BATSON CHIROPRACTIC GROUP

2517 Lebanon Pike, Suite 101
Nashville, Tennessee 37214
615.751.0958

Confidential Patient Data

If you need any assistance completing this form, please ask any team member. Thank you!

Patient Information First Appointment Date_____

First Name_____ Last Name _____ MI_____ ☐ Male

Social Security #_____ Date of Birth _____ Age_____ ☐ Female

Address_____ City_____ ST_____ Zip_____

Home Phone_____ Work Phone_____ Mobile Phone_____

Email_____ Full-time student? ☐ Yes

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other_____ ☐ No

Name of Spouse or Nearest Relative_____ Phone_____

Your Occupation_____ Your Employer_____

How did you hear about Batson Chiropractic Group? ☐ Family / Friend / Coworker (Full Name: _____)

☐ Google ☐ Other Search Engine: _____ ☐ Mailing ☐ Billboard ☐ Sign ☐ Insurance Website: _____

☐ Facebook ☐ Google+ ☐ Twitter ☐ Event (Date: _____) ☐ Other: _____

T-Shirt Size: ☐ S ☐ M ☐ L ☐ XL ☐ 2XL ☐ 3XL

Payment for services will be by: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance ☐ Auto Insurance

Name of insurance company: _____ Name of insured: _____

Insured's Social Security # _____ Attorney involved: _____

Do you have a secondary insurance? ☐ Yes ☐ No Secondary insurance company: _____

Medical/Family History S = Self M = Mother F = Father

(Please indicate whether you or your biological parents have experienced any of the following conditions. Mark all that apply.)

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS/HIV	☐	☐	☐	Epilepsy	☐	☐	☐	Neck Pain
☐	☐	☐	Anemia	☐	☐	☐	German Measles	☐	☐	☐	Nervousness
☐	☐	☐	Arthritis	☐	☐	☐	Headaches	☐	☐	☐	Numbness
☐	☐	☐	Asthma	☐	☐	☐	Heart Problems	☐	☐	☐	Polio
☐	☐	☐	Back Pain	☐	☐	☐	Hepatitis	☐	☐	☐	Poor Circulation
☐	☐	☐	Bladder Trouble	☐	☐	☐	High Blood Pressure	☐	☐	☐	Reproductive Disorders
☐	☐	☐	Bone Fracture	☐	☐	☐	HIV/ARC	☐	☐	☐	Rheumatic Fever
☐	☐	☐	Cancer	☐	☐	☐	Indigestion	☐	☐	☐	Rheumatism
☐	☐	☐	Chest Pain	☐	☐	☐	Kidney Disorder	☐	☐	☐	Scarlet Fever
☐	☐	☐	Concussion	☐	☐	☐	Loss of Bowels	☐	☐	☐	Serious Injury
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual Cramps	☐	☐	☐	Sinus Problems
☐	☐	☐	Diabetes	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Tuberculosis
☐	☐	☐	Dislocated Joints	☐	☐	☐	Muscular Dystrophy	☐	☐	☐	Venereal Disease

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe condition: _____

Date of last physical exam: _____ Doctor's name: _____

(OVER PLEASE)

BY COMPLETING THIS PACKET PRIOR TO YOUR APPOINTMENT, YOU'RE HELPING US HONOR YOUR SCHEDULED TIME. THANK YOU!

Confidential Patient Data (Continued)

Surgical History

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Have you ever had a metal implant? ☐ Yes ☐ No Have you ever had a gunshot wound? ☐ Yes ☐ No

Accident History

☐ Job ☐ Auto ☐ Other 1. _____ Date: _____

☐ Job ☐ Auto ☐ Other 2. _____ Date: _____

☐ Job ☐ Auto ☐ Other 3. _____ Date: _____

Please describe present major complaints:

Please list your symptoms and rate your pain 1-10, *with 1 being the least painful and 10 the most painful*.

1. _____ = _____

2. _____ = _____

3. _____ = _____

Symptoms are worse during: ☐ Morning ☐ Afternoon ☐ Night

Pain radiates to: ☐ Leg/Hip/Foot ☐ Arm/Hand/Shoulder ☐ Head ☐ Other: _____

How did the symptoms occur? _____

_____

Symptoms origin: ☐ Job-related injury ☐ Auto accident ☐ Other ☐ Illness ☐ Unknown ☐ Gradual onset Date: _____

Symptoms have persisted for (in numbers): _____ hour(s) _____ day(s) _____ week(s) _____ month(s) _____ year(s)

Symptoms/Complaint: ☐ Comes and goes ☐ Constant **Describe symptoms:** ☐ Sharp ☐ Dull ☐ Ache ☐ Burning

Have you ever had this problem before? ☐ Yes ☐ No When? _____ ☐ Tingling ☐ Numb ☐ Throbbing

Names and locations of Doctors previously seen for this condition(s): _____

_____

_____

Are you allergic to any foods/vitamins/supplements? ☐ Yes ☐ No If so, which? _____

Are you taking any vitamins? ☐ Yes ☐ No If so, which? _____

Are you pregnant? ☐ Yes ☐ No Date of last menstrual cycle: _____

Previous imaging studies: _____

Select any that <u>AGGRAVATE</u> your condition: ☐ Bending ☐ Reaching ☐ Standing ☐ Working ☐ Lifting
☐ Straining during defecation ☐ Coughing/Sneezing ☐ Sitting ☐ Walking ☐ Sleeping ☐ Turning your head

Please select any of the following activities that <u>RELIEVE</u> your condition: ☐ Bending ☐ Sitting ☐ Lifting ☐ Standing
☐ Lying down ☐ Turning your head ☐ Reaching ☐ Walking ☐ Other: _____

Please select any <u>ADDITIONAL SYMPTOMS</u> that you may be experiencing: ☐ Fainting ☐ Fatigue ☐ Fever ☐ Depression
☐ Diarrhea ☐ Dizziness ☐ Headaches ☐ Insomnia ☐ Constipation ☐ Cold sweats ☐ Heavy head
☐ Sensitivity to light ☐ Neck stiffness ☐ Muscle spasms ☐ Upset stomach ☐ Blurred vision ☐ Loss of smell ☐ Loss of taste
☐ Ringing in ears ☐ Shortness of breath ☐ Redness in face ☐ Loss of balance ☐ Poor circulation to hands ☐ Poor circulation to feet
☐ Loss of concentration ☐ Numbness in toes ☐ Numbness in fingers ☐ Low immune system
☐ Tingling/Pins and needles in arms ☐ Tingling/Pins and needles in legs

_____ _____

PATIENT SIGNATURE DATE

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Informed Consent to Treatment

The nature of chiropractic treatment: The doctor may use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic laser, acupuncture or mechanical traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics.* Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization.* In conjunction with medical care, hospitalization adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery*. In conjunction with medical care, surgery adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks from remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment. I am here solely for the purpose of my health, and I represent no other agency, group, organization other than myself.

PATIENT PRINTED NAME	PATIENT SIGNATURE	DATE
WITNESS PRINTED NAME	WITNESS SIGNATURE	DATE

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Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand to what extent your low back pain has affected your ability to manage your everyday activities. Please answer each section by selecting the ONE CHOICE that most applies to you. Please select one statement in each section which most closely describes your problem right now.

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

Personal Care

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing, even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
- ☐ Due to the pain, I am unable to do some of the washing and dressing without help.
- ☐ Due to the pain, I am unable to do any washing or dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights, at the most.

Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk while using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for longer than one hour.
- ☐ Pain prevents me from sitting for longer than 30 minutes.
- ☐ Pain prevents me from sitting for longer than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 30 minutes without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain immediately.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Due to the pain, my normal night's sleep is reduced by less than ¼.
- ☐ Due to the pain, my normal night's sleep is reduced by less than ½.
- ☐ Due to the pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of my pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life, and I do not go out very often.
- ☐ Pain has limited my social life to my home.
- ☐ I have hardly any social life because of the pain.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek other forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except those done while lying down.

Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

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Neck Pain Questionnaire

This questionnaire is designed to enable us to understand to what extent your neck pain has affected your ability to manage your everyday activities. Please answer each section by selecting the ONE CHOICE that most applies to you. Please select one statement in each section which most closely describes your problem right now.

Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than one hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Recreation

- ☐ I am able to engage in all of my recreational activities with no neck pain.
- ☐ I am able to engage in all of my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all, of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of pain in my neck.
- ☐ I can hardly engage in any recreational activities because of pain in my neck.
- ☐ I cannot engage in any recreational activities at all.

PATIENT PRINTED NAME _____ PATIENT SIGNATURE _____ DATE _____

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How We Protect Your Private Health Information

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I consent to the use or disclosure of my protected health information by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that **Dr. Batson, Dr. Powers, Dr. McClure & Dr. Lamberth** may refuse to diagnose or treat me, if I do not consent to the use or disclosure of my protected health information for the above stated purposes. My signature on this document is evidence of this consent.

I understand I have a right to request a restriction as to how my personal health information is used or disclosed to carry out treatment, payment or health care operations at the practice. This office is not required to agree to the restrictions that I may request. However, if this office agrees to a restriction that I request, the restriction is binding.

I understand I have a right to review this office's Notice of Privacy practices prior to signing this document. This office's Notice of Privacy has been provided to me. This Notice of Privacy Practices describes the type of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of this office. The Notice of Privacy Practices for this office is also provided upon request at the main administrative desk of this office. Notice of Privacy Practices also describes my rights and this office's duties with respect to my protected health information.

This office has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the Privacy Officer at **615-751-0958** and requesting a hard copy to be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that this office or **Drs. Batson, Powers, McClure & Lamberth** have taken action in reliance on this consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions regarding the Privacy Policies, and all my questions have been answered fully and satisfactorily.

PATIENT PRINTED NAME	PATIENT SIGNATURE	DATE
WITNESS PRINTED NAME	WITNESS SIGNATURE	DATE

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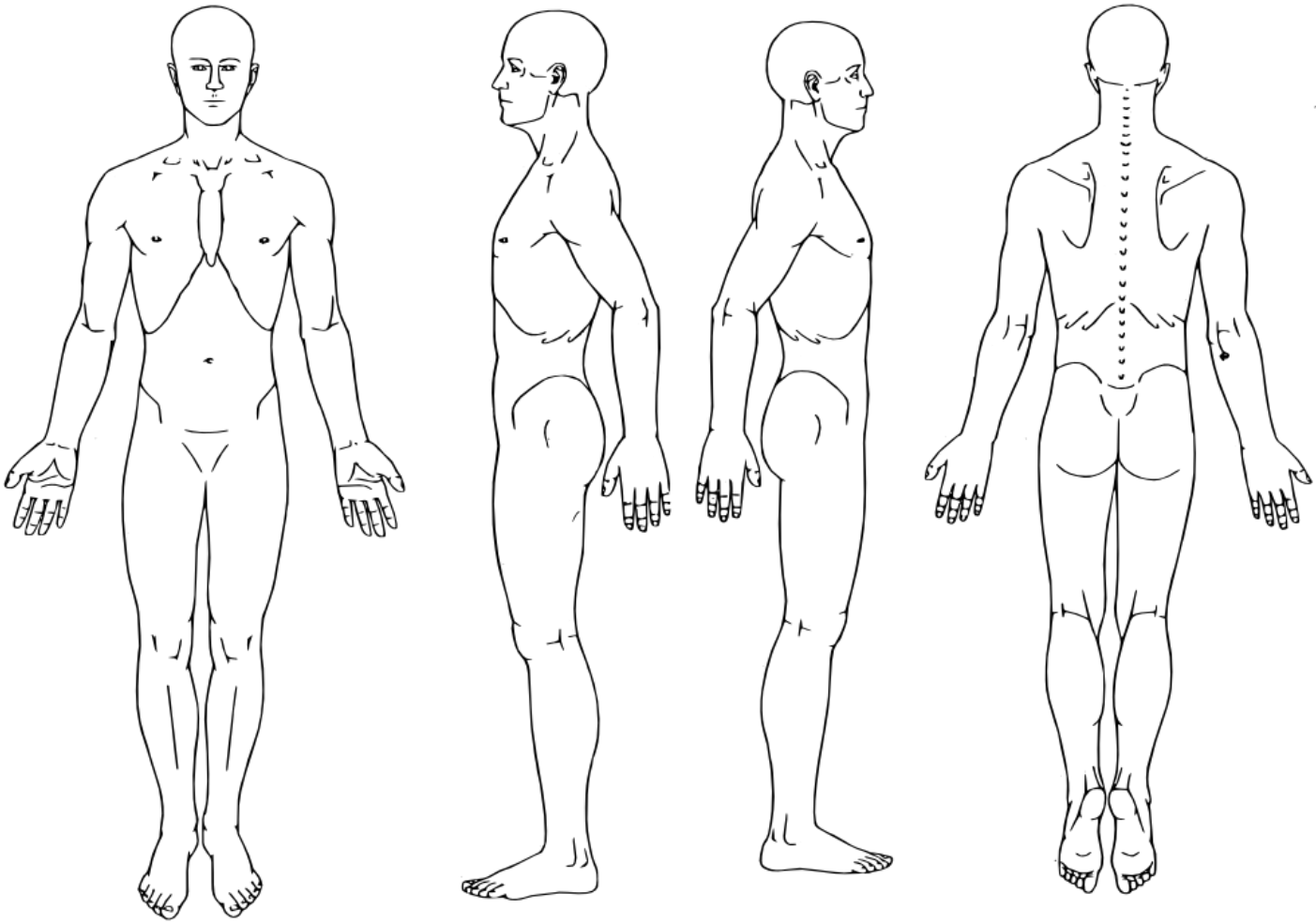
Pain Location



Please indicate the areas of your complaint on the pain diagram above, using the following symbols 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 _____

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