HealthSource
America's Chiropractor®

Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member.
Thank you and welcome to HealthSource!

Patient Information

First Name: _____ Middle _____ Last _____ Gender: __M __ F

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Social Security Number: _____

Email Address: _____ Birthdate: _____ Age: _____

Marital Status: __S __M __W __D Job Title: _____ Work Phone: _____

Spouse Name: _____ Birthdate: _____ Social Security Number: _____

Children: Names and Ages: _____

Insurance Information

Name of person on the insurance card: _____ DOB: _____

Name of employer: _____

Employer phone number: _____ City: _____

Person responsible for this account: _____

Additional Information

In case of emergency, whom should we contact? _____

Relation to patient: _____ Phone Number: _____

Family Physician: _____

May we send your Family Physician updates on your progress? _____Yes _____ No

What is your primary complaint? _____

_____

Is this worker's compensation? _____ Is this personal injury? _____

Office use only **Account Number** **Date**

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Acknowledgement of Notice of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that this Notice is available by request.

_____

Name of Patient or Legal Representative *Date*

_____

Signature of Patient or Legal Representative *Date*

Facility Use Only

○ Patient has been provided Acknowledgement of Notice of Privacy Practices and has refused to sign.

_____ _____

Authorized Staff Signature *Date*

HealthSource® Chiropractic
Progressive Rehab & Wellness®

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

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Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE INSURED'S SIGNATURE

_____

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I assign, authorize, transfer and convey to [PROVIDER/CLINIC NAME] all of my rights, title and interest to all of the insurance benefits to which I may be entitled according to my insurance policy with the companies noted to the extent necessary to provide for payment of my bill. I hereby designate, authorize, and convey to [PROVIDER/CLINIC NAME], to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan, including but not limited to with respect to internal appeals or litigation; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as provided in 29 *C.F.R.* §2560.5031(b)(4)), with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines or injunctive relief. By signing this form, I understand that [PROVIDER/CLINIC NAME] is not assuming any obligation or duty to assert such rights and I agree to release any claim I might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE DATE

HSHealthSource
Chiropractic & Progressive Wellness

Pregnancy Release and Consent Form

Patient Name: _____ DOB:_____

Please answer the following questions:

Are you pregnant or any chance you may be? YES OR NO

Date of the start of your last period:_____

What type of birth control do you use:

_____None _____ Birth Control Pill _____ IUD ____ Depo Provera _____Patch

_____Other _____

Are you trying to get pregnant? YES NO

Any surgeries? _____ Hysterectomy _____ Tubal Ligation

Please initial the line indicating your agreement.

_____ I do not feel it is necessary for me to take a pregnancy test before I have any imaging procedures. I am aware of the potential medical risks due to exposure of radiation to myself and if I were pregnant, my unborn child.

Your signature indicates that you have read, understand and accurately answered the above statements, and give your consent to take any necessary x-rays.

Signature: _____ Date:_____

Witness Signature: _____ Date:_____

DRY NEEDLING CONSENT TO TREAT FORM

Dry Needling (DN) involves inserting a tiny monofilament needle into symptomatic tissue with the intent to reduce pain, increase circulation and improve function of the neuromusculoskeletal system. DN is not traditional Chinese Acupuncture, but instead is based on neurology, physiology and western medical principles. DN is a valuable treatment for musculoskeletal pain; however, like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and/or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:

- Are you taking blood thinners? Yes / No
- Are you or is there a chance you could be pregnant? Yes / No
- Are you aware of any problems or have any concerns with your immune system? Yes / No
- Do you have any known disease or infection that can be transmitted through bodily fluids? Yes / No

Patient's Consent:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I, _____authorize the performance of Dry Needling.

_____ _____

Patient or Authorized Representative Date

_____ _____

Relationship to patient (if other than patient) Date

I was offered a copy of this consent and refused.

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The Neck Disability Index

Patient Name:_____ **Account:**_____

PLEASE READ INSTRUCTIONS: This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and circle the number that most applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1 - Pain Intensity
0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
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.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
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 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.

SECTION 3 - Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, 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 lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 4 - Reading
0. I can read as much as I want to, with no pain in my neck.
1. I can read as much as I want to, with slight pain in my neck.
2. I can read as much as I want to, with moderate pain in my neck.
3. I can't read as much as I want, because of moderate pain in my neck.
4. I can hardly read at all, because of severe pain in my neck.
5. I cannot read at all.

SECTION 5 - Headaches
0. I have no headaches at all.
1. I have slight headaches that come infrequently.
2. I have moderate headaches that come infrequently.
3. I have moderate headaches that come frequently.
4. I have severe headaches that come frequently.
5. I have headaches almost all the time.

SECTION 6 - Concentration
0. I can concentrate fully when I want to, with no difficulty.
1. I can concentrate fully when I want to, with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

SECTION 7 - Work
0. I can do as much work as I want to.
1. I can do my usual work, but no more.
2. I can 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 can't do any work at all.

SECTION 8 - Driving
0. I can drive my car without any neck pain.
1. I can drive my car as long as I want, with slight pain in my neck.
2. I can drive my car as long as I want, with moderate pain in my neck.
3. I can't drive my car as long as I want, because of moderate pain in my neck.
4. I can hardly drive at all, because of severe pain in my neck.
5. I can't drive my car at all.

SECTION 9 - Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hr sleepless).
2. My sleep is mildly disturbed (1-2 hrs sleepless).
3. My sleep is moderately disturbed (2-3 hrs sleepless).
4. My sleep is greatly disturbed (3-5 hrs sleepless).
5. My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 - Recreation
0. I am able to engage in all my recreation activities, with no neck pain at all.
1. I am able to engage in all my recreation activities, with some neck pain.
2. I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
3. I am able to engage in few of my recreation activities, because of pain in my neck.
4. I can hardly do any recreation activities, because of pain in my neck.
5. I can't do any recreation activities at all.

SCORE: _____

Instructions: 1. The NDI is scored in the same way as the Oswestry Disability Index. 2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Patient's / Guardian's Signature: **Date:**

Chiropractor's Signature: _____ **Date:** _____

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Revised Oswestry Low Back Pain Disability Questionnaire

Patient Name:_____ **Account:**_____

Please rate the severity of your pain by circling a number: ***No pain*** 0 1 2 3 4 5 6 7 8 9 10 ***Unbearable pain***

Instructions: Please circle the ONE NUMBER in each section which most closely describes your problem.

SECTION 1 - 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 severe.
5. The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
0. I would 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 increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase 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.

SECTION 3 - Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

SECTION 4 - Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not 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.

SECTION 5 - Sitting
0. I can sit in any chair as long as I like.
1. I can sit only 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.

SECTION 6 - Standing
0. I can stand as long as I want without pain.
1. I have some pain on 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 the pain immediately.

SECTION 7 - 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 nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

SECTION 8 - Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect 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.

SECTION 9 - Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under 1/2 hour.
5. Pain restricts all forms of travel.

SECTION 10 - Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but 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.

Instructions: 1. To determine the patient's index, add up the total points from all sections and divide this total by 50 (total possible points). Multiply that number by 100. 2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

SCORE:_____

Patient's Signature: **Date:**

Chiropractor's Signature:_____ **Date:**_____