

Marty Chiropractic
Patient Information

DATE _____

DOCTOR _____

Full Name _____ Date of Birth _____ E mail _____

Address _____ Home Phone _____

City, State _____ Zip _____ - _____ MaritalStatus S M Spouse/Parent _____

Occupation _____ Employer _____ Work Phone _____

May we leave messages at Home Phone YES NO May we leave messages at Work Phone? YES NO

Primary Physician _____ May we contact your physician? _____

Primary Clinic _____ Emergency Contact/Phone # _____

Policy Holder _____ Date of Birth _____ Employer _____

-----INSURANCE INFORMATION ----- NOT A GUARANTEE OF PAYMENT -----

Insurance: _____

Effective Date _____ ID / Claim _____ Acct / Group _____

Co-Pay? _____ Deductible? _____ Percent Covered? _____ Prior Auth? _____

Exams? ____ % Therapy? ____ % X-Rays? _____ Limit No. of Visits? _____

OUT-OF-POCKET MAX _____ Contact Person _____ Date & Confirmed by _____

AUTO W/COMP Date of Injury _____ Adjuster _____ Phone _____

AGREEMENT TO PAY FOR TREATMENT: The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors, such as massages, orthotics or supplements.

ASSIGNMENT OF INSURANCE: I hereby authorize and instruct the insurance company mentioned above to pay any insurance benefits otherwise payable to me under my current insurance policy directly to MARTY CHIROPRACTIC, 2424 East 117th Street, Burnsville, MN 55337, for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay any balance of said professional service charges over and above this insurance payment according to the financial policy of the above assignee, which may include interest, service fees and/or collections costs. I understand that my signature on this document may replace the need for my signature on each claim form. A photo copy of this assignment shall be considered as effective and valid as the original.

RELEASE OF MEDICAL INFORMATION: I also authorize the release of any information concerning my medical history, diagnosis, and treatment pertinent to my case to any insurance company, adjuster, or attorney involved in this case. THIS AUTHORIZATION AND ASSIGNMENT SHALL BE IRREVOCABLE FOR THE FULL EXTENT OF MY TREATMENT AT MARTY CHIROPRACTIC CLINIC AND UNTIL SUCH TIME THAT ANY AND ALL EXPENSES INCURRED HAVE BEEN PAID IN FULL.

I UNDERSTAND that I am authorizing Marty Chiropractic to proceed with any treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

PERMISSION TO TREAT MINOR: I hereby authorize the doctors and staff of Marty Chiropractic to examine, X-ray and treat _____ (name of patient).

Signed _____ Date _____

Patient Health Questionnaire

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____

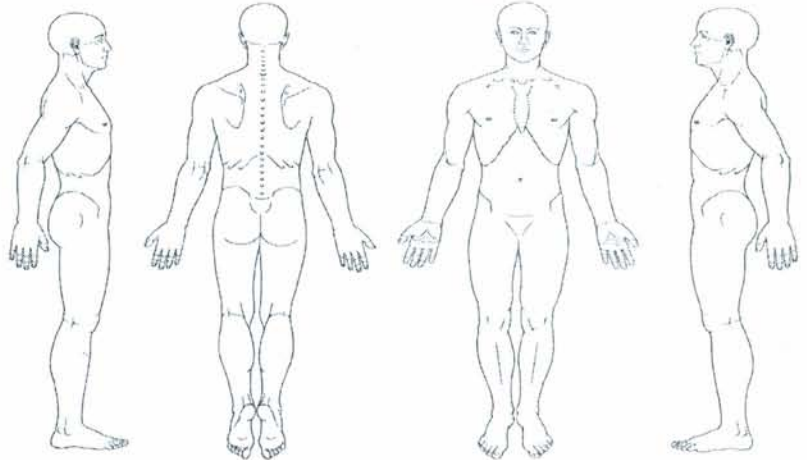
Date _____

1. When did your symptoms start: _____

Describe your symptoms and how they began:

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

- None Unbearable
- a. worst: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. best: ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

- ① No complaints ② Mild, forgotten with activity ③ Moderate, interferes with activity ④ Limiting, prevents full activity ⑤ Intense, preoccupied with seeking relief ⑥ Severe, no activity possible

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

10. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

11. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

12. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms
- ② Resume/increase activity
- ③ Explanation of condition/treatment
- ④ Learn how to take care of this on my own
- ⑤ How to prevent this from occurring again
- ⑥

Patient Signature _____

Date _____

Neck Index

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 is moderate at the moment.
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.

Personal Care

0. I can look after myself 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 manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, 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 positions (e.g. on a table).
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights
5. I cannot lift or carry anything at all.

Reading

0. I can read as much as I want with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate neck pain.
4. I can hardly read at all because of severe pain in my neck.
5. I cannot read at all because of neck pain.

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.

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 to.
3. I have a lot of difficulty concentrating when I want to.
4. I have a great deal of difficulty concentrating when I want to.
5. I cannot concentrate at all.

Work

0. I can do as much work as I want to.
1. I can only do my usual work but no more.
2. I can 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.

Driving

0. I can drive my car without any neck pain.
1. I can drive as long as I want with slight pain in my neck.
2. I can drive as long as I want with moderate pain in my neck.
3. I cannot drive as long as I want because of moderate pain in my neck.
4. I can hardly drive at all because of severe pain in my neck
5. I cannot drive my car at all because of neck pain.

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).

Recreation

0. I am able to engage in all my recreation activities with no neck pain at all.
1. I am able to engage in all my recreation activities with some pain in my neck.
2. I am able to engage in most but not all my usual recreation activities because of pain in my neck.
3. I have neck pain with most recreational activities.
4. I can hardly do any recreation activities because of neck pain.
5. I cannot do any recreation activities at all.

TOTAL _____

Back Index

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 is moderate and comes and goes.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is very severe.
5. The pain is severe and does not vary much.

Personal Care

0. I would 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, at the most.

Walking

0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than 1 mile.
2. Pain prevents me from walking more than ½ mile.
3. Pain prevents me from walking more than ¼ mile.
4. I can only walk using a cane or crutches.
5. I am in bed most of the time and have to crawl to the toilet

Sitting

0. I can sit in any chair as long as I like without pain.
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 ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

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 ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. Pain prevents me from standing at all.

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 night's sleep is reduced by less than one quarter.
3. Because of pain my normal night's sleep is reduced by less than one half.
4. Because of pain my normal night's sleep is reduced by less than three quarters.
5. Pain prevents me from sleeping at all.

Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it 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.

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 compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels me to seek alternate forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except those done lying down.

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 at present.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use his/her Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of his/her PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, than this clinic will not treat/admit you.

I have read this form and understand how my Patient Health Information will be used. I agree to these policies and procedures.

Print your name here: _____

Sign your name here: _____ Date _____

I hereby authorize Marty Chiropractic to send to my e-mail address, _____ periodic health-related educational material. I understand that this address will not be sold to any marketing companies for solicitation purposes.

Sign your name here: _____ Date _____

Please let us know how you heard about our clinic!

Mark all that apply

- Family member: Name* _____
- Friend: Name* _____
- Co-worker: Name* _____
- Your insurance provider booklet or their website
- Internet browsing
- Yellow Pages
- Medical Doctor: Name* _____
- Another Chiropractor: Name* _____
- Any other Health Care Provider: Name/Specialty* _____
- Attorney: Name/Firm Name* _____
- Church Bulletin
- Feed My Starving Children Organization.
- Other: _____

*We like to express our appreciation for patient referrals. Patient's names are kept confidential.