Name ___________________________ Date ____________

Advantage Family Chiropractic

Health Information and Health History

Patient Name: ______________________________________ Gender: Male Female

Marital Status: (Circle one) M S D W Other: _________________ Date of Birth ____/____/____

Patient Social Security Number: _______-_______-_________

Spouse Name: ____________________________How many children: ___________

Patient Address: ______________________________ City _____________Zip Code: ________

Patient Phone Number: _______-_______-_______ Cellular Number: _____-_____-____

Email: ______________________________ ___ Employer: ___________________________

Occupation: _________________________ Referred By: _______________________________

Is this condition due to: Auto Accident Personal Injury Work Related Accident

Do you have health insurance? **Yes** **No**

Do you have more than one insurance? **Yes** **No**

Is your spouse employed? **Yes** **No** Is your spouse the primary insured? **Yes** **No**

Are you covered by Medicare? **Yes** **No**

I authorize Advantage Family Chiropractic to release medical information to my insurance company:

Signature: ____Date___________________

I understand and agree that health and accident policies are an arrangement between the insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay. I also understand that payment of services is due at the time of service unless other financial arrangements have been made.

Signature: ____Date___________________

Name _________________________ Date ___________

Advantage Family Chiropractic

Health Information and Health History

Insurance Information:

Please present a Copy of All Insurance Cards	
Insurance Information – CHECK ONE □ Primary Health Ins □ HAS/HRA □ Auto Ins. Med Pay (drivers policy)	**Other Insurance Information- CHECK ONE** □ 2nd Health Ins □ 3rd party Auto Ins (at fault driver) □ Workers Comp Ins/ Employer
Insurance Company	Insurance Company
Insured Name	Insured Name
Insured DOB	Insured DOB
Insured SS#	Insured SS#
ID/Claim #	ID/Claim #
Group/Policy #	Group/Policy #
Phone # - -	Phone # - -
Attorney Name (if applicable)	Phone # - -
□ **I do not have health insurance and wish to receive time-of-service fees.** I understand that the reduced fee is offered to non-insured patients and is extended to those with current accounts only. Past due accounts will be billed at the regular rate.	

Authorization and Release: I authorize payment of insurance benefits directly to Advantage Family Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of my benefits. I understand that I am responsible for all costs of Chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 15%.

Patient Signature	Date
Parent/Guardian Signature	Date

Name ________________________ Date __________

Advantage Family Chiropractic

Health Information and Health History

COMPLAINTS

Primary Complaint? ____

Secondary Complaint? ____

When did your problem begin? ____

How did your problem begin? ____

Is this problem interfering with your: (circle one)

Activities of daily living   Work   Social Activities   Hobbies   Sleep

Rate your pain: (Circle one) 0 being no pain or 10 being the worst pain

0   1   2   3   4   5   6   7   8   9   10

Is your health problem worse: (Circle one)   Morning   Day   Evening   Night

Does your health problem occur: (Circle one)

Occasionally   Intermittently   Constantly   Frequently

Is your problem getting: (Circle one)   Better   Worse   Staying the Same

Have you had this problem before? ____________________ When? ____________________

What aggravates your health problem: circle all that apply:

Coughing   Sneezing   Walking   Reaching   Lifting
Bending   Sitting   Lying down   Standing   Neck movement
Straining at stool   Other: ____

What relieves your health problem: circle all that apply:

Nothing   Resting   Heat   Sitting   Standing   Ice

Other____

Have you had recent treatment for this condition?   **Yes**   **No**

Who did you see? ______________________________Treatment ____________________

Have you had any changes in bowel or bladder habits since your problem began?   **Yes**   **No**

Name ___________________________ Date ____________

Advantage Family Chiropractic

Health Information and Health History

List your hobbies: 1) ______________________
2) ______________________
3) ______________________

What are your habits?

Smoking	never	packs per day ________
Alcohol	never	drinks per day ________
Caffeinated Drinks	never	drinks per day ________
Exercise	never	times per week ________
Drug/Substance Abuse	never	Yes, if yes discuss with your doctor

MEDICAL HISTORY

Have you seen a doctor of chiropractic? **Yes** **No**

Who is your Family Physician: ____________________ Date of last physical exam: ___________

Do you give us permission to send your family doctor your progress and treatment notes? **Yes/No**

Have you been hospitalized in the past five years? **Yes** **No**
Date and Reason: ____

Have you had any serious accidents in the past five years: **Yes** **No**
Date and Describe: ____

List your medications: ____

In the past 6 months have you suffered from: Circle all that apply or circle normal

General:	Fatigue	Weakness	Weight change	Loss of sleep	Normal
Neurological:	Headaches	Seizures	Dizziness	Nervousness	Normal
Eyes:	Vision trouble	Dryness	Redness	Cataract Glaucoma	Normal
Nose:	Pain	Bleeding	Sinus trouble	Infections	Normal
Mouth/Throat:	Sores	Bleeding	Enlarged Glands	Tonsillitis	Normal
Cardiovascular:	Coughing Palpitations	Sneezing Hypertension	Wheezing	Chest Pain	Normal
Gastrointestinal:	Diarrhea Constipation	Vomiting Gas	Appetite Change	Heartburn	Normal
Endocrine:	Goiter	Sugar in Urine	Heat Intolerance	Cold Intolerance	Normal
Psychologic:	Anxiety	Depression	Memory Loss	Mood Swings	Normal

Name __________________________ Date ___________

Advantage Family Chiropractic

Health Information and Health History

Have you ever had any of the following: Circle all that apply

Arthritis	Heart Trouble	Pacemaker
Diabetes	Dislocated Joints	Hay Fever
Asthma	Bone Fracture	Tuberculosis
Epilepsy	High blood pressure	Serious Injury
Allergies	Low blood pressure	Prostate Trouble
Sinus	Rheumatic Fever	Kidney Trouble
Scoliosis	Spinal Disease	Polio
Cancer	Thyroid Trouble	HIV
Ulcer	Sexually Transmitted Disease	AIDS

FAMILY HISTORY

Has any one in your family had any of the following: (if yes list relationship to patient)

Cancer: _____________________________ Diabetes:_______________________________

Heart Trouble: ______________________ High Blood Pressure: ___________________

Do any family members suffer from the following: please circle and list the relationship to you

Neck Problems: ____

Back Problems: ____

Headaches: ____

Arthritis: ____

Disc Problems: ____

Pinched Nerves: ____

Bad Posture: ____

Scoliosis: ____

Osteoporosis: ____

Doctor's Signature: ____

For Office Use Only: **Height**_________________ **Weight**___________
Pulse __________________ **Blood Pressure**________________

Name _________________________ Date ___________

DOCTOR ____

DATE OF VISIT ___/___/20___ Patient ____ Age_________________

Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

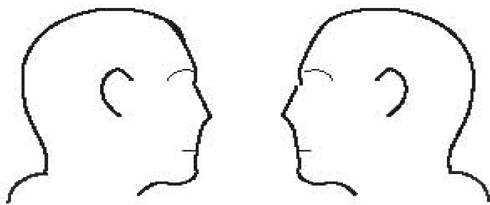
1

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms ____________________

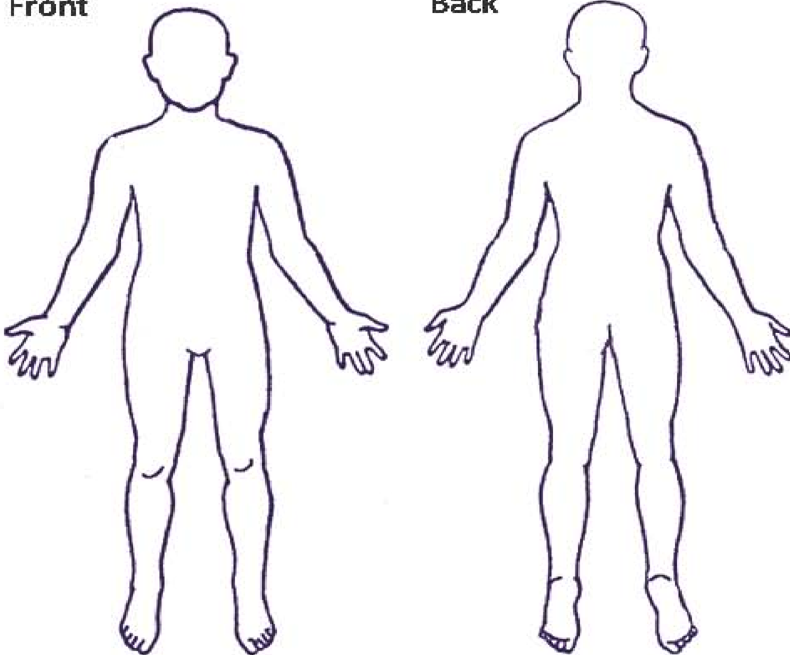
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? ______________________________

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

____ ______________

Name ________________________ Date __________

Goals for my 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 the correction of whatever is malfunctioning in their bodies.

Your Doctor will weigh your needs and desires when making recommendations for care. 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 symptoms
- ☐ Comprehensive Care – bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic adjustments
- ☐ I want the Doctor to select the type of care appropriate to my health status.

____

(Signature) (Date)

Name ________________________ Date __________

ADVANTAGE FAMILY CHIROPRACTIC

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is our policy to collect in advance full payment for the initial visit, once the insurance company has considered your bill; any reimbursement will then be credited back to your account. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. *Pay cash for your care and we will submit reports whenever necessary.*
2. *We will bill (accept assignment) from the Med Pay portion of your auto insurance.*
3. *We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.*
4. *We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.*

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **(six)** months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Name ________________________ Date __________

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We are preferred providers for the following companies:

Blue Cross Blue Shield	**Health Link**	**Aetna**
Medicare	**Cigna PPO**	

We are out of network Providers for the following, and would be happy to bill your insurance for you:

GHP	**Carpenters health and welfare**	**United Healthcare**	**Cigna HMO**

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of **Advantage Family Chiropractic**. I understand that my insurance is an arrangement between myself and my insurance company, NOT between **Advantage Family Chiropractic** and my insurance company. I request that **Advantage Family Chiropractic** prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Advantage Family Chiropractic that fees will be due and payable immediately.

In the event that I allow my account to become more than 60 days delinquent, I will be responsible for all charges incurred for collection which include but are not limited to; all collection agency fees, court costs and filing fees, legal representation for the plaintiff, serving of legal documents, and all interested accrued.

____ ____________________

Patient's signature (or guardian if patient is a minor) Date

____

Print Name

Name ________________________ Date ___________

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name________________________________ Date_______________
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _______ day of ______________________, 20___

By__________________________________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By___________________________________
Signature of Parent/Guardian (circle one)

Name _________________________ Date ___________

Advantage Family Chiropractic

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice or as soon as possible, in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Our office does not charge for appointments cancelled 24 hours in advance, we do however charge a $50 missed appointment fee for appointments that are missed repeatedly without notice. We will attempt to reach you within 15 minutes of your missed appointment and if we are unable to reach you, the missed appointment fee **MAY** be charged to your account.

Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

_________________________________ ________________

Signature Date

Missed Appointment policy/Revised 10/2012

Name ____________________________ Date ____________

STEP 1.

Welcome! We are excited to serve your health care needs in an effective and efficient manner. Please select times that would work best for your follow-up visits. Please circle all that might apply for any 3 days:

Monday:	Early Morning	Late Morning
	Early Afternoon	Late Afternoon
Tuesday:	Early Afternoon	Late Afternoon
Wed:	Early Morning	Late Morning
	Early Afternoon	Late Afternoon
Thursday:	Early Afternoon	Late Afternoon
Friday:	Early Morning	

Clinical Hours are	M, W	9:00 am to 12:00 pm and 2:00 pm to 6:00 pm
	T, TH	2:00 pm to 7:00 pm
	Friday	9:00 am to 12:00p,

STEP 2.

When it comes to your health, we believe medical doctors and chiropractors should work together for YOUR benefit.

Dr. Meese, I agree! I give you permission to inform my personal medical doctor of my condition, treatment and expected / actual response to care at this office.

____ ______________________

Signature of Patient or Guardian Date

____

Please print your name

Your Medical Doctor ____

Doctor's Address ____

Doctor's Phone ____

Name ________________________ Date __________

INFORMED CONSENT

PATIENT NAME ____

Clinic Name **ADVANTAGE FAMILY CHIROPRCATIC LLC**

Doctor's Name **GAIL A. MEESE DC**

Address **2347 OLD COLLINSVILLE RD SUITE G**

Phone **618-234-6000** Fax **618-234-6009**

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

DATE ____________________________

Printed Name ____________________________

Signature ____________________________

Signature of Parent or Guardian (if a minor) ____________________________

Oswestry "BACK" Disability Index

Section 1 – Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ❑ I can look after myself normally but it is very painful.
- ❑ I can look after myself normally but it is very painful.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing for more than 10 minutes.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and cause me no extra pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ❑ I have no pain at the moment. (0)
- ❑ The pain is very mild at the moment. (1)
- ❑ The pain is moderate at the moment. (2)
- ❑ The pain is fairly severe at the moment. (3)
- ❑ The pain is very severe at the moment. (4)
- ❑ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- ❑ I can look after myself normally without causing extra pain. (0)
- ❑ I can look after myself normally but it causes extra pain. (1)
- ❑ It is painful to look after myself and I am slow and careful. (2)
- ❑ I need some help but manage most of my personal care. (3)
- ❑ I need help every day in most aspects of self care. (4)
- ❑ I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- ❑ I can lift heavy weights without extra pain. (0)
- ❑ I can lift heavy weights but it gives extra pain. (1)
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- ❑ I can lift very light weights. (4)
- ❑ I cannot lift or carry anything at all. (5)

Section 4 – Reading

- ❑ I can read as much as I want to with no pain in my neck. (0)
- ❑ I can read as much as I want to with slight pain in my neck. (1)
- ❑ I can read as much as I want with moderate pain in my neck. (2)
- ❑ I cannot read as much as I want because of moderate pain in my neck. (3)
- ❑ I can hardly read at all because of severe pain in my neck. (4)
- ❑ I cannot read at all. (5)

Section 5 – Headaches

- ❑ I have no headaches at all. (0)
- ❑ I have slight headaches that come infrequently. (1)
- ❑ I have moderate headaches which come infrequently. (2)
- ❑ I have moderate headaches which come frequently. (3)
- ❑ I have severe headaches which come frequently. (4)
- ❑ I have headaches almost all the time. (5)

Section 6 – Concentration

- ❑ I can concentrate fully when I want to with no difficulty. (0)
- ❑ I can concentrate fully when I want to with slight difficulty. (1)
- ❑ I have a fair degree of difficulty in concentrating when I want to. (2)
- ❑ I have a lot of difficulty in concentrating when I want to. (3)
- ❑ I have a great deal of difficulty in concentrating when I want to. (4)
- ❑ I cannot concentrate at all. (5)

Section 7 – Work

- ❑ I can do as much work as I want to. (0)
- ❑ I can do my usual work, but no more. (1)
- ❑ I can do most of my usual work, but no more. (2)
- ❑ I cannot do my usual work. (3)
- ❑ I can hardly do any work at all. (4)
- ❑ I cannot do any work at all. (5)

Section 8 – Driving

- ❑ I can drive my car without any neck pain. (0)
- ❑ I can drive my car as long as I want with slight pain in my neck. (1)
- ❑ I can drive my car as long as I want with moderate pain in my neck. (2)
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- ❑ I can hardly drive at all because of severe pain in my neck. (4)
- ❑ I cannot drive my car at all. (5)

Section 9 – Sleeping

- ❑ I have no trouble sleeping. (0)
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- ❑ My sleep is mildly disturbed (1-2 hours sleepless). (2)
- ❑ My sleep is moderately disturbed (2-3 hours sleepless). (3)
- ❑ My sleep is greatly disturbed (3-5 hours sleepless). (4)
- ❑ My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

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

0-4	**No disability**
5-14	**Mild disability**
15-24	**Moderate disability**
25-34	**Severe disability**
> 35	**Complete disability**

TO: Medicare Patients

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated.

1. We will file ALL Medicare claims.

2. We will file ALL Medicare secondary/supplemental insurance.

3. We are participating providers with Medicare, which means that Medicare pays us directly, however, Medicare patients must meet an annual $131 deductible, which we are required to collect at the beginning of services for each calendar year. Supplemental coverage may pay the deductible but if no such coverage is available, the patient is responsible for the deductible.

4. Medicare pays for 80% of allowed charges. Supplemental coverage may pay the 20%, but if no coverage is available, the patient is responsible.

5. Medicare does not pay for maintenance care. This will be your responsibility.

6. Medicare does not pay for all of your health care costs. The fact that Medicare does not pay for a particular item or service does not mean that you should not receive it.

Medicare Pays For:	Medicare Does Not Pay For:
Manual manipulation of spine	Examinations
IF SUPPORTED BY X-RAY AND/OR EXAMINATION	Physical Therapy
After the deductible is met	X-Rays
Depending upon the condition	Orthopedic Supplies
	Maintenance care

If you have questions regarding these guidelines, please ask, we are here to help you!!

I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for the payment of non-covered services if I choose to receive those services.

____ ________________________

Signature of patient or person acting on patient's behalf Date

Advantage Family Chiropractic

Health Information and Health History

AUTO ACCIDENT QUESTIONAIRE

Date of Accident: ______________________________

Time of Accident: ______________________________

To your knowledge what caused the accident? ____

What occurred following the accident? Circle all that apply

Received emergency care   Felt confused   Felt nervous

Loss of consciousness   Felt weak   Transported to the hospital via ambulance

After accident you were taken to? ____

Position in vehicle?   **Driver**   **Front seat passenger**   **Back seat passenger**

Were you wearing a seat belt?   **Yes**   **No**

Was the accident: **Expected**   **Complete surprise**

How was your vehicle struck?   **Front end**   **Rear end**   **Right side**   **Left side**

Did the air bags deploy?   **Yes**   **No**   Did the seat break?   **Yes**   **No**

Did your vehicle have headrest?   **Yes**   **No**

What speed were you traveling? __________ What speed was other vehicle traveling? _______

What type of vehicle were you in? _______________Type of other vehicle involved? _________

Was visibility (circle one)   **Poor**   **Good**

What was the condition of the roadway?   **Wet**   **Dry**   **Other**: ____________________

Where did you feel pain immediately following the accident?_____________________________

____

____

Do you or did you have any visible abrasions? **Yes**   **No**   Where? ___________________

____

What type of treatment have you had since the accident? ___________________________________

____.

Are you taking medication due to injuries from this accident? **Yes** **No**
If yes, what type of medication? ____

____.

Where x-rays or special test performed following the accident? **Yes** **No**
If yes, list name or facility where tests were performed:_____________________________________

____.

Do you have additional symptoms or complaints that have occurred since the accident? **Yes No**
If yes, please list: ____

____.

Is there any additional information you would like us to know?

____

____

____

____

____

____

Doctor's Notes: ____

____

____

____

____

____

____

____

Advantage Family Chiropractic

Work Injury Questionnaire

Date of injury: ______________________________

Time of injury: ______________________________

Did you report this injury to your employer? **Yes** **No** Who did you report it to? ___________

What caused the injury? ____

____

Describe in your own words what happened? ____

____

____

____

What is your major complaint? ____

____

____

Do you have any secondary complaints as a result of this accident? _______________________

____

____

Have you missed work due to this injury? **Yes** **No** How many days? ___________

Describe your job duties: ____

____

Additional information: ____

____

Doctor's Notes: ____

____

____

____