Chiro-TECHNOLOGY
Spinal Health & Wellness Center

PATIENT INFORMATION

Name: _____ Age: _____ Birth Date: _____

Primary Address: _____
Street City State Zip Code

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

E-mail: _____

Employer's Name: _____ Work Phone: (_____) _____-_____

Marital Status: _____Single _____ Married _____Divorced _____Widowed Sex: _____M _____F

Spouse's Name (If applicable) _____

How did you find out about Chiro-Technology? _____

Are your present problems due to an injury? ____Yes ____No **IF YES:** ___Auto ___Work ___Personal ___Other

INSURANCE INFORMATION

Primary Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's Birth Date: _____

Policy Number: _____ Group Number: _____

NAME:_____ DATE OF BIRTH:_____
DATE:_____

** PLEASE COMPLETE ALL ANSWERS. IF A QUESTION DOES NOT PERTAIN TO YOU, PLEASE WRITE "N/A." **

REASON(S) FOR VISIT (NECK PAIN, ETC.):

#1 COMPLAINT _____
#2 COMPLAINT _____
#3 COMPLAINT _____

HOW BAD IS YOUR PAIN?

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE)

FREQUENCY OF PAIN? □ CONSTANT (76-100% OF THE TIME) □ FREQUENT (51-75%) □ INTERMITTENT (26-50%) □ OCCASIONAL (25% OR LESS)

HOW DID THE PROBLEM BEGIN?

_____

_____

WHEN DID THE PROBLEM BEGIN (BE SPECIFIC)_____

DESCRIBE THE CHARACTER OF YOUR PAIN (CHECK ALL THAT APPLY) □ Sharp □ Stabbing □ Dull □ Sore □ Weak □ Throbbing □ Gnawing □ Numbing □ Shooting □ Gripping □ Constricting □ Burning □ Tingling □ Crawling □ Pinching □ Radiating □ Pins and Needles □ Stinging □ Dead □ Prickling □ Other_____

WHAT SITUATIONS WORSEN YOUR PAIN?

□ Bending
□ Walking
□ Sleeping
□ Standing
□ Other_____
□ Moving from Sitting to Standing
□ Laying Down
□ Emotional Stress
□ Touching Affected Area
□ Other_____

WHAT SITUATIONS IMPROVE YOUR PAIN?

□ Ice
□ Stretching
□ Standing
□ Movement
□ Other_____
□ Heat
□ Rest
□ Medication (Type)_____
□ Laying Down
□ Other_____

WHAT TYPES OF TREATMENT HAVE YOU RECIEVED? □ Physical Therapy □ Epidural Injections □ Chiropractic Care □ Nerve Block □ Visit to Urgent Care □ Cervical Collar □ Brace □ Other_____

ARE YOU INVOLVED IN ANY LITIGATION OR LAWSUIT RELATED TO YOUR INJURIES? □ No □ Yes

If Yes, Please Explain:_____

HAS THIS PROBLEM DECREASED YOUR ABILITY TO EXERCISE? □ No □ Yes

PRIMARY CARE PHYSICIAN CONTACT INFO:_____

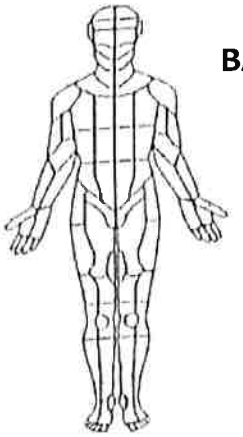
MAY WE HAVE YOUR PERMISSION TO CONTACT YOUR PCP REGARDING YOUR CURRENT CONDITION? □Yes □ No

IS THERE ANYONE YOU WOULD LIKE TO HAVE ACCESS TO YOUR MEDICAL RECORDS?

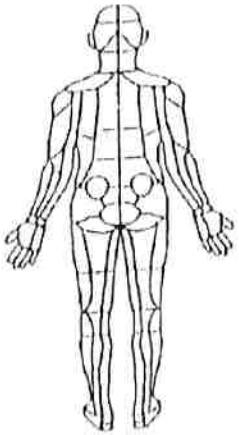
NAME:_____ PHONE:_____ DATE OF BIRTH:_____

MARK THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS, INCLUDING NUMBNESS, ACHE, OR TINGLING.

FRONT



BACK



CHIRO-TECHNOLOGY SPINAL HEALTH CENTER 2385 DELHI COMMERCE DR., STE. 1A, HOLT, MI 48842
PHONE: (517) 694-4972 FAX: (517) 694-5898 WEBSITE: WWW.HOLTCHIROPRACTOR.COM

FAMILY HISTORY – CHECK ALL THAT APPLY

- ☐ N/A
- ☐ Acid Reflux
- ☐ Anxiety
- ☐ Arthritis (Type) _____
- ☐ Asthma
- ☐ Chronic Pain
- ☐ High Cholesterol
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Cancer (Type) _____
- ☐ Diabetes (Type I) (Type II)
- ☐ Heart Disease _____
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hepatitis/HIV
- ☐ Hypertension
- ☐ TB
- ☐ Thyroid Problems_____
- ☐ Respiratory Problems
- ☐ Cardiovascular Problems
- ☐ Osteoperosis
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

PATIENT PAST AND PRESENT MEDICAL HISTORY – CHECK ALL THAT APPLY

	Past	Present		Past	Present
Diabetes (I) (II) (circle one)	☐	☐	Cancer (Type)_____	☐	☐
Lung Disease	☐	☐	Dislocation	☐	☐
Stomach Problems	☐	☐	Seizures	☐	☐
Kidney Disease/Stones	☐	☐	Holter Monitor	☐	☐
Thyroid (Hypo) (Hyper) (circle one)	☐	☐	Degenerative Disc Disease	☐	☐
Heart Disease _____	☐	☐	Degenerative Joint Disease	☐	☐
High Cholesterol	☐	☐	Respiratory Problems	☐	☐
High BP	☐	☐	Nausea	☐	☐
Low BP	☐	☐	Cardiovascular Problems	☐	☐
Asthma	☐	☐	IBS/Colitis/GI Dysfunction	☐	☐
Arthritis (Type) _____	☐	☐	Fatigue	☐	☐
Bleed Easily	☐	☐	Depression	☐	☐
Anemia	☐	☐	Anxiety	☐	☐
Acid Reflux	☐	☐	Migraines/Headache (circle one)	☐	☐
Stroke	☐	☐	Tinnitus	☐	☐
Rapid Heart Beat	☐	☐	Constipation	☐	☐
Dizziness/Fainting	☐	☐	Frequent Urination	☐	☐
Hepatitis/HIV(circle one)	☐	☐	Osteoporosis	☐	☐
Pacemaker	☐	☐	Other _____	☐	☐
Chronic Sinusitis	☐	☐	Loss of Appetite	☐	☐
Breast Soreness/Lumps	☐	☐	Allergies	☐	☐
PMS/Irregular Menstrual Flow	☐	☐	Muscular Incoordination	☐	☐

FRACTURE AND SURGICAL HISTORY – PLEASE LIST SURGERY AND DATE (BE AS SPECIFIC AS POSSIBLE)

_____ _____

_____ _____

_____ _____

ADDITIONAL HEALTH HISTORY

DO YOU HAVE A PERMANANT DISABILITY RATING? □ No □ Yes If yes, what body part(s)? _____

DATE OF DISABILITY RATING: ____/____/____ Disability Percentage: _____%

PRESENT BODY WEIGHT: _____ Pounds **PRESENT HEIGHT:** _____

TOBACCO USE: □ Current □ Former □ Never

ALCOHOL USE: □ Never □ 1-2 per week □ 1-2 per day □ 2 or more per day □ Other _____

RECREATIONAL DRUG USE: □ No □Yes

PREGNANCY? □ Past □ Present Dates:_____

ARE YOU WORKING? □ No □Yes **OCCUPATION:** _____

IF YES, ACTIVITY LEVEL AT WORK? □ Sedentary (sit 50% of day) □ Light Duty (20lbs max)
□ Medium Duty (50lbs max) □ Heavy Duty (100lbs max)

COFFEE/CAFFINE (CUPS PER DAY): _____ **WATER (8oz GLASSES PER DAY):** _____

DEMOGRAPHICS

ETHNICITY
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown
□ Decline to Answer

RACE
□ American Native or Alaskan Native
□ Asian
□ Black or African American
□ White
□ Native Hawaiian or Pacific Islander
□ Other_____
□ Unknown
□ Decline to Answer

LANGUAGE _____

WOULD YOU LIKE A COPY OF EXAM NOTES FROM TODAY'S APPOINTMENT? **YES** **NO**

Revised Oswestry Back Pain and Disability

Name: _____ **Chart #:** _____ **Date:** _____

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle which most closely describes your problem.

Section 1 - Pain Intensity

- ☐ **A.** The pain comes and goes and is very mild.
- ☐ **B.** The pain is mild and does not vary much.
- ☐ **C.** The pain comes and goes and is moderate.
- ☐ **D.** The pain is moderate and does not vary much.
- ☐ **E.** The pain comes and goes and is very severe.
- ☐ **F.** The pain is severe and doesn't vary much.

Section 2 - Personal Care

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

Section 3 - Lifting

- ☐ **A.** I can lift heavy weight without extra pain.
- ☐ **B.** I can lift heavy weight but it gives extra pain.
- ☐ **C.** Pain prevents me from lifting heavy weights off the floor.
- ☐ **D.** Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- ☐ **E.** Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- ☐ **F.** I can only lift very light weights at the most.

Section 4 - Walking

- ☐ **A.** I have no pain walking.
- ☐ **B.** I cannot walk more than one mile without increasing pain.
- ☐ **C.** I cannot walk more than 1/2 mile without increasing pain.
- ☐ **D.** I cannot walk more than 1/4 mile without increasing pain.
- ☐ **E.** I can walk with crutches.
- ☐ **F.** I cannot walk at all without increasing pain.

Section 5 - Sitting

- ☐ **A.** I can sit in any chair as long as I like.
- ☐ **B.** I can only sit in my favorite chair as long as I like.
- ☐ **C.** Pain prevents me from sitting more than one hour.
- ☐ **D.** Pain prevents me from sitting more than a half hour.
- ☐ **E.** Pain prevents me from sitting more than 10 minutes.
- ☐ **F.** I avoid sitting because it increases pain straight away.

Section 6 - Standing

- ☐ **A.** I can stand as long as I want without pain.
- ☐ **B.** I have some pain on standing but it does not increase with time.
- ☐ **C.** I cannot stand for longer than one hour without increasing pain.
- ☐ **D.** I cannot stand for longer thanf 1/2 hour without increasing pain.
- ☐ **E.** I can't stand for longer than 10 minutes without increasing pain.
- ☐ **F.** I avoid standing because it increases the pain straight away.

Section 7 - Sleeping

- ☐ **A.** I get no pain in bed.
- ☐ **B.** I get pain in bed but it doesn't prevent me from sleeping well.
- ☐ **C.** Because of pain my normal night's sleep is reduced by < 1/4.
- ☐ **D.** Because of pain my normal night's sleep is reduced by < 1/2.
- ☐ **E.** Because of pain my normal night's sleep is reduced by < 3/4.
- ☐ **F.** Pain prevents me from sleeping at all.

Section 8 - Traveling

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

Section 9 - Social Life

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

Section 10 - Changing Degree of Pain

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

Office Use Only

Score: _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature:

REV. 10/01/97

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NECK PAIN DISABILITY INDEX QUESTIONNAIRE

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

SECTION 1 - Pain Intensity

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

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

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

SECTION 3 - Lifting

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

SECTION 4 - Reading

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

SECTION 5 - Headaches

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

SECTION 6 - Concentration

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

SECTION 7 - Work

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

SECTION 8 - Driving

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

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

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

COMMENTS: _____

_____

_____

NAME: _____ **DATE:** _____ **SCORE:** _____

Chiro-TECHNOLOGY
Spinal Health & Wellness Center

Medication List

Patient's Name _____ Date _____

Please list all vitamins, supplements, and medications that you take.

Medication/Supplement	Dosage (mg., etc.)	Frequency (1x/day, as needed, etc.)	Allergies

Chiro-TECHNOLOGY
Spinal Health & Wellness Center

Financial Policy

Investing in your health is always a value, allowing you to live a more productive, pain free life. We understand that directing time and money toward your health can be a delicate balance between positive results and financial stress. We are committed to providing options so you can focus on getting well in the shortest time possible and maintain that investment in wellness.

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will have coverage under one of the plans discussed below. *We ask that you read and understand our policy as it applies to your particular situation.*

Patients Without Insurance

We request that all fees be paid at the time of each visit. We accept check, cash, MasterCard, VISA & Discover. If you are a member of Preferred Chiropractic Discount, you are entitled to network discounts. Membership is $37 a year and covers you and your dependents. Ask our staff for more information.

Patients With Insurance

When possible, we will call to verify benefits on your insurance. It is your responsibility to notify our office of any changes in your insurance carrier(s). The benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due at the time of service for any non-covered services, deductibles or copays. Your insurance contract is between you (the patient) and your insurance company. You are responsible for any amount not paid by your insurance company.

Medicare

We accept assignment from Medicare. Please note, however, that Medicare will ONLY cover manual manipulation of the spine (adjustments). Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible, your 20% copay, and any non-covered services. If you are a member of Preferred Chiropractic Discount, we will be able to discount any non-covered services.

Secondary Insurance

Please inform us of any secondary insurance you may have. Our office will complete all billing at no charge.

Prior Authorization

For plans requiring that chiropractic care be authorized, please have your primary care physician submit an authorization prior to treatment.

Personal Injury or Automobile Accidents

Please notify your insurance carrier that you are treating with our office. We require the following billing information: name of insurance company, billing address, claim number, date of accident, and adjuster's name.

Worker's Compensation

If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. Treatment must be pre-approved.

Initial here _____

Chiro-TECHNOLOGY
Spinal Health & Wellness Center

Missed Appointments

If you need to cancel or change an appointment, please call 24 hours in advance. This allows us to fill the appointment time with someone from our waiting list. Patients canceling or changing an appointment with the doctor without a 24 hour notice may be charged a fee of $25.

If you are scheduled for a massage or exercise session and fail to give 24 hours notice, there will be a charge of 50% of the total appointment charge.

Assignment of Benefits

I authorize that any insurance benefits or reimbursement for services rendered payable to me under any insurance or Medicare be made directly to: Chiro-Technology, 2385 Delhi Commerce Drive, Suite 1A, Holt, MI 48842.

I authorize the release of any information concerning my health and health care services to my insurance companies or Medicare.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Payment Agreement

I understand that there is no guarantee that my insurance companies or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction or benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Notice of Privacy Practices

I acknowledge that Chiro-Technology's "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review Chiro-Technology's Notice of Privacy Practices prior to signing this document. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of the health care operations of Chiro-Technology. The Notice of Privacy Practices for Chiro-Technology is also provided on request at the reception desk. This Notice of Privacy Practices also describes my rights and Chiro-Technology's duties with respect to my protected health information.

Chiro-Technology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

Patient's Name_____

Signature _____ Date: _____