Patient:_____File#:_____Date:_____

Insight Chiropractic
New Patient Information

Welcome to Insight Chiropractic!! You have chosen a great office for your chiropractic care!

New Patient Introduction forms maybe filled out on-line in this PDF format or printed and filled out by hand- IN INK. Please read and answer the forms thoroughly before you come into the office. The better the history you can provide the better the doctor can understand your condition(s.) If you need, please write on the back of the forms to explain anything further. Please have your paperwork filled out before your first visit, this will ensure more time with the doctor and limit the possibility of returning for another visit because the examination was not completed in the allotted appointment time.

If you have insurance, please bring your insurance card and your photo ID so we can photo copy it and begin your insurance verification process.

Everyone starts as cash patients and then transfers over to other designated patient types (insurance, personal injury, worker's compensation, Medicare) once verification has been determined. Please bring a form of payment for this first visit. If your insurance covers the first visit, then a credit will be placed on your account and future "co-pays/patient portions" will be deducted from the credit balance until the balance is zero.

Please dress in loose fitting sports clothes and expect to be at the office for your first visit at least 1 hour. The doctor will perform a detail history and examination during this time. Based on your history and condition, x-rays or a medical consultation may be necessary before a chiropractic treatment is given. The doctor will alert you when certain circumstances arise and request an x-ray or medical consultation before treating. X-rays or medical consultations help to provide better tools for diagnosis when the need arises.

Your chiropractic treatment is generally provided on your second visit as well as your report of findings; which is a verbal report of the doctor's findings. Additionally, in the next 4 visits after your report of findings you will receive your chiropractic education so you may better understand chiropractic and how various other healthy alternatives help to maintain wellness and long-term prevention care.

Our office consists of various areas of treatment including open adjusting and open exercising areas. Please be aware of your conversations with the doctor, staff and other patients within the office. If needed, private treatment areas are available, please know this option is available up request.

Our address is listed below. Please visit the **Contact Us tab** on the website for driving directions or to email.

Yours in Health,
Dr. Jennifer L. Forster

Patient:_____File#:_____Date:_____

INTRODUCTION FORM

Today's Date: _____ Account #_____

Last Name: **MI:** **First Name:**	
Home Address: City: State: Zip:	
Home Phone: ( )	Cell Phone: ( )
Email:	
Birth Date: Age:	Social Security Number:
Height: Weight:	Marital Status (Circle): Single, Married, Divorced, Widow
Employer's Name:	**Occupation:**
Employer's Address:	City: State: Zip:
Work Phone:	Email:
Who Referred You to Our Office:	
Name and # of Family Physician:	
Emergency Contact: (Name, Relationship, Phone#)	

PLEASE READ: ☐ **YES,** ☐ **NO I authorize the following telephone numbers:**
☐ **YES,** ☐ **NO I authorize the use of my name/address**

Federal/State HIPAA patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. We need your permission to contact you via telephone at your work or home, cellular telephone, or to leave messages on your answering machine. Your agreement will allow our office to use your name and mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. If you have a telephone number that you do not want used for messages or calls to, please avoid writing these numbers down. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

IS THIS VISIT RELATED TO A:

☐ Work Related Injury/Symptoms ☐ Motorcycle-Bicycle Injury ☐ Non-Injury Pain/Symptoms
☐ Sport or Recreational Injury ☐ Home/Fall Injury Symptoms ☐ Check-up Only
☐ Motor Vehicle Crash Injury ☐ School/Employment Physical ☐ Other (Describe):

HEALTH-MEDICAL INSURANCE INFORMATION

Does your insurance plan cover Chiropractic treatment?	☐ Yes ☐ No ☐ Not Sure?
If yes, indicate Insurance Company Name (Need copy of card). Name: COPIED: Y N	Insurance Name: _____ Telephone: _____
Are you the insured person or dependent (wife/husband/child)?	☐ Insured ☐ Dependent
If you are the insured person's dependent (spouse or child), we need the insured person's name, date of birth, social security number, and the name of the insured employers business in order to do billing.	Name of Insured Person: _____ Social Security Number: _____ Insured Date of Birth: _____ Name of Insured Employer:_____

OUR OFFICE WILL PROVIDE INSURANCE BILLING SERVICES AS A COURTESY. HOWEVER, IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT AND/OR DEDUCTIBLE FOR REGULAR HEALTH INSURANCE PATIENTS.

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine and extremities, as he or she deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed condition nor for any medical diagnosis. Additionally, I am a responsible party and agree to pay for any outstanding bills incurred in this office. It is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health insurance carrier. Minors must have parent's signature.

Patient Signature:_____ Date:_____

If Minor, Parent Signature: _____ Date:_____

Patient:_____File#:_____Date:_____

Financial Responsibility Appointment Acknowledgment

CASH

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable.

INSURANCE

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I comprehend that benefits and eligibility of my insurance is not a guarantee of coverage or payment. Insurance payment is based on actual terms and condition of my insurance plan. Additionally, it is my responsibility to pay any deductible, co-insurance, and/or any other balances not paid by my health insurance carrier.

I have read and understand my Financial Responsibility: _____

Initials

Cancellation, Missed Appointment and Late Policy

CANCELLATIONS with less than 24 hours notice will result in a $35 charge and MISSED appointments will result in a $55 charge to your account and cannot be bill to your insurance company.

LATE arrival appointments may result in your visit being reduced to a chiropractic adjustment only and a forfeiting of soft tissue treatment procedures.

I have read and understand the Cancellation and "No Show" Policy: _____

Initials

Patient Acknowledgment of HIPAA Privacy Practices

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much you acknowledging your receipt of our policy by signing and returning this document. We look forward to seeing you again.

I have Received and Read the copies of HIPAA privacy practices & Patient Rights:_____

Initials

"Signature On File"

Provider: Jennifer L. Forster, D.C.

- I authorize "The Provider" to use the "Signature on File" on all future billings on the CMS 1500 forms
- I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I authorize payment of medical benefits to "The Provider" for services or supplies described below.
- I authorize a copy of this form serve as an original.
- I authorize "The Provider" to use the "Signature on File" on medical documents associated with my file that has been discussed to me prior to signature.

Print Patient Name:_____

Signature of Patient:_____Date:_____

Patient:_____File#:_____Date:_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable, restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble a copy.

Amend Your Health Information

You have the right to ask to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representatives this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgment

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this document. We look forward to seeing you again.

Received HIPAA privacy practices Received Patient Rights

PLEASE RETAIN THIS COPY FOR YOUR RECORDS. PLEASE SIGN THE PATIENT ACKNOWLEDGEMENT SECTION ON THE PRIOR PAGE. THANK YOU!

Patient Signature **Date**

Patient:_____File#:_____Date:_____

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US.

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA- Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?

Why a privacy policy now?

Those are very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardized and protect the privacy of the electronic exchange of your health information. This challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws; we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USE

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

Patient:_____File#:_____Date:_____

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes the public safety could benefit when the information could lead to a control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim or a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping your with your home hygiene, treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this document. We look forward to seeing you again.

Received HIPAA privacy practices Received Patient Rights

PLEASE RETAIN THIS COPY FOR YOUR RECORDS. PLEASE SIGN THE PATIENT ACKNOWLEDGEMENT SECTION ON THE PRIOR PAGE. THANK YOU!

Patient Signature **Date**

Patient:_____File#:_____Date:_____

Insight Chiropractic's Financial Policy (Pg 1)

This is an agreement between Dr. Jennifer L. Forster, D.C., as creditor, and the Patient/Debtor named on this form.

NAME:

In this agreement the words, "you," "your," and "yours," mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Jennifer L. Forster, D.C.

By executing this agreement, you are agreeing to pay for all services that are received.

Payment options if you have no insurance:

1. You choose to pay by _____cash, _____check, or ____credit card on the day that treatment is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

1. You choose to pay your deductible $_____ and any out-of-pocket portions at the time services are rendered by ____cash, ____check, or ____credit card. Additionally, the insurance carrier may send the remaining payment to the healthcare provider.
2. You choose to pay all of your treatment by _____cash, _____check, or ____credit card. We will request your insurance carrier send their payment directly to you. Otherwise, we will estimate your patient portion
3. All insurance checks and payments will be assigned to our office. If you mistakenly receive an insurance check in your mail, please bring the check and all attached paperwork to our office so that we may properly credit your account.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by insurance.** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and you may be responsible for your entire account.

Non-contracted insurance: Insurance is a contract between you and your insurance company. We are NOT a party in this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although, we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by insurance.** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company and you may be responsible for your entire account.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Finance Charge: A finance charge will be imposed on each item of your account that has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of twelve (12%) percent or highest legal amount by law. The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Patient:_____File#:_____Date:_____

Insight Chiropractic's Financial Policy (Pg 2)

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Santa Clara County, California.

Returned checks: **There is a fee of twenty-five ($25) dollars for any checks returned by the bank.**

Missed appointment fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours notice a $25 cancellation fee or a $45 no show fee will be charged to your account and **cannot be billed to your insurance company**. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Transferring of Records: You will need to request in writing 10 days in advance, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is report to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, your case shall be closed and transferred to a provider with the authorization to treat you. **Additionally, you may be responsible for payment in full of all services rendered to date.**

Personal Injury: If you are being treated as a part of a personal injury lawsuit or claim, we require verification from your attorney and/or insurance company prior to your initial visit. In addition to this verification, we require that you allow us to bill your health and/or personal insurance (MEDPAY.) In the absence of insurance, other financial arrangements may be discussed. **Payment of the bill remains the patient's responsibility.** We cannot bill your attorney for charges incurred due to a personal injury case.

Co-Signature: If this or another Financial Policy is sign by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name:_____

Responsible Party (if not patient):_____

Signature:_____ Date:_____

Co-Signature:_____ Date:_____

Patient:_____File#:_____Date:_____

GENERAL HEALTH HISTORY

Circle *only those conditions that apply to you and write if you have had in the past or presently have. Additionally, indicate conditions that your parents or grandparents have had.*

Bruise easily
Heal Slowly
Body Temperature (Feels Cold)
Body Temperature (Feels Hot)
Smoke Cigarettes
Chew Tobacco
Diabetes
Hypoglycemia
Thyroid disorder
Kidney disease
Liver disease
Heart Attack
Heart Pacemaker
Neck or Chest Shunts
AIDS or STDs
Tuberculosis
Dizziness
Blackouts
Balance Problems
Fainting
Tripping
Osteoporosis or Osteopenia
Gout of your spine or joints
Headaches/Migranies

Allergies
Allergies to Lotions/Tapes
Epilepsy-Seizure-Convulsion
Other Muscular/Neurological Disease
Multiple Sclerosis
Lupus
Psoriasis
Temporary Paralysis
Meningitis
Cancer or Cancer Treatment
Scoliosis
Spondylolisthesis
Spina Bifida
Fused Vertebrae
Bulging or Herniated disc
Disc Degeneration
Blood Clots
Bleeding or Vascular Disorder
Abdominal Aneurysm
Hypertension or High Blood Pressure
Ankylosing Spondylitis
Osteoarthritis/Rheumatoid Arthritis
Psychiatric/Bipolar/Depression disorder
Other:

WOMEN ONLY:	Do you currently have any type of breast implants?	Y	N
WOMEN ONLY:	Is there any chance that you are currently pregnant?	Y	N

PRIOR INJURY OR MUSCULOSKELETAL PAIN HISTORY

(☐ I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain/Arm Pain	☐ Middle Back Pain	☐ Low Back/Leg Pain	☐ Other Pain

FRACTURES/BROKEN BONES

(☐ I have never had any broken bones). If you have broken any bones, indicate where and when below:

Region	Year	Region	Year
☐ Spinal Vertebra		☐ Skull	
☐ Collar bone (clavicle)		☐ Rib bone	
☐ Arm or hand bone		☐ Leg or foot bone	
☐ Pelvis or hip bones		☐ Other	

PREVIOUS SURGERIES

(☐ I have never had any surgical procedure). If you have had any previous surgery, indicate type and when:

Surgery	Year	Surgery	Year
☐ Spine Surgery (neck, back, or pelvis)		☐ Appendix	
☐ Disc surgery in neck or back		☐ Gallbladder/Stomach/Kidney	
☐ Heart		☐ Cancer (any type)	
☐ Tonsillectomy		☐ Rib/Collar bone	
☐ Head/Brain		☐ Hernia	
☐ Shoulder/Arm/Hip/Leg		☐ Other	

Patient:_____File#:_____Date:_____

GENERAL HEALTH HISTORY (Page 2)

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

	Muscle Relaxants		Blood pressure/Stroke prevention medications		Cortisone injections
	Pain/Anti-inflammatory meds		Osteoporosis (bone strengthening) medications		Other:

EXERCISE AND DIET?

	I do not regularly exercise		I do weight lifting at gym/home		I do regular sports activities
	I stretch regularly		I am not willing to do exercises		I eat / like fresh fruits & vegetables
	I am willing to do exercise		I exercise 3-5 times a week		I eat/like processed foods (fried/packaged)
	I exercise 1-2 times a week		I do cardiovascular work outs		I eat / like sugary foods or drinks

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Hip Pain	
☐ Neck Pain, Soreness, or Stiffness		☐ Arm/Hand Pain, Numbness, or Tingling	
☐ Upper/Mid Back Pain, Soreness, or Stiffness		☐ Leg / Foot Pain, Numbness, or Tingling	
☐ Low Back Pain, Soreness, or Stiffness		☐ Other:	

SYMPTOM/PAIN DESCRIPTION

Please circle any word or all words below that best describes how your symptoms currently feel to you.

Pain or soreness	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Swelling
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

WHEN IS PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN LEVELS?

	Morning pain is worse		Bending your back increases pain		Walking increases pain
	Afternoon/evening pain worse		Lying down flat increases pain		Standing increases pain
	During sleep hours pain worse		Sitting increases pain		Exercise/Stretching increases pain
	Standing up from sitting		Poor posture increases pain		Other:

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

	Excessive fatigue-malaise		Bowel or bladder disorders		Night pain or night time sweats
	Weight loss		Ovarian pain		Abdominal pain
	Low grade fever		Kidney pain/painful urination		Balance problems

Have you seen another health care practitioner for your recent complaint? ☐ No ☐Yes_____

Did your symptoms come on? ☐ Suddenly, ☐ Gradually

Are your symptoms getting consistently worse as time goes on? ☐ No ☐ Yes_____

Have you ever been to a Chiropractor before for any condition?

☐ No, ☐ Yes If yes, Chiropractor's Name : _____Year:_____

Problem seen for: _____

☐ No, ☐ Yes Do you have any problems laying face down on an examination table? If yes, why: _____

History of Motor Vehicle Accidents or other major injuries- Please Explain:_____

_____

_____

Patient:_____File#:_____Date:_____

Exam#:

Patient's Pain or Discomfort Awareness Scale

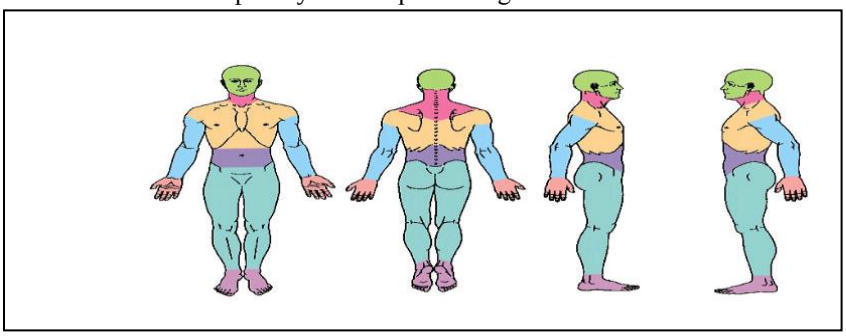
1. Describe the discomforts you want the doctor to address today. (Current Complaints/Conditions)

_____

_____

2. Mark the location of your discomfort and write next to it the description you're experiencing.

SHARP & STABBING	DULL & ACHY
NUMBNESS	TIGHT
PINS & NEEDLES	GRIPPING
DEEP	BURNING
LOCKED UP	LIMITED Range
PINCHING	SPASM



3. Rate your discomfort level from 0 to 10 (0=None10=Unbearable):
   TODAY___/10 **YESTERDAY**___/10
4. What makes your complaint feel:
   WORST? (Explain)_____
   Sit Stand Walk Run Exercise Ice Heat Stretching Shoes Clothing Chiropractic Massage ART
   BETTER? (Explain)_____
   Rest Sit Stand Walk Run Exercise Stretch Ice Heat OTC Pain Meds Shoes Chiropractic Massage ART
5. What percentage of the **DAY** do you experience your discomfort?
   Minimal 10-30% 0ccasional 40-60% Frequent 70-90% Constant 90-100%
6. What percentage of the **WEEK** do you experience your discomfort?
   Minimal 10-30% 0ccasional 40-60% Frequent 70-90% Constant 90-100%
7. Has chiropractic helped? **Y** **N** What percentage improvement have you received since last treatment? _____%
   Explain your improvements:_____

Normal = 0 Severe Pain = 10

Area of Pain	Normal	Mildly in pain	Moderate pain	Severe Pain
Headaches	0 1	2 3 4	5 6 7	8 9 10
Neck	0 1	2 3 4	5 6 7	8 9 10
Middle back	0 1	2 3 4	5 6 7	8 9 10
Lower back	0 1	2 3 4	5 6 7	8 9 10
Hip(s) L R	0 1	2 3 4	5 6 7	8 9 10
Leg(s) L R	0 1	2 3 4	5 6 7	8 9 10
Knee(s) L R	0 1	2 3 4	5 6 7	8 9 10
Feet L R	0 1	2 3 4	5 6 7	8 9 10
Shoulder(s) L R	0 1	2 3 4	5 6 7	8 9 10
Arm(s) L R	0 1	2 3 4	5 6 7	8 9 10
Wrist/hand L R	0 1	2 3 4	5 6 7	8 9 10
Other:	0 1	2 3 4	5 6 7	8 9 10
Other:	0 1	2 3 4	5 6 7	8 9 10

Experiencing any internal symptoms?_____

_____

Neck Index

Managed Physical Network

MPN Use Only rev 5/7/99

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 care 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.

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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 _____