAHOE CHIROPRACTIC 32201 QUEEN ANNE HWY, QUEEN ANNE, MD 21657 410-364-9222

FINANCIAL OPTIONS

Welcome to our practice! We are proud to provide three options for the handling of our patient's financial accounts. Please review the following choices and check the type of arrangement that best depicts the way you would like us to handle your account.

Thank-you!

☐ Non-Insured / Cash Option

The following policy applies to those patients who do not have health insurance benefits or to those who prefer to pay for their services and handle their own insurance processing.

1. Our office does not routinely bill patients for their care. Payment is requested at time of service.
2. We accept cash, check, MasterCard, VISA, and Discover as payment for your care.
3. We will not deny care to anyone based on their inability to pay for our services.
4. If necessary, we will make arrangements with patients who request that such arrangements be made.
5. We will provide forms, information, and the guidance to enable patients to process their own insurance claims if they so desire.

☐ Approved Insurance Option

The following policy applies to those patients with appropriate health insurance coverage. (We do not accept assignment on personal injury nor secondary insurance benefits.)

1. We will accept written assignment on the estimated amount of insurance benefits available through your primary insurance carrier.
2. Our office will estimate the total cost of non-insurance covered care, and pro-rate your portion into weekly payments.
3. Only patients undergoing active care will be eligible to assign their insurance benefits to this office.
4. If you should discontinue care prior to being released by doctor, all outstanding balances will immediately become due and payable.

☐ Medicare Option

The following policy applies to those patients with Medicare insurance coverage. We are a Medicare approved, õnon-participatingö provider. (Please ask for details.) The following policies are federally mandated.

1. We cannot accept assignment on the Medicare benefits, however we will make financial arrangements if necessary.
2. We must file for benefits on your behalf, but Medicare reimbursement checks will be sent directly to you. To avoid delays in your reimbursement, do not send any claims to Medicare yourself.
3. Medicare requires chiropractic x-rays, but will not pay for them.

I understand & agree to the policy option noted above.

Signature:____ Date:_____________

Patient: ____

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INFORMED PATIENT CONSENT

AND THE DOCTOR-PATIENT RELATIONSHIP

Chiropractic Care	It is the premise of Chiropractic that the human body possesses the inherent potential to maintain itself in a natural state of homeostasis. A state of normal homeostasis allows the body to establish normal function, express appropriate adaptation, and employ its recuperative, health sustaining powers. The relationship between the spine and the nervous system may affect the conduction of the nerve impulses over the nervous system affecting that inherent potential. Therefore, chiropractic care focuses primarily on the chiropractic adjustment for the purpose of establishing proper spinal alignment thus allowing normal nerve conduction throughout the body. The success of chiropractic care often depends on the environment, underlying causes and the physical and spinal conditions of each individual patient.
Chiropractic Analysis	The doctor will conduct a clinical analysis for the express purpose of determining the presence of the vertebral subluxation and the effects of the vertebral subluxation complex. If such is not detected, the patient will be informed and an attempt to refer the patient to an appropriate health care provider will be made.
Clinical Results	The purpose of chiropractic care is to promote health though the correction of the vertebral subluxation complex. Since there are so many variables, it is difficult to predict the time schedule, degree of response, or the efficacy of the chiropractic adjustment for any given patient. However, the doctor may make recommendations for clinical management based upon known circumstances and clinical experience. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patientøs response, no doctor can promise specific results. The Doctor of Chiropractic is licensed to provide a specialized unique, non-duplicating health service. The Chiropractor is licensed in a special area of practice and is available to work with other providers in your health care regimen.
Medical Diagnosis	Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine and its effects on the nervous system, they are not internal medical or surgical specialists. Therefore, every patient should be mindful of their own symptoms and should secure other opinions should they have any concerns as to the nature of any other symptoms or their total health picture. Your Doctor of Chiropractic may express an opinion as to whether or not further consultation is necessary, but the patient is responsible for the final decision and any subsequent action.
Contra-indications To Chiropractic Care	Where vertebral subluxations are detected, the chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to such injuries as vascular accidents, fractures and disc injury. The doctor, of course, will not perform any procedures if there is awareness that such care may be contra-indicated. It is the responsibility of the patient to make it known if they are aware that they are suffering from: pathological conditions, illnesses, injuries, or deformities which may be known to the patient but have not have otherwise come to the attention of this doctor. By signing below, the patient affirms that they have been open and truthful in disclosing their health history, and gives the doctor permission and authority to examine and care for them in accordance with recognized standards and acceptable chiropractic analytical and corrective procedures.
Patient Consent For Care	***Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.*** I have read and understand the foregoing. I hereby request and authorize the doctor to render chiropractic care to me: ______________________________ *Signature of Patient, Parent, or Guardian* ____________ *Date*

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient (Print) (Signature) Date

MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Telephone: (763)595-3200 | Fax (763) 595-3333

The Keele STarT Back Screening Tool

Patient name: ______________________________ Date: ____________

Thinking about the **last 2 weeks** tick your response to the following questions:

		No 0	Yes 1
1	Has your back pain spread down your leg(s) at some time in the last 2 weeks?	☐	☐
2	Have you had pain in the shoulder or neck at some time in the last 2 weeks?	☐	☐
3	Have you only walked short distances because of your back pain?	☐	☐
4	In the last 2 weeks, have you dressed more slowly than usual because of back pain?	☐	☐
5	Do you think it's not really safe for a person with a condition like yours to be physically active?	☐	☐
6	Have worrying thoughts been going through your mind a lot of the time?	☐	☐
7	Do you feel that your back pain is terrible and it's never going to get any better?	☐	☐
8	In general have you stopped enjoying all the things you usually enjoy?	☐	☐

9. Overall, how **bothersome** has your back pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Total score (all 9): ________________ **Sub Score (Q5-9):** ____________

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Funded by Arthritis Research UK

Back Index

Form BI100

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 ____

Neck Index

Form N1-100

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