EXCEL FAMILY CHIROPRACTIC & WELLNESS, INC. **Acct # _____**
820 Geneva Pkwy N, Ste 105
Lake Geneva WI 53147
Phone: 262-248-6700 Fax: 262-248-6764 Email: frontdesk@excelfamilychiro.com

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Patient Name: _____ **Date:** _____

Address_____ City/State_____ Zip Code _____

Home. Phone _____ Cell: _____ Work. _____

Email Address: _____ Sex: **M** **F** (*Please circle*) Date of Birth: _____

Referred by: _____

Have you ever received chiropractic care? (*Please circle*) **Yes** **No** If yes, when? _____

Name of most recent Chiropractor: _____

Health History:

1. Previous Injury or Trauma:

2. Have you ever broken any bones? Which?

3. Allergies:

4. Medications:

5. Surgeries:
   Date Type of Surgery
   _____
   _____
   _____

Family Health History:

Do you have a family history of? (*Please indicate all that apply*)
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Social and Occupational History:

Job description:
_____

Level of Activity? (*Please check one)* _____High ____ Medium ____Low

Any alcohol, tobacco or drug use: **Yes** **No** *(Please circle)* **Frequency** _____per day week month

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Review of Systems (***Please check all that apply)***

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____□ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia
□ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease
□ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastro esophageal reflux/heartburn
□ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hyper coagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy
□ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____
□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery
□ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____
□ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations
□ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with State of Wisconsin statutes.

Patient or Guardian Signature _____Date_____

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PATIENT SYMPTOM FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

SYMPTOM 1

1. Exact Location (right, left, front, back, etc.) _____
2. When did the symptom begin? _____
   - Did the symptom begin suddenly or gradually? *(please circle one)*
   - Describe how the symptom began? _____
   - Describe the quality of the symptom (circle all that apply):
     Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, or Other *(please describe):*
     _____
3. On a scale 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
4. What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
5. Does the symptom radiate to another part of your body (*please circle one*): Y**es** **No**
   - If yes, where does the symptom radiate? _____
   - Is the symptom worse at certain times of the day or night? *(please circle)*
     Morning Afternoon Evening Night Unaffected by time of day
6. What makes the symptom worse? *(please circle all that apply):*
   - Bending neck backward or forward, tilting head to left, tilting head to right, turning head to left or right, bending forward or backward at waist, tilting left or right at waist, twisting right or left at waist, sitting, standing, or describe below:

     _____
7. What makes the symptom better? *(please circle all that apply):*
   - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
   - Other *(please describe):*

     _____

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SYMPTOM 2:

1. Exact Location (right, left, front, back, etc.) _____

2. When did the symptom begin? _____

    - Did the symptom begin suddenly or gradually? *(please circle one)*

    - Describe how the symptom began? _____

    - Describe the quality of the symptom *(please circle all that apply):*
      Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, or Other *(please describe):*
      _____

3. On a scale 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

4. What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

5. Does the symptom radiate to another part of your body (*please circle one*): Y**es** **No**
    - If yes, where does the symptom radiate? _____

    - Is the symptom worse at certain times of the day or night? *(please circle)*
      Morning Afternoon Evening Night Unaffected by time of day

6. What makes the symptom worse? *(please circle all that apply):*
    - Bending neck backward or forward, tilting head to left, tilting head to right, turning head to left or right, bending forward or backward at waist, tilting left or right at waist, twisting right or left at waist, sitting, standing, or describe below:

      _____

7. What makes the symptom better? *(please circle all that apply):*
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
    - Other *(please describe):*

      _____

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PATIENT SYMPTOM FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

SYMPTOM 3

1. Exact Location (right, left, front, back, etc.) _____

8. When did the symptom begin? _____

   - Did the symptom begin suddenly or gradually? *(please circle one)*
   - Describe how the symptom began? _____
   - Describe the quality of the symptom (circle all that apply):
     Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, or Other *(please describe):*
     _____

9. On a scale 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

10. What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

11. Does the symptom radiate to another part of your body (*please circle one*): Y**es** **No**
    - If yes, where does the symptom radiate? _____
    - Is the symptom worse at certain times of the day or night? *(please circle)*
      Morning Afternoon Evening Night Unaffected by time of day

12. What makes the symptom worse? *(please circle all that apply):*
    - Bending neck backward or forward, tilting head to left, tilting head to right, turning head to left or right, bending forward or backward at waist, tilting left or right at waist, twisting right or left at waist, sitting, standing, or describe below:

      _____

13. What makes the symptom better? *(please circle all that apply):*
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
    - Other *(please describe):*

      _____

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HIPAA NOTICE OF PRIVACY PRACTICES AND INFORMED CONSENT FOR TREATMENT

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your Protected Health Information (PHI) to carry our treatment, payment or health care operations for other purposes that are permitted or required by law. Your "Protected Health Information" is information pertaining to you, including your demographic information that may identify you and that is related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your Protected Health Information may be used and disclosed by your chiropractor, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, request and receive payment for your health care bills, to support the operations of this chiropractic practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your health care information may be provided to a physician or health care facility to whom you have been referred to ensure that the physician or facility has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information will be used as needed, to obtain payment for your health care services from your insurance company or insurance representatives.

Informed Consent for Chiropractic Treatment: We may disclose, as needed, your Protected Health Information in order to support the business activities of this office. Some of these activities may include, but not limited to:

1. Quality assessment activities; training of chiropractic office personnel, marketing, and fund raising activities in and outside the office.
2. We may ask for your permission to use your photograph for promotions or activities within our office.
3. We may contact you regarding your appointment and/or account, using text alerts, phones messages and emails.
4. I (patient) give us consent to the performance of chiropractic spinal manipulations/adjustments and other procedures, which may include an examination, spinal x-rays, massage therapy, kinesiotaping, at the Doctor's discretion and as part of my spinal care plan.
5. I(patient) understand that my spinal manipulations will be performed in a semi-private setting. If I request additional privacy, this office will try to accommodate me.
6. I (patient) may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.
7. If my insurance is billed, I authorize payment of medical benefits directly to Excel Family Chiropractic & Wellness, Inc. for services performed.

We are happy to provide a copy of this information for your review, please let us know.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

_____
Minor Child Name: (if applicable)

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

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 comes and goes and is moderate.
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.

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).

Reading

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

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

Work

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

Personal Care

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

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

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

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 sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
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 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

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 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do 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.

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 cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

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

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____