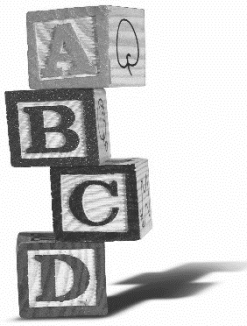
Stevens Chiropractic Center Dr. Matthew Stevens

903 Williams Street ● Angola, Indiana 46703 ● (260) 665-9479



Patient ID#_____

CONFIDENTIAL PATIENT INFORMATION

Date_____ SS# _____

Name_____ Email Address_____

(First) (MI) (Last)

Phone#: Cell/Home_____

Local Address_____ City/State/Zip _____

Age_____ DOB_____/_____/_____ Marital Status: S M W D Number of Children_____

Occupation_____ Employer_____ Work Phone #_____

Work Address_____ City/State/Zip_____

Emergency Contact _____ Relation_____ Phone #_____

Who may we thank for referring you to our office? _____

Have you had an X-ray or MRI of your spine in the last year? ❑ Yes ❑ No

Have you ever had Chiropractic care before? _____ If so, when? _____

List your primary complaints:

(1) _____ For how long? _____

(2) _____ For how long? _____

List any other doctors you have consulted for these conditions:

(1) _____ Specialty: _____

(2) _____ Specialty: _____

Did this injury occur while at work? _____ Have you reported it to your employer? _____

Is this an injury related to an auto accident? _____

List major surgeries:

(1) _____ When: _____

(2) _____ When: _____

List all current medications. If no current medications, check here: ❑

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

List known allergies you have had to any medications. <u>If no allergies are known, check here</u>: ❑

1) _____ 2) _____ 3) _____

Do you currently use tobacco of any kind? ❑ Yes ❑ Former user ❑ Never been a user

If yes, how often do you use: ❑ Every Day ❑ 1-4 times per week ❑ 1-4 times per month

If yes, what is your level of interest in quitting smoking?

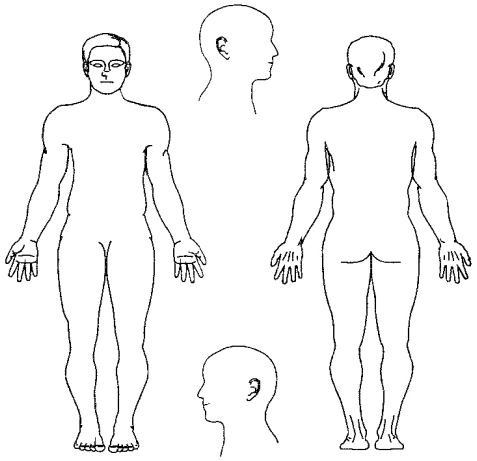
□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

No interest *Very Interested*

Please mark your areas of pain on the figure below.

0----------5----------10

Circle how bad your pain is: 0 = no pain, 10 = unbearable



<u>HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:</u>

<u>Check Current and Circle Past Health Issues</u>

□ Stroke
□ Fatigue
□ Nervousness
□ Numbness in arms or legs
□ Weakness in arms or legs
□ Spinal Curvature
□ Heart Disease
□ High Blood Pressure
□ Heart Attack
□ Headaches / Migraines
□ HIV/AIDS
□ Dizziness
□ Cancer
□ Diabetes
□ Neck Pain
□ Low Back Pain
□ Depression
□ Anxiety

LIST any of the above conditions that run in your family: _____

<u>LIST all other known health issues</u>:

Gastrointestinal complaints: □ None List: _____

Ear, Nose, Throat complaints: □ None List: _____

Muscle, Joint, Bone complaints: □ None List: _____

Genital, Urinary complaints: □ None List: _____

Cardiovascular complaints: □ None List: _____

Male Related complaints: □ None List: _____

Female Related complaints: □ None List: _____

Other Related complaints: □ None List: _____

Check method of payment for today's service:

□ Cash □ Check □ MasterCard □ Visa □ Care Credit

Major Medical Insurance Co. _____

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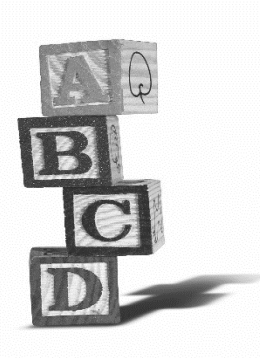

X-RAY Confirmation:

This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic imaging.

Notice to Insurance Company of Assignment:

You are instructed to pay directly to Stevens Chiropractic Center, P.C., for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent credited to my account and I shall be personally liable for any unpaid balance to the doctor. I am also personally liable for any unpaid accounts for hospital, diagnostic, and consultation services at Stevens Chiropractic Center, P.C., Located at 903 Williams St., Angola, IN 46703

I hereby authorize the chiropractic office listed above to furnish you the information and evidence in the doctor's possession regarding my history and physical condition.

Informed Consent to Treatment:

I hereby request and consent to the performance of chiropractic adjustments, via manual techniques or instrument assisted techniques, and other chiropractic procedures, including various modes of physical therapy and diagnostic radiology, on me (or on the patient for whom I am legally responsible) by Matthew T. Stevens, D.C. and/or other licensed doctors of chiropractic who now or in the future work at Stevens Chiropractic Center, P.C.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Insurance and Payment Coordination

I understand that Stevens Chiropractic Center, P.C. will file my claims with my insurance carrier if requested, however, it is no guarantee of coverage. I understand that I am ultimately responsible for my account. If my account is past due, and I am not on an approved payment agreement or I am not making payments as promised in an agreement, I understand that I may be turned over to a collection agency or law firm and any associated collection costs, including but not limited to reasonable attorney fees, may be added to my account balance.

Privacy Policy

I have been provided a copy of the Privacy Policy for Stevens Chiropractic Center, P.C., and I fully understand its contents.

Signature _____ Date _____

Printed Name _____

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the *overall* impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed. **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Revised March 15, 1993

1. ***Family/Home Responsibilities.*** This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

2. ***Recreation.*** This category includes hobbies, sports, and other similar leisure time activities.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

3. ***Social Activity.*** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

4. ***Occupation.*** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

5. ***Self Care.*** This category includes activities which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.).

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

6. ***Life-Support Activity.*** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0	1	2	3	4	5	6	7	8	9	10
Completely able to function										Totally unable to function

TOTAL SCORE: _____ SIGNATURE: _____ DATE: _____

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317 Telephone: (602) 224-0220; Facsimile: (602) 224-0230