CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

Thank You!

PART A

Name: _____ Phone: _____

E-mail address: _____ Fax # _____ Cell Phone _____

Address: _____

Purpose of this appointment: _____

Is this the same problem you were originally under care for? ( ) Yes ( ) No

If yes, are there any additional symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

PART B

Occupation: _____ Employer: _____

Employer's address: _____ Work Phone: _____

Spouse: _____ Spouse's Employer: _____

PART C

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of 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 my schedule of 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 (16%).

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Date Signed: _____ Signature: _____

Health Insurance Coverage ( ) Yes ( ) No

Company: _____

1. What is your major symptom? _____

2. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____

3. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____

4. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

5. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____

6. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____

7. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____

8. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____
   _____

9. List any major accidents you have had other than those that might be mentioned above: _____
   _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____
    _____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____

12. Remarks: _____
    _____
    _____

NO SYMPTOMS — EXTREME SYMPTOMS

Please place an “X” on the line above to indicate your level of problem.

Doctor’s Signature _____ Date _____

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ Age_____

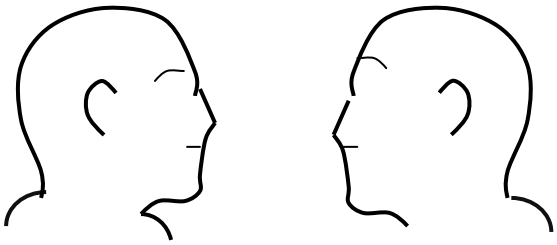
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

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

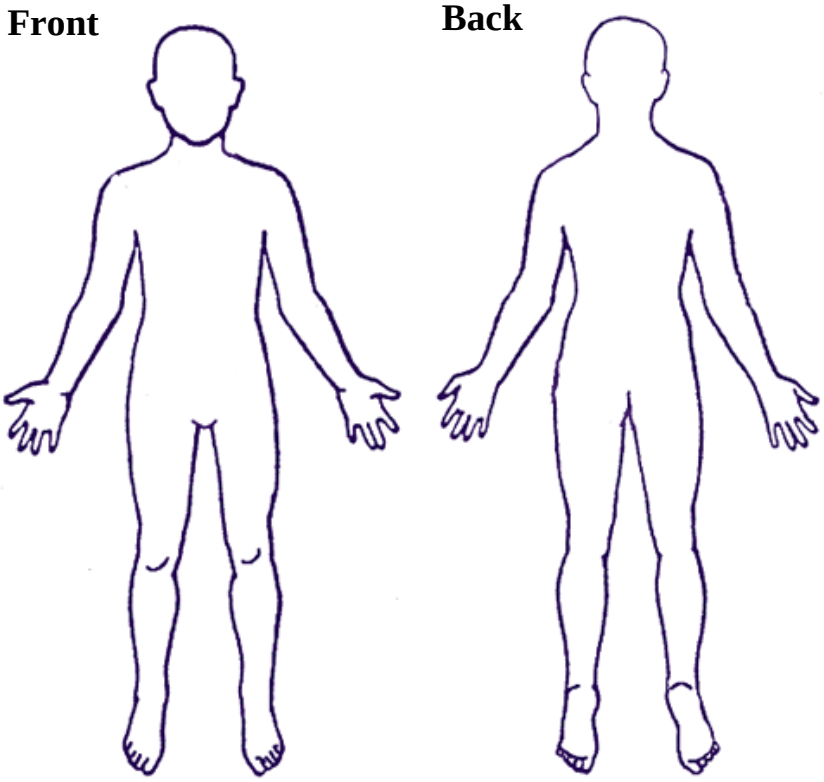
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

Right **Left**

SUBJECTIVE PAIN ASSESSMENT



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**

_____ _____

OUTCOME ASSESSMENT

Name_____Date _____

NO SYMPTOMS ——————————————————————— EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

1. What was the chief symptom or reason you visited the office? (low back pain, neck pain, etc.) _____

2. How do you classify your improvement so far since beginning your care?
   Excellent _____Good _____Fair _____Poor _____

3. On a scale of 1 to 10 with 10 being the best, how would you rate your improvement?_____

4. What symptoms have improved? _____
   _____

5. What symptoms do you still have? _____
   _____

6. What changes have been made in your general feelings? Are you: (check those indicated)
   Stronger _____ More Relaxed _____More Alert _____
   Less Nervous_____ Sleep Better _____Appetite Improved _____

7. Do you find it easier: (check those indicated)
   Walking _____ Riding _____ Working _____ Bending____
   Standing_____ Sitting _____ Lifting _____ Same _____

8. Is there any other condition you have that we have not discussed that you would like to discuss at this time?_____If yes, please explain _____
   _____

9. Is there any confusion or question about any phase of your progress? _____
   _____

10. Do you intend to continue care to avoid problems in the future (check one)
    Yes_____ No_____Will follow my doctor's recommendations _____

11. Have you had an opportunity to refer anyone to the Doctor? (check one)
    Yes_____ No____ Intend to do so _____

12. Your honest evaluation of the Doctor's office is always appreciated. Please comment on any areas where the Doctor may improve. _____
    _____
    _____

_____
Patient's Signature

DOCTOR _____
DATE OF VISIT ___/___/20___ Patient_____
Age_____
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

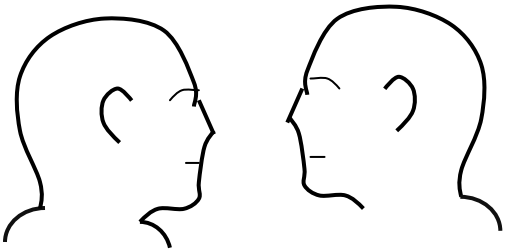
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

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

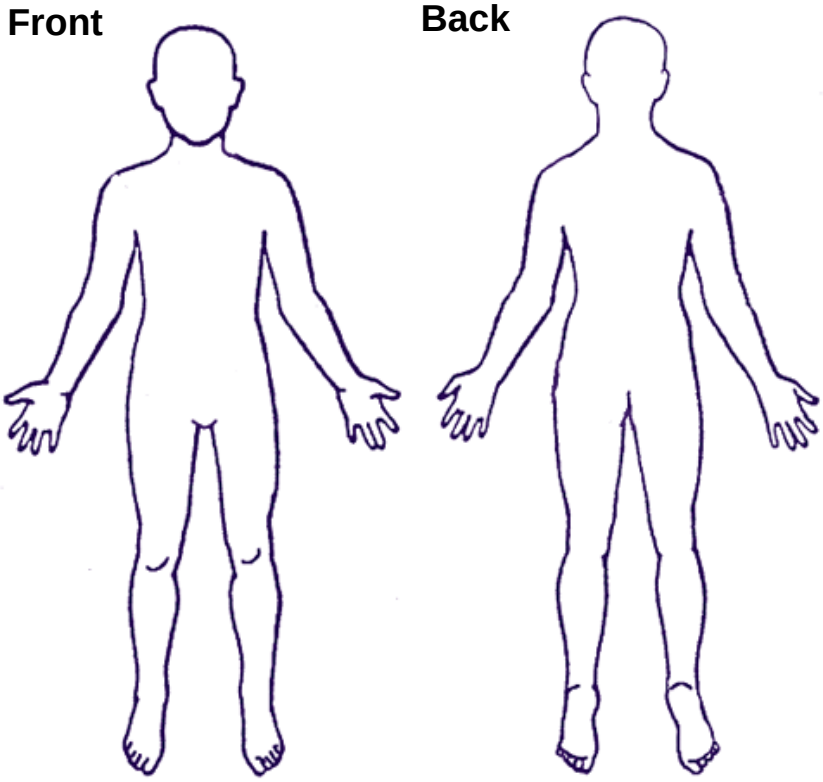
_____

SUBJECTIVE PAIN ASSESSMENT

RATE YOUR PAIN



Front **Back**



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** _____

Outcome Assessment