Terms of Acceptance

PATIENT NAME: _____ **DATE:** _____

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.
Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at 1st Choice Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____ Phone# _____

Children: _____ Phone# _____

Others: _____ Phone# _____

No One _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Consent &Missed Appointments:

I hereby authorize payment of benefits directly to 1st Choice Chiropractic. Our policy requires payment in full for all services rendered at the time of visit. If my account is not paid within 60 days of the date of service and no financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my payment. A $5.00 charge will be added to my account if I do not pay my copay/office visit fee at the time of service. A $10.00 fee will be charged if I fail to show for scheduled appointments and do not call to cancel prior to the scheduled appointment. If my account is turned over to a collection agency, I understand that a $25.00 collection fee will be added.

I authorize the staff to perform any necessary services for the diagnosis and treatment of my condition and I authorize the provider to release any information required to process my insurance claims. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(Women- circle one): To the best of my knowledge I **am / am NOT** pregnant and **(give my permission / don't give permission)** to x-ray me for diagnostic interpretation.

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

PRINT NAME: _____

X _____ _____

SIGNATURE OF INSURED/GUARDIAN **DATE**

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____ Date _____

Please read carefully:

*This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just **mark the one box which most closely describes your problem right now.***

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 severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

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

SECTION 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

_____

_____

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

A I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, 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 9 – 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 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 at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

_____

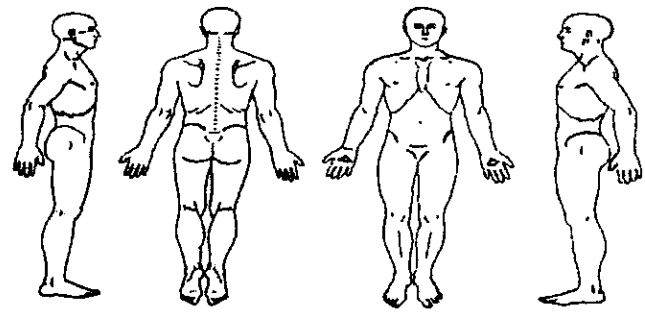
Examiner

CASE HISTORY

Name: _____ **Date:** _____

1. What is your present complaint: _____

(Please MARK the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day

-afternoon -same all day

-night -decrease during the day

3. Using a scale, 0 being no pain, 10 being severe pain, where would you rate your current condition: _____
4. Are your symptoms: Constant (76-100%) / Frequent (51-75%) / Occasionally (26-50%) / Intermittently (1-25%)
5. Symptoms are: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles / Shooting
6. When did your symptoms begin (onset date)? _____
7. How did your symptoms begin? _____
8. Have you experienced these before? _____
9. Do your symptoms radiate? _____
10. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
11. What makes your problems worse: _____
12. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
13. Have you been treated for this before? ____No ____Yes How long ago? _____
14. If you received treatment, where did you go? _____
15. What treatment did you receive? _____
16. Results of previous treatment? ____Good ____Poor Comments _____
17. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation _____ Social Life
18. List any other major injuries you have had, other than those mentioned above: _____

_____

19. Any other Musculoskeletal problems? ____No ____Yes Neurological problems? ____No ____ Yes
21. What concerns you most about your problem? What does it prevent you from doing? _____
22. What is your Height:_____ Weight:_____
23. Do you smoke? How many packs per day?_____
24. Are you pregnant? How many weeks? _____
25. What do you do outside of work? Any hobbies? _____
26. Did you hear about our office via: Yellow Pages:_____ Online Resource (which one):_____

    Your Insurance:____ Your Doctor (name):_____ Friend/Family (name):_____

    Other:_____

I certify that the above information is accurate to the best of my knowledge.

X_____ _____

SIGNATURE OF INSURED/GUARDIAN **DATE**

1st Choice Chiropractic

Dr. Timothy Trax, Dr. Connie Smith, and Dr. Casie Carr

2955 W. Sylvania Ave., Toledo. Ohio 43613

UPDATED HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

Please check the box to indicate whether you have had any of the following:

- ❑ ADDICTIONS
- ❑ AIDS/HIV
- ❑ ALCOHOLISM
- ❑ ALLERGIES
- ❑ ANOREXIA/BULIMIA
- ❑ APPENDICITIS
- ❑ **ARTHRITIS**
- ❑ BLEEDING DISORDERS
- ❑ **BLOOD PRESSURE (HIGH/LOW)**
- ❑ BRONCHITIS
- ❑ **CANCER**
- ❑ CARPAL TUNNEL SYNDROME
- ❑ CATARACTS
- ❑ CHOLESTEROL ELEVATION
- ❑ DEPRESSION
- ❑ DIABETES
- ❑ EPILEPSY
- ❑ **FRACTURES**
- ❑ GI ISSUES (STOMACH/S1/L1)
- ❑ GLAUCOMA
- ❑ GOITER
- ❑ GOUT
- ❑ HEADACHES
- ❑ HEARING ABNORMALITY
- ❑ **HEART DISEASE**
- ❑ HERNIA
- ❑ **HERNIATED DISC**
- ❑ HORMONE REPLACEMENTS
- ❑ HYSTERECTOMY
- ❑ JOINT REPLACEMENTS
- ❑ KIDNEY OR BLADDER DISEASE
- ❑ LIVER DISEASE (HEPATITIS, ETC.)
- ❑ LUNG ISSUES (BRONCHITIS, ASTHMA, ETC.)
- ❑ MEASLES
- ❑ **METAL IMPLANTS**
- ❑ MISCARRIAGE
- ❑ MONONUCLEOSIS OR MUMPS
- ❑ MULTIPLE SCLEROSIS
- ❑ ORTHOPEDIC PROBLEMS (SHOULDER, KNEE, HIP, ETC)
- ❑ **OSTEOPOROSIS**
- ❑ PANCREATITIS
- ❑ PARKINSON'S DISEASE
- ❑ PINCHED NERVES
- ❑ POLIO
- ❑ PREGNANCIES
- ❑ PROSTATE PROBLEMS
- ❑ PROTHESIS
- ❑ PSYCHIATRIC CARE
- ❑ RHEUMATOID ARTHRITIS
- ❑ SCARLET FEVER
- ❑ **SCOLIOSIS**
- ❑ **SHINGLES**
- ❑ SINUS ISSUES
- ❑ **SPINAL STENOSIS**
- ❑ **STROKE**
- ❑ SUICIDE ATTEMPT
- ❑ THYROID PROBLEMS
- ❑ TINNITUS/ VERTIGO
- ❑ ULCERS
- ❑ VAGINAL INFECTIONS
- ❑ VASCULAR (BLOOD CLOTS, ANEMIA, ETC.)
- ❑ VENEREAL DISEASE (HERPES/STD)
- ❑ OTHER _____

LIST ALL OF THE SURGERIES YOU HAVE HAD:

_____

_____

LIST ALL OF THE MEDICATIONS YOU CURRENTLY ARE ON:

_____

_____

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR: YES OR NO

OTHER: _____

SIGNATURE: _____

PATIENT INTAKE

Confidential Patient Information

Patients Name: _____

Address: _____

City: _____ Zip:_____

SS#: _____

Date of Birth: _____Age:_____

Name of Spouse: _____

Employer: _____

Occupation: _____

What do you prefer to be called: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Male ( ) Female ( ) Marital Status: M S W D

Number of Children: _____

Email: _____

Work Address: _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Primary Ins. Company: _____ ID#: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Secondary Ins. Company: _____ ID#: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Why? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? If so, Where?

_____

_____

What is your goal in our office?

_____

_____

_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to 1st Choice Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

X _____ _____

SIGNATURE OF INSURED/GUARDIAN **DATE**