

Patient History Update

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Date _____

If there has been a change in your address, please update below:

Address _____ City _____ State _____ Zip _____

Please describe in your own words the new condition you are experiencing:

Have you had this or similar conditions in your past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition interfering with your work: () Work () Sleep () Daily Routine

() Other _____

Other doctors or therapists who have treated THIS condition:

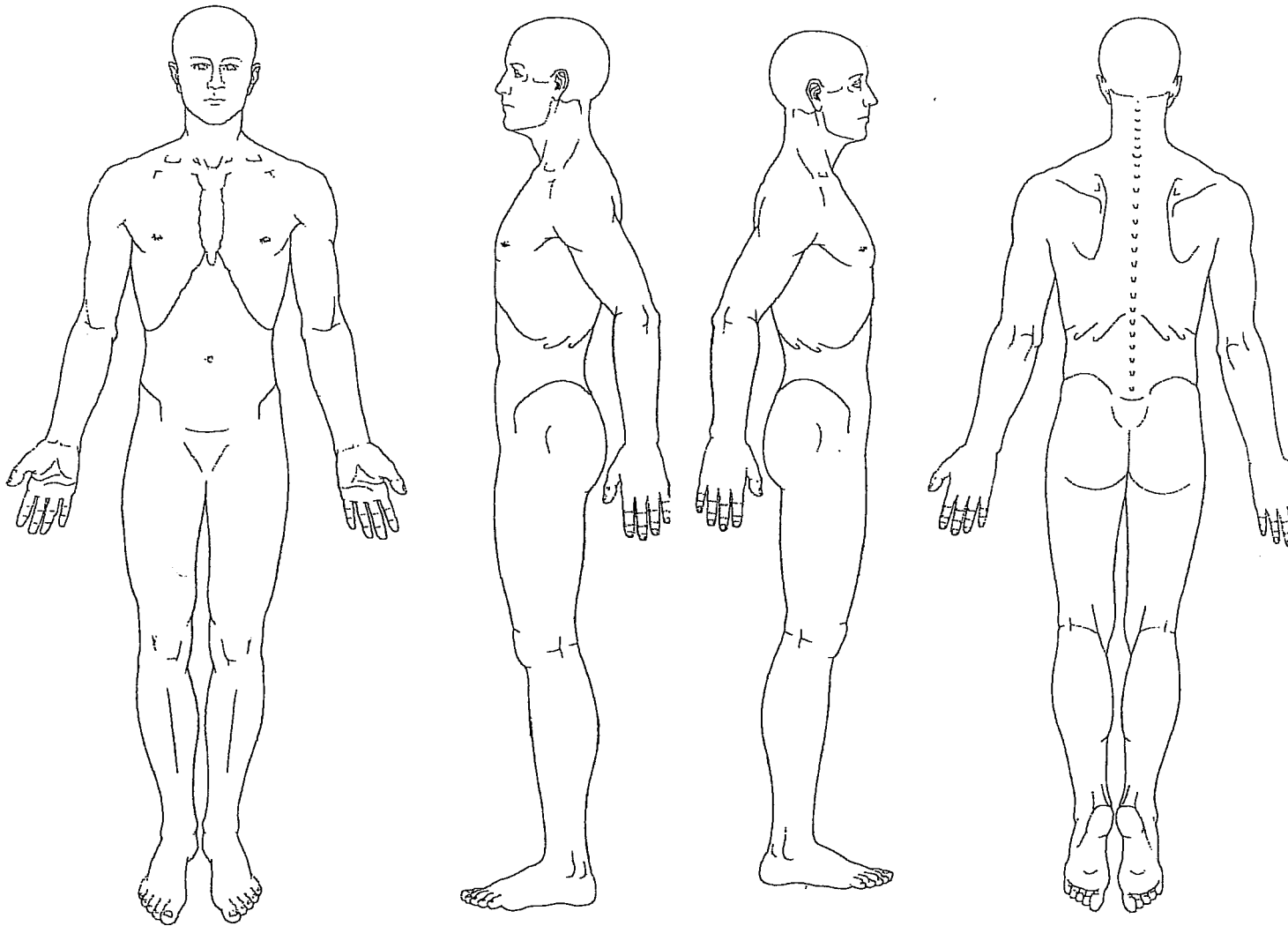
What do you think caused this condition? _____

SIGNATURE _____ DATE _____

PARENT/GUARDIAN _____ DATE _____

PATIENT HISTORY

PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately
describe your condition.**

- | | |
|------------|--------------------------------------|
| PPP | Where you experience Pain |
| NNN | Where you experience Numbness |
| TTT | Where you experience Tingling |
| BBB | Where you experience Burning |
| CCC | Where you experience Cramping |

PATIENT SIGNATURE _____

DATE _____

OUTCOME ASSESSMENT

Name _____ Date _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

1. What was the chief symptom or reason you visited the office? (low back pain, neck pain, etc.) _____
2. How do you classify your improvement so far since beginning your care?
Excellent _____ Good _____ Fair _____ Poor _____
3. On a scale of 1 to 10 with 10 being the best, how would you rate your improvement? _____
4. What symptoms have improved? _____

5. What symptoms do you still have? _____

6. What changes have been made in your general feelings? Are you: (check those indicated)
Stronger _____ More Relaxed _____ More Alert _____
Less Nervous _____ Sleep Better _____ Appetite Improved _____
7. Do you find it easier: (check those indicated)
Walking _____ Riding _____ Working _____ Bending _____
Standing _____ Sitting _____ Lifting _____ Same _____
8. Is there any other condition you have that we have not discussed that you would like to discuss at this time? _____ If yes, please explain _____

9. Is there any confusion or question about any phase of your progress? _____

10. Do you intend to continue care to avoid problems in the future (check one)
Yes _____ No _____ Will follow my doctor's recommendations _____
11. Have you had an opportunity to refer anyone to the Doctor? (check one)
Yes _____ No _____ Intend to do so _____
12. Your honest evaluation of the Doctor's office is always appreciated. Please comment on any areas where the Doctor may improve. _____

Patient's Signature

Social History Questionnaire

Occupation

Job Title: _____ Work Hours Per Day: _____
 Max Lifting Req'd: Sed (<5 lbs.) Light (5-20 lbs.) Med (20-50 lbs.) Hvy (>50 lbs.)
 Lifting Frequency: Constant (66-100% of day) Frequent (33-66% of day) Occasional (0-33% of day)
 Lifting Postures: Knee Torso Arm Shoulder Off Posture

Work Activity Postures:

Sitting: _____ Hrs per day Standing: _____ Hrs per day Walking: _____ Hrs per day
 Climbing: _____ Hrs per day Pushing: _____ Hrs per day Pulling: _____ Hrs per day
 Kneeling: _____ Hrs per day Reaching: _____ Hrs per day Twisting: _____ Hrs per day

Repetitive Activities:

Computer: _____ Hrs per day Phone: _____ Hrs per day Machinery: _____ Hrs per day
 Hand Tools: _____ Hrs per day Assembly: _____ Hrs per day Grasping: _____ Hrs per day
 Other: _____ / _____ Hrs per day

Impact of Current Condition on Work Capacity: No Effect Painful Limits Unable

Recreational Activity

Effect of Current Condition on Performance

| | | | | |
|-------|------------------------------------|----------------------------------|---------------------------------|---------------------------------|
| _____ | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| _____ | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| _____ | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| _____ | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| _____ | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |

Daily Activities

Effect of Current Condition on Performance

| | | | | |
|-------------------------|------------------------------------|----------------------------------|---------------------------------|---------------------------------|
| Washing/Bathing | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Household Chores | | | | |
| Sweeping/Vacuuuming | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Dishes | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Laundry | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Yard Work | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Garbage | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Other: _____ | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Climbing Steps | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Lifting Groceries | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Dressing | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Sleep | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Driving | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Concentration (Reading) | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |
| Sexual Activity | No Effect <input type="checkbox"/> | Painful <input type="checkbox"/> | Limits <input type="checkbox"/> | Unable <input type="checkbox"/> |

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back 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.**

| | |
|--|--|
| <p><i>SECTION 1 - Pain Intensity</i></p> <p>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.</p> | <p><i>SECTION 6 - Standing</i></p> <p>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 one hour without increasing pain. D I cannot stand for longer than 1/2 hour without increasing pain. E I cannot stand for longer than ten minute without increasing pain. F I avoid standing, because it increases the pain straight away.</p> |
| <p><i>SECTION 2 - Personal Care</i></p> <p>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.</p> | <p><i>SECTION 7 - Sleeping</i></p> <p>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 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.</p> |
| <p><i>SECTION 3 - Lifting</i></p> <p>A I can lift heavy weights without extra pain. B I can lift heavy weights, but it causes 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.</p> | <p><i>SECTION 8 - Social Life</i></p> <p>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, My 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.</p> |
| <p><i>SECTION 4 - Walking</i></p> <p>A Pain does not prevent me from walking any distance. B Pain prevents me from walking more than one mile. C Pain prevents me from walking more than 1/2 mile. D Pain prevents me from walking more than 1/4 mile. E I can only walk while using a cane or on crutches. F I am in bed most of the time and have to crawl to the toilet.</p> | <p><i>SECTION 9 - Traveling</i></p> <p>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.</p> |
| <p><i>SECTION 5 - Sitting</i></p> <p>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 from sitting more than one hour. D Pain prevents me from sitting more than 1/2 hour. E Pain prevents me from sitting more than ten minutes. F Pain prevents me from sitting at all.</p> | <p><i>SECTION 10 - Changing Degree of Pain</i></p> <p>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.</p> |

COMMENTS: _____

NAME: _____ DATE: _____ SCORE: _____

CLINIC POLICIES

Thank you for choosing Chiropractic 1st as your health care provider. We are committed to the success of your treatment. The following are statements of our Policies which we require you read and sign prior to any treatment.

-All patients must complete our Patient Information, Health Information, Policy and Coverage forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. WE ACCEPT CASH, CHECKS, CREDIT AND DEBIT CARDS. WE OFFER AN EXTENDED PAYMENT PLAN WHERE NECESSARY AND A FINANCIAL AGREEMENT IS SIGNED.

REGARDING INSURANCE

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed to you, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Chiropractic 1st is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. Specifically, most insurance plans do not provide coverage for maintenance or palliative care. If you are unsure as to the nature of the treatment you are receiving, please ask your doctor.

REGARDING DEDUCTIBLE AND CO-INSURANCE/CO-PAYMENT OBLIGATIONS

By law we are required to make reasonable efforts to collect deductibles and co-insurance and/or co-payment obligations. All co-insurance and/or co-payments and deductibles are required to be paid under the terms of your contract with your insurance carrier. By law we are responsible to attempt collections of these amounts once they are identified to us on your explanation of benefits. It is the policy of this clinic to bill for all co-insurance, co-payment and deductible amounts. If you have difficulty meeting your full responsibility under the terms of your insurance contract, please contact a member of our billing staff so that financial arrangements for payment can be made.

USUAL AND CUSTOMARY FEES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Our fees are generally considered to fall within the acceptable range by most companies, and the charge for each service is determined based on the relative value (RVU) of the service as published by the Center for Medicare/Medicaid Services (CMS) formerly known as HCFA. Not all carriers utilize CMS RUV's when determining their allowances for a service. Many carriers implement an arbitrary schedule of allowances. This clinic will accept your carrier's allowance as your payment as full provided that you meet any co-insurance, co-payment and/or deductible obligation assigned by your carrier within 60 days of the date of the EOB. This statement does mean that we accept the carrier's payment as payment in full. Your carrier generally only pays a portion or percentage of the allowed fee for a particular service in accordance with the terms of your benefit plan. Deductible, co-insurance and/or co-payment amounts are your responsibility.

NON-COVERED SERVICES

Your treatment may involve services that are not covered under your health benefit plan. You have the right to deny receipt of these services. If you elect to receive any or all services recommended, you will be fully responsible for payment of these services. We make every attempt to verify the limitations of your health insurance benefit plan. As the information we receive is not a guarantee of coverage or benefits, we cannot be responsible for the validity of the information supplied to us by your carrier. You are responsible to verify your coverage limitations based on your benefit contract.

ADULT PATIENT

Adult patients are responsible for full payment at time of service unless we are accepting assignment for insurance. In this case, we recommend that you make some payment toward your obligation each visit. As detailed above you agree to be responsible for all co-insurance, co-payment, deductible and non-covered services as determined by your insurance carrier. For patients without insurance coverage, you agree to be responsible in full for all services provided in accordance with our negotiated fee schedule. In order to avoid fees for production of statements in the event we have to bill you for unpaid balances, we offer the option of billing your remaining balance to your credit card provided that you provide necessary information and authorization for credit card billing.

