FIRST STATE HEALTH & WELLNESS
Confidential Patient Health Record

(please print)

Name_____ Home Phone_(_____)_____
Address_____ Work Phone _(_____)_____
_____ Cell Phone _(_____)_____
_____ E-Mail_____
Age_____ (May we send you our email newsletter? Y N)
Birth Date_____/_____/_____ Occupation_____
SSN_____ Employer_____
Marital Status_____# Children_____ Spouses Name_____
Emergency Contact_____ Phone_(_____)_____
How were you referred to our office?_____

Treatment you are seeking: □Chiropractic □Acupuncture □Massage □Pain Management
(check all that apply) □DRX □Med-X □Rehabilitation □Nutritional Counseling

People go to chiropractors for a variety of reasons, and there are different levels of care.
Please check the type of care desired so that we may provide you the most appropriate care:

Stage 1 ___ Pain Relief: Just get rid of the pain. Relief is short term.
Stage 2 ___ Rehabilitation: Get rid of the pain, but then fix the problem so it won't come back.
Stage 3 ___ Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan so that I stay as healthy as possible.

Primary Physician Name_____ Phone_(_____)_____
Is your visit due to an accident? Y N Date of Injury_____/_____/_____

Present Complaints_____
_____
_____
Other doctors seen for this problem_____
Significant Health History_____
Medications/Supplements: _____
Eye Color_____ Hair Color_____ Height_____ Weight_____

Who is responsible for your bill? **You and:** □Personal Insurance □Medicare □Workers Comp □Auto
Personal Insurance Carrier_____ Referral Required? Y N

In order to receive the best care possible within your benefits, it is important that you comply with our financial policy:

1. Payment is expected at the time of service in the form of a deductible, co-payment or co-insurance payment. **It is illegal to waive these fees.**
2. Your insurance policy is a contract between you and the insurance company, and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office.

"I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for services rendered to me or my dependents."

Printed name of person authorizing treatment of minor or dependent_____

X Patient/Guardian Signature_____Date_____/_____/_____

HIPPA: My signature stands proof that I give First State Health & Wellness my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice. (If you would like a obtain a copy of this notice, please feel free to ask the front desk)

Patient Print Name_____

X Patient/Guardian Signature_____Date_____/_____/_____

FIRST STATE HEALTH & WELLNESS

Signature on File

- ♦I understand that I am responsible for my bill
- ♦I authorize use of this form on all my insurance submissions
- ♦I authorize release of information to all my insurance companies
- ♦I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies
- ♦I authorize direct payment to my doctor
- ♦I permit a copy of this authorization to be used in place of the original

Patient Name (print)_____ Medicare #_____

X Signature _____ Date_____/_____/_____

FIRST STATE HEALTH & WELLNESS
HMO/PPO Limitation of Liability

Your insurance plan may have limitation for services covered in our office. According to your specific plan, the following services may not be covered:

- ♦Examinations
- ♦Re-exams
- ♦X-rays in this office
- ♦Diagnostic Tests
- ♦Acupuncture
- ♦Rehabilitation
- ♦Massage Therapy
- ♦Vitamins, Supplements, or Supports
- ♦Modalities (such as EMS, Ultrasound, Hot/Cold packs)

Should any of these determinations be made by your plan, you agree that you have been informed before the services were rendered and you agree to be responsible for payment of the specific services listed above.

Patient Name (print)_____

X Patient Signature_____Date_____/_____/_____

X Witness Signature_____Date_____/_____/_____

AUTO ACCIDENT INFORMATION

Name:_____ Date of Accident: _____/_____/_____

Make/Model of vehicle you were in:_____
Position in vehicle:_____
Amount of damage to vehicle:_____
Action of your vehicle at the time of collision?_____
In what state did the collision occur? _____
Weather Conditions:_____Road Conditions:_____
Time of Day:_____Visibility:_____
Describe the collision:_____
_____
_____
Did you lose consciousness? Y N
Seatbelt? No Lap Only Shoulder Only Shoulder/Lap Belt
Did the airbags deploy? Y N Position of headrests? Up Down
Did you anticipate the collision / brace for impact? Y N
Were you taken to the ER? Y N
What did they do at the ER?_____

Make/Model of the other vehicle:_____
Amount of damage to other vehicle?_____

Policy Holder of the car you were in during the accident:_____
Relationship to Policyholder:_____
Insurance Company:_____
Address:_____
Phone #_____ Claim Adjuster:_____
Policy or Claim #_____ Reported to Insurance Co? Y N
Was there a Police Report? Y N

Have you contacted an Attorney? Y N
Attorney's name?_____
Address:_____
Phone #:_____

Have you been involved in any prior motor vehicle collision? Y N
If yes, please describe:_____
_____

FIRST STATE HEALTH & WELLNESS

Part of the new government rules for medical documentation and billing requires that we record and maintain specific data point on every patient. All of this information is necessary as part of your medical record. Please fill out the form below as completely as possible. This information is kept in your private medical file, and is not made public. However, many insurers will require that we have this information in you record to process your claims or benefits.

Name:
Address:

Primary Phone: M H W
Primary Email:
May we send you our email newsletter? Y N
Preferred contact method: phone email text
Cell Carrier: AT&T Verizon T-Mobile _____

Primary Physician:
Other doctors you see (OB, Neurologist, Orthopedist, etc.):
Attorney (if you are treating for an injury):

Current Problems / Complaints:

Personal Demographics:

Gender: M F
Race:
Date of Birth: _____/_____/_____
Social Security #:

Preferred Language:
Ethnicity:

Dominant Hand: R L
Eye Color:
Hair Color:

Smoking Status: Current Occasional Past Never
Do you Drink Alcohol?: Yes No
Do you Drink Coffee?: Yes No

What medications are you currently taking?

Are you allergic to any medications?

We also need to update your Vitals:

Height:
Weight:
Temperature:

Blood Pressure: _____/_____ R L
Pulse: _____ bpm
Respiration:

Thank you for your help in understanding as we try to maintain a complete and accurate record of your medical information. You are welcome to a copy of this data at any time. If you have any questions regarding this information, please let us know.

FIRST STATE HEALTH & WELLNESS

Neck Disability Index

Patient Name:_____ Date:_____

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage every day 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 closely describes your problem *right now*.**

	SECTION 1 – Pain Intensity
A	I have no pain at the moment.
B	The pain is mild at the moment.
C	The pain comes and goes and is moderate.
D	The pain is moderate and does not vary much.
E	The pain is severe and comes and goes.
F	The pain is severe and does not vary much.

	SECTION 2 – Personal Care (Washing, Dressing etc.)
A	I can look after myself without causing extra pain.
B	I can look after myself normally but it causes pain.
C	It is painful to look after myself and I am slow and careful.
D	I need some help, but manage most of my personal care.
E	I need help every day in most aspects of self-care.
F	I do not get dressed, I wash with difficulty and stay in bed.

	SECTION 3 - Lifting
A	I can lift heavy weights without extra pain.
B	I can lift heavy weights, but it causes extra pain.
C	Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E	I can lift very light weights.
F	I cannot lift or carry anything at all.

	SECTION 4 - Reading
A	I can read as much as I want to with no pain in my neck.
B	I can read as much as I want to with only slight pain in my neck.
C	I can read as much as I want with moderate pain in my neck.
D	I cannot read as much as I want because of moderate pain in my neck.
E	I cannot read as much as I want because of severe pain in my neck.
F	I cannot read at all.

	SECTION 5 – Headache
A	I have no headaches at all.
B	I have slight headaches which come infrequently.
C	I have moderate headaches which come infrequently.
D	I have moderate headaches which come frequently.
E	I have severe headaches which come frequently.
F	I have headaches almost all the time.

	SECTION 6 – Concentration
A	I can concentrate fully when I want to with no difficulty.
B	I can concentrate fully when I want to with slight difficulty.
C	I have a fair degree of difficulty concentrating when I want to.
D	I have a lot of difficulty in concentrating when I want to.
E	I have a great deal of difficulty concentrating when I want to.
F	I cannot concentrate at all.

	SECTION 7 – Work
A	I can do as much work as I want to.
B	I can only do my usual work, but no more.
C	I can do most of my usual work, but no more.
D	I cannot do my usual work.
E	I can hardly do any work at all.
F	I cannot do any work at all.

	SECTION 8 – Driving
A	I can drive my car without neck pain.
B	I can drive my car as long as I want with slight pain in my neck.
C	I can drive my car as long as I want with moderate pain in my neck.
D	I cannot drive my car as long as I want because of moderate pain in my neck.
E	I can hardly drive my car at all because of severe pain in my neck.
F	I cannot drive my car at all.

	SECTION 9 – Sleeping
A	I have no trouble sleeping.
B	My sleep is slightly disturbed (less than 1 hour sleepless).
C	My sleep is mildly disturbed (1-2 hours sleepless).
D	My sleep is moderately disturbed (2-3 hours sleepless).
E	My sleep is greatly disturbed (3-5 hours sleepless).
F	My sleep is completely disturbed (5-7 hours sleepless).

	SECTION 10 – Recreation
A	I am able to engage in all recreational activities with no pain my neck at all.
B	I am able to engage in all recreational activities with some pain my neck.
C	I am able to engage in most, but not all recreational activities because of pain in my neck.
D	I am able to engage in a few of my usual recreational activities because of pain in my neck.
E	I can hardly do any recreational activities because of pain in my neck.
F	I cannot do any recreational activities at all.

FIRST STATE HEALTH & WELLNESS

Revised Oswestry Low Back Pain Questionnaire

Patient Name:_____ Date:_____

Please Read: This questionnaire is designed to enable us to understand how much your back pain has affected your ability to manage every day life. 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 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 (Washing, Dressing etc.)
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 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 and 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 from sitting more than 1 hour.
D	Pain prevents me from sitting more than ½ hour.
E	Pain prevents me from sitting more than 10 minutes.
F	Pain prevents me from sitting at all.

	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 I'm 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.