

**Welcome!**

**Patient Information**

Chart # \_\_\_\_\_

**Please Complete the information below as complete as possible**

First Name	MI	Last Name	Title Suffix		
Street		SS# DOB			
City		Marital Status		Sex	
State	Zip	Work Phone	Home Phone	Cell Phone	Email address

**Employment Information**

Employer's Name	Position
What do you do there?	Spouse Name
Spouse's Employer	Time Employed?

**Insurance Information**

Primary Insurance Company			Insured's Name		
Address			Relationship to Insured		
City	State	Zip	SS#	DOB	
Secondary Insurance Company			Insured's Name		
Address			Relationship to Insured		
City	State	Zip	SS #	DOB	

**Account Information**

**Desired Method of Payment: Circle One**   Cash   Check   Visa   Mastercard   Amex

Card Number	EXP, Date	Name of Person to be Billed			
Billing Address		Relationship			
City	State	Zip	SS#	Driver's License #	
Who Referred you to our Office?					

**Attorney**

Have you retained an attorney? **Yes**   **No**

Attorney's Name					
Address			Phone		
City	State	Zip	Copywrite 1989		

Dr Nixdorf \_\_\_ Dr. Stabile X Covid-19 Patient Screening

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Temperature \_\_\_\_\_ Washed Hands \_\_\_ Wearing Gloves \_\_\_ Wearing Mask \_\_\_

Do You have any of the following symptoms?

1. Fever and/or chills Yes \_\_\_ No \_\_\_
2. Cough (usually dry) Yes \_\_\_ No \_\_\_
3. Shortness of breath or difficulty breathing Yes \_\_\_ No \_\_\_
4. Tiredness (sometimes) Yes \_\_\_ No \_\_\_
5. Aches and pains (sometimes) Yes \_\_\_ No \_\_\_
6. Headaches (sometimes) Yes \_\_\_ No \_\_\_
7. Sore throat (sometimes) Yes \_\_\_ No \_\_\_
8. Upper respiratory symptoms, like runny nose and sinus congestion, are very uncommon in COVID-19. Yes \_\_\_ No \_\_\_
9. In the past two to three weeks have you been in contact with anyone that has tested positive for the COVID-19 Virus? Yes \_\_\_ No \_\_\_
10. Have you received the Covid Vaccine Yes \_\_\_ No \_\_\_
11. If this is your follow-up visit and you have answered these questions at your last visit then have any of your answer's changed since that visit?
12. Yes \_\_\_ No \_\_\_

I have read the above and certify that it is correct to the best of my knowledge. The doctor is compliant with the necessary, accepted, and recommended precautions as they relate to the Covid 19 guidelines. I agree that if at any time on future visits any of the answers to the above questions should change I will notify the doctor immediately.

I was instructed to wash my hands prior to and after my encounter. I am socially distanced from any other patient in the office during my visit. The doctor has hand sanitizer, antiseptic spray, is wearing a N 95 Face masks and Surgical gloves. The office was sanitized prior to my entering and as I am leaving. My temperature was taken, and I was asked the above questions. I indemnify the doctor for any health problems I may have prior to and after my visit to the office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_



ASSIGNMENT OF INSURANCE BENEFITS

PATIENT'S NAME: \_\_\_\_\_

DATE OF ACCIDENT or Start of Condition: \_\_\_\_\_

In consideration for services rendered to me or to be rendered to me in the future, I hereby authorize payment to the above-referenced provider of any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider.

In the event that the provider's charges are outstanding, I hereby assign and authorize the provider to institute arbitration proceedings or other litigation for the purpose of the provider realizing payment for services rendered. It is also my intent that the provider receives payment directly from the insurance carrier, whether payment is issued prior to or as a result of arbitration proceedings or litigation.

This authorization and assignment or photocopy thereof shall authorize you to furnish all information you may have concerning my condition while under your observation or treatment, including, but not limited to the history obtained, x-ray, MRI, physical findings, diagnosis and prognosis.

SIGNATURE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

DATED: \_\_\_\_\_

Claim # \_\_\_\_\_

First Date of Treatment \_\_\_\_\_



**INFORMED CONSENT**

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following:

Patient should initial the procedures they are consenting to.

- |                           |                      |                              |
|---------------------------|----------------------|------------------------------|
| X Spinal Manipulation     | X Palpation          | X Vital Signs                |
| X Range of Motion Testing | X Orthopedic Testing | X Basic Neurological Testing |
| X Muscle Strength Testing | X Postural Testing   | X Ultrasound                 |
| X Hot/Cold Packs          | X EMS                | X Radiographic Studies       |

\_\_\_ Other (please explain) \_\_\_\_\_

The material risk inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications of care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which I check during he is taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and are estimated to occur between one in one million and one in five million in cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

Self-administered, over-the-counter analgesics and rest

Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers.

Hospitalization

Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time the process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN.

I have read [ X ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Stabile and have had my questions answered to my satisfaction. By my signature below I state that I have weighed the risks involved n undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Doctor's Signature

## **HIPAA Notification**

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Dr. Albert Stabile Jr. Chiropractic Physician

EFFECTIVE DATE OF THIS NOTICE: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAYBE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your .PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI. .

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE at QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Dr. Albert Stabile Jr. Chiropractic Physician

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other, health care providers for purposes related to your treatment.
2. **Payment** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Appointments and Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment.
5. **Non-Medical Communications.** Our practice may use your PHI to contact you for non-medical reasons. For example, we may send you a birthday card or a holiday greeting via mail.
6. **Health-Related Benefits and Services** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you for example, we may send you newsletters that may include information about our practice, health related issues and products and services.
8. **Release of Information to.** Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
9. **Disclosures Required By Law,** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

## **D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The; following categories describe unique scenarios in which we may use or disclose your Identifiable health information.

1. **Public Health Risks:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
  - A. Maintaining vital records, such as births and deaths.
  - B. Reporting child abuse or neglect
  - C. Preventing or controlling disease, Injury or disability.
  - D. Notifying a person regarding potential exposure to a communicable disease.
  - E. Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
  - F. Reporting reactions to drugs or problems with products or diseases
  - G. Notifying individuals of a product or device they may be using has been recalled.

H. Notifying appropriate government agency and authority regarding the potential abuse or neglect of an adult patient (Including domestic violence): however, we will only disclose this information if the patient agrees, or we are required or authorized by law to disclose this information; and

I. **Notifying your employer** Under limited circumstances related primarily to workplace Injury or Illness or medical surveillance.

2. **Health Oversight Activities:** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedure or actions; or other activities necessary for the government to monitor government programs, compliance With Civil rights laws and the health care system In general.

3. **Lawsuits and Similar Proceedings** Our practice may use and disclose your PHI In response to court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI In response to a discovery request, subpoena, or other lawful process by another party Involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

6. **Workers' Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing your request must describe in a clear and concise fashion.

A. The information you wish restricted.

B. Whether you are requesting to limit our practice's use, disclosure, or both; and

C. To whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the 'practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the billing department using your information to file your insurance claim in order to obtain an accounting of disclosures, you must submit your request in writing to Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

7. **Right to File a Complaint.** If you believe your privacy fights have been violated; you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for other Uses and Disclosures:** Our practice will maintain your Written authorization for uses and disclosures that are not Identified by this notice or permitted by applicable law Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing after you revoke your authorization, we Vvil1 no longer use or disclose your PHI for the reasons described in the authorization. **Please note, we are required to retain records of your care.**

Again. If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

I have read a copy of the notice of privacy practices document.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Witness

## OFFICE POLICY

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PLEASE READ ALL TEXT, IF YOU UNDERSTAND WHAT YOU HAVE READ, PLEASE SIGN WHERE INDICATED AT THE BOTTOM OF THIS FORM.

**AUTHORIZATION TO RELEASE INFORMATION** ---I hereby authorize any provider insurance company, physician, employer or organization to release any information regarding history, treatment, or benefits payable and related information concerning this claim, to the plan administrator or it's authorized agent, for the purpose of validating and determining benefits in connection with this claim and to any reviewer that Albert Stabile Jr., Chiropractic Physician may deem necessary to perform a file review for the purposes of payment, rebuttal of treatment denial, retroactive review, current denial of care, payment or nonpayment of my claims.

**PAYMENT AUTHORIZATION**---I authorize payment of all benefits for services rendered from Chiropractic Physician and Albert Stabile Jr., Chiropractic Physician and/or the offices known as indicated on the enclosed bills.

This statement applies to insurance assignment and/or an Attorney Lien against any settlement made in conjunction with the above named for condition or injuries which I am being treated for in the offices of the above-named physicians.

**OFFICE POLICY REGARDING APPOINTMENTS** --- Multiple appointments may be given to you for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily schedule. Regardless of how many appointments are scheduled for you each week, please remember that it is frequency of the visits that is important, and not the days. If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. IF YOU NEGLECT TO CALL TO RE-SCHEDULE AN APPOINTMENT THAT YOU CAN NOT MAKE, AND DO NOT SHOW UP FOR THAT APPOINTMENT, YOU WILL BE CHARGED. If you are late for an appointment you may have to wait for the next available opening. If you have any questions please ask the receptionist.

**OFFICE POLICY REGARDING ASSIGNMENT** ---Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in any way that we can. However, it must be fully understood that the Contract is between you and your insurance company, and you are fully responsible for the amount that is not paid by your insurance company.

### **Our Policy is as follows:**

1. Since, by taking your insurance assignment, we have to wait for payment, this courtesy may be withdrawn at any time if the situation warrants it.
2. If you discontinue care without the doctor's consent, the balance of your account is due to be paid in full, even if insurance has been filed. (You will be reimbursed if your balance is zero)
3. Your insurance company should pay within 30 days. If they do not pay within 60 days, you must pay the balance due and be reimbursed by the insurance company.
4. We will bill your insurance company in 15-day cycles, for as long as you receive care.
5. All deductible payments MUST be made prior to insurance submittal. You are required to pay your co-payment as you go along.
6. You are required to sign for "Authorization to Pay the Provider" (above) and any other documents required by your insurance company, on your first visit.
7. Our office does not guarantee that your insurance company will pay. We will make every attempt to verify your coverage and collect, but all claims are your responsibility.
8. Since we do not own your policy, and occasionally, we have trouble in collecting from the carrier, we may ask for your active assistance in rectifying this situation.
9. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1½% per month. Charges may also be made for missed appointments and those canceled without 24 hours' notice.

10. All patients whose visitation schedule is once per month (or longer) will not be eligible for insurance assignment. Charges for services rendered will again be due as they are received.
11. This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.
12. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. Any over payments will be refunded to you.
13. This office does not file for or accept co-payment for secondary Insurance coverage.
14. The privilege of Insurance assignment begins when our office receives your insurance forms, and your insurance is "Qualified" for coverage. You are considered a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy.
15. Lastly, it is the goal of this office to provide you with the finest quality Chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

\_\_\_\_\_

PATIENT SIGNATURE                  DATE                  Witness

All accounts not paid within 90 days will automatically be put through your personal credit card for collection.

I \_\_\_\_\_ hereby authorize Albert Stabile Jr., Chiropractic Physician to charge my AMEX\_\_\_ VISA\_\_\_ MC  
 \_\_\_ Credit card account # \_\_\_\_\_ for the following services and or supplies:

\_\_\_\_\_

\_\_\_\_\_

Signature,                                  Please Print Name                                  Date

**INITIAL HEALTH HISTORY**

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**FAMILY HISTORY:**

Do you feel that your family history has had an effect on your current condition?

Yes  No

If yes, explain why \_\_\_\_\_

Are your parents alive? Yes  No

If deceased at what age? Mother \_\_\_\_\_ Cause of death? \_\_\_\_\_

Father \_\_\_\_\_ Cause of death? \_\_\_\_\_

Are your parents healthy? Yes  No

If not what conditions do they have? Mother \_\_\_\_\_

Father \_\_\_\_\_

Do you have brothers and sisters? Yes  No

How many? Brothers? \_\_\_\_\_ Ages? \_\_\_\_\_ Sisters? \_\_\_\_\_ Ages? \_\_\_\_\_

Are they healthy? Brothers Yes  No  Sisters Yes  No

If not healthy what illnesses do they have? Brothers? \_\_\_\_\_

Sisters? \_\_\_\_\_

Are they alive? Yes  No

If not at what ages did they die and what was the cause of death?

Brothers? Ages? \_\_\_\_\_ Cause of death? \_\_\_\_\_

Sisters? Ages? \_\_\_\_\_ Cause of death? \_\_\_\_\_

Do you have children? Yes  No

How Many? \_\_\_\_\_ Boys \_\_\_\_\_ Ages \_\_\_\_\_ Girls \_\_\_\_\_ Ages \_\_\_\_\_

Are they all healthy? Yes  No

If not healthy, what illness do they have? \_\_\_\_\_

**SOCIAL HISTORY:**

What is your **occupation**? \_\_\_\_\_

Do you feel that your **Social History** has had an effect on your current condition? Yes  No

Do you drink **alcoholic** beverages? Yes  No

Do you use **tobacco** products? Yes  No

Do you use **recreational drugs**? Yes  No

Do you drink beverages with **caffeine**? Yes  No

Do you take **vitamin** supplements? Yes  No

Why? \_\_\_\_\_

Do you go to a **gym or Health Club**? Yes  No

Why? \_\_\_\_\_

Do you drink **Bottled water**? Yes  No

Why? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Have you been to a **Chiropractor**? Yes  No

How Long Ago? \_\_\_\_\_ Name of Chiropractor? \_\_\_\_\_ Do Not Recall

What were you treated for? \_\_\_\_\_

Do you have any **drug or other allergies**? Yes  No

What drugs? \_\_\_\_\_ \_\_\_\_\_

Do you have any **other allergies**? Yes  No

What are they? \_\_\_\_\_ \_\_\_\_\_

Other than for your current problem, have you been **hospitalized** in the past **five years**?

Yes  No

Date \_/\_/ Reason \_\_\_\_\_

How Long ? \_\_\_\_\_

Have you had any other accidents? Yes  No

Slip and Fall Yes  No

Workers Compensation? Yes  No

Auto? Yes  No

If yes please describe \_\_\_\_\_

Describe any treatment: \_\_\_\_\_

Have you had any significant **health problems** in the past? Yes  No

If you have had any of the following health problems in the past, please check any of the following that may pertain to you. If not continue to the next topic.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Attack               | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Heart Murmur      |
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Artificial Valves |
| <input type="checkbox"/> Congenital Heart Defect    | <input type="checkbox"/> Venereal Disease        | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> Alcohol Abuse              | <input type="checkbox"/> Shingles                | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Drug Abuse                 | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Anemia            |
| <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Rheumatic Heart   |
| <input type="checkbox"/> Frequent Neck Pain         | <input type="checkbox"/> Psychiatric Problems    | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Low Blood Pressure         | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Chemotherapy      |
| <input type="checkbox"/> Severe/Frequent Headaches  | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Lower Back Problems        | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Colitis           |
| <input type="checkbox"/> Other-Describe: _____      |  |  |

**WOMEN ONLY**

- To the best of your knowledge are you pregnant? **Yes**  **No**
- Have your past pregnancies been normal? **Yes**  **No**
- If not, why? \_\_\_\_\_
- I have never been pregnant. **Yes**  **No**
- Do you consult an OB/GYN regularly? **Yes**  **No**
- If Yes what is the OB/GYN's Name? \_\_\_\_\_

**Date of Onset of your Current Condition? When did it start?**     /  /

**Description of Accident/Injury/Condition?**

How did it happen?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Type:**     **Automobile Accident**     **Slip/Fall Accident**
- Pedestrian Accident**     **Workmen's Compensation**
- Not an Accident -Explain** \_\_\_\_\_

Were you treated by any other doctors for this condition? Yes  No

Name of treating doctors and Specialists: \_\_\_\_\_

Are you currently taking any medications? Yes  No

Anti-Inflammatory  Tranquilizers  Insulin Injection  Diabetes medication Pills

Muscle Relaxants  Pain Medication  Antibiotics  Blood Thinners

Thyroid Medication  Birth Control Pills  Blood Pressure Medications

Other List: \_\_\_\_\_

Please complete the following indicating those items that pertain to your current health:

Heart Attack  Heart Surgery/Pacemaker  Heart Murmur

Stroke  Mitral Valve Prolapse  Artificial Valves

Congenital Heart Defect  Venereal Disease  Hepatitis

Alcohol Abuse  Shingles  Cancer

Drug Abuse  Emphysema  Anemia

HIV/AIDS  Glaucoma  Rheumatic Heart

Frequent Neck Pain  Psychiatric Problems  Ulcers

High Blood Pressure  Kidney Problems  Asthma

Low Blood Pressure  Sinus Problems  Chemotherapy

Severe/Frequent Headaches  Difficulty Breathing  Arthritis

Fainting/Seizures/Epilepsy  Artificial Bones/Joints  Tuberculosis

Lower Back Problems  Diabetes  Colitis

Other-Describe: \_\_\_\_\_

Did you receive treatment in a hospital for your current condition? Yes  No

When did you go to the hospital?  Immediately  Next day  Days later

Later that day

How did you get to the hospital?  Ambulance  Police  Drove Self  Someone else



Use Heat

Rest

None

If you had these symptoms before please describe:

[Redacted]

**DIFFICULTY IN:**

Bending  Standing  Walking  Lying  Reaching

Lifting  Twisting  Coughing  Sitting  Sneezing

Rising to walk after sitting or lying down

**PAIN IS RELIEVED BY:**

Rest  Nothing  Ice  Heat  Sitting

Aspirin  Advil  Standing  Exercise  Tylenol

**SYMPTOMS ARE:**

Improving Slowly  Improving Moderately  Improving Greatly

Recurrent  Getting Worse  Not Improving

Have you missed work due to this accident/condition?  Missed No Work  Limited

Work Activity  Missed Work From [Redacted] / [Redacted] / [Redacted] to [Redacted] / [Redacted] / [Redacted]

I  **Have**  **Have Not** had these symptoms before.

I  **Was**  **Was Not** symptomatic prior to the start of this condition or injury.

Did you self-treat your symptoms?  Yes  No

Ice  Heat  Bed Rest  Over-The-Counter Medication

**ACTIVITIES OF DAILY LIVING GENERAL PAIN DISABILITY INDEX-This information is very important.**

The rating scales are designed to measure the degree to which several aspects of the patient's life are presently disrupted by acute or chronic pain. In other words, we determine how much the pain the patient is experiencing is preventing the patient from doing what would normally be done, or-from doing it as well as the patient normally would. Each category was responded to by indicating the overall impact of pain in the patient's life, not just when the pain is at its worst.

For each of the six categories of daily living listed, the patient writes the number, which best described the typical level of activities. A score of 0 means no disruption in functioning at all, and a score of 10 signifies that all of the activities in the specific category in which the patient would normally be involved have been totally disrupted or prevented by the pain.

**FAMILY/HOME RESPONSIBILITIES:** This category refers to activities related to the home or family. It includes chores and duties performed around the house and errands or favors for other family members (e.g., driving the children to school, Travel, Driving, Riding as a passenger, Driving for more than 15-20 minutes, Riding as a passenger for more than 15-20 minutes, Sitting, Climbing stairs, Getting in/out of auto, Kneeling, Lifting children, Using telephone, Using computer, Yard Work, Mowing lawn, Raking leaves, Gardening, Housework, Doing Laundry, Making beds, Bending, Running, Walking, Walking for long distance, Sitting for long periods of time, Lifting more than a few pounds, Vacuuming, Washing dishes, Ironing, Carrying groceries, Caring for pets, Cooking.)

The patient indicated that Family/Home Responsibilities were affected at a level of \_\_\_\_.

**RECREATIONAL ACTIVITIES:** This category includes hobbies, Reading, Playing piano, Exercising, Swimming, sports and other similar leisure time activities.

The patient indicated that Recreation Activities were affected at a level of \_\_\_\_.

**SOCIAL ACTIVITY:** This category refers to activities, which involve participation with friends and acquaintances other than family members, it includes parties, theater, concerts, dining out, and other social functions.

The patient indicated that Social Activities were affected at a level of \_\_\_\_.

**OCCUPATIONAL ACTIVITIES:** This category refers to activities that are a part of our directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.

The patient indicated that Occupational Activities were affected at a level of \_\_\_\_.

**SELF CARE ACTIVITIES:** This category includes activities which involve personal maintenance and independent daily living (e.g., taking a shower, Personal Grooming, combing hair, Shaving, In/out bathtub, brushing teeth, Getting dressed, etc.)

The patient indicated that Social Care Activities were affected at a level of \_\_\_\_.

**LIFE-SUPPORT ACTIVITY:** This category refers to basic life-supporting behaviors such as eating, sleeping, lying in bed, Chewing, Sitting in recliner and breathing.

The patient indicated that Life-Support Activities were affected at a level of \_\_\_\_.

**The above Activities of Daily Living Pain Indexes totaled \_\_\_\_\_.**

By dividing the sum total of all the Activities of Daily Living Ratings by the total of possible Total

Disability you arrive at a percentage of Total Activities of Daily Living Disability. The patient was given a Activities of Daily Living General Pain Disability Index Questionnaire on \_\_\_\_\_ and had a score of \_\_\_\_/60 and a percentage of General Pain Disability of \_\_\_\_% .

The percentage of disability is rated 0-20% No Disability to Minimal disability, 21-40% Moderate disability, 41-60% Severe disability, 61-80% Crippling disability, 81-100% Bed-bound or exaggerating.

**INITIAL COMPLAINTS**

**PAIN SCALE - BASED ON A SCALE OF 0 TO 10, WITH 10 BEING THE MOST SEVERE and 0 being no pain. 1-2=Mild 3-4=Mild to Moderate 5-6=Moderate 7-8+ Moderate to Severe 9-10=Severe**

**PLEASE RATE EACH SYMPTOM ACCORDINGLY.**

**JAW PAIN:**  Right  Left  Both **Jaw Pops**  Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**NECK PAIN:**  Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

**PAIN INCREASED BY MOVEMENT:**

**ROTATION**  Right  Left

**BENDING**  Forward  Backward  Right  Left

Neck Stiffness  Muscle Spasm  Grinding and Grating Sounds

Constant  Frequent  Occasional  Intermittent

**HEADACHES:**

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

**LOCATED:**

Front  Back  Temples  Forehead  Behind Eyes

Constant  Frequent  Occasional  Intermittent

**SHOULDER PAIN:**  Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**SHOULDER LIMITED MOVEMENT:**  Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**ARM PAIN:**  Right  Left  Both  Forearm  Upper Arms

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**ARM NUMBNESS: Hand**  Right  Left  Both **Arm**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**ARM PINS/NEEDLES:**

**Hand**  Right  Left  Both **Arm**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**ARM WEAKNESS:**

**Hand**  Right  Left  Both **Arm**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**ELBOW**  Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**WRIST**

Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**HAND PAIN:**

Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**HAND PINS/NEEDLES:**

**Hand**  Right  Left  Both **Arm**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**HAND NUMBNESS:**

**Hand**  Right  Left  Both **Arm**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**HAND WEAKNESS:**

**Hand**  Right  Left  Both **Arm**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**UPPER BACK PAIN:**     Right  Left  Both

**SPASM**                     Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**LOWER BACK PAIN:**     Right  Left  Both

**SPASM**                     Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**SACRO-ILIAC:**             Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**HIP PAIN:**                 Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**BUTTOCK PAIN**             Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**LEG PAIN**                 Right  Left  Both

**RADIATING TO THE**     Knee  Calf  Foot

**DOWN THE**             Front  Back  Side

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**LEG NUMBNESS**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**LEG PINS & NEEDLES**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**LEG WEAKNESS**  Right  Left  Both **in the**  Thigh  Calf

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**KNEE PAIN**  Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**ANKLE PAIN**  Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**FOOT PAIN**  Right  Left  Both

**PAIN SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**FOOT PINS & NEEDLES**  Right  Left  Both

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

**FOOT WEAKNESS**  Right  Left  Both **in the**  Thigh  Calf

**DEGREE SCALE**  0  1  2  3  4  5  6  7  8  9  10

Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

Constant  Frequent  Occasional  Intermittent

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Name (Print)  Date / / Signature

Form #1201 Revised 6/22/2016 copy write 2016.