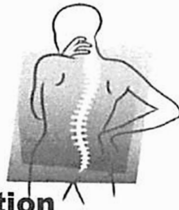

Chugach Chiropractic Clinic LLC

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Patient Information

PLEASE PROVIDE A VALID PICTURE ID TO THE FRONT DESK

SOCIAL SECURITY #: ________-__________-________

FIRST NAME: ____________________ MIDDLE: ________

LAST NAME: ____________________ SEX: MALE *or* FEMALE

DATE OF BIRTH: ____/____/____ MARITAL STATUS: M S D W

CIRCLE ONE: EMPLOYED STUDENT RETIRED UNEMPLOYED

EMPLOYER/OCCUPATION: ______________________________

EMAIL ADDRESS: __________________@______________

IS THIS A WORK RELATED INJURY/AUTO ACCIDENT? YES or NO
(IF YES, PLEASE SEE THE FRONT DESK)

MAILING ADDRESS: ______________________________

CITY, STATE, ZIP: ______________________________

PHYSICAL ADDRESS: ______________________________

CELL PHONE: (____)______-______________

WORK PHONE: (____)______-______________

HOME PHONE: (____)______-______________

HOW DID YOU HEAR ABOUT US? *(PLEASE CIRCLE ONE)*
FACEBOOK LOCATION
ANOTHER PROVIDER WEBSITE
STAFF:
WHO? ______________________
EXISTING PATIENT:
WHO? ______________________
OTHER:
(SPECIFY): ______________________

Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK

INSURANCE COMPANY: ______________________________

SOCIAL SECURITY #: ______________________________

POLICY ID NUMBER: ______________________________

POLICY HOLDER'S NAME: ______________________________

POLICY HOLDER'S BIRTHDATE: ______________________________

GROUP NUMBER: ______________________________

Secondary Insurance Information

INSURANCE COMPANY: ______________________________

SOCIAL SECURITY #: ______________________________

POLICY ID NUMBER: ______________________________

POLICY HOLDER'S NAME: ______________________________

POLICY HOLDER'S BIRTHDATE: ______________________________

GROUP NUMBER: ______________________________

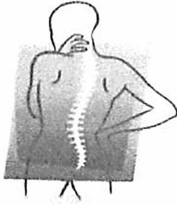
Emergency Contact

NAME: ____________________ HOME PHONE #: ________________ CELL/WORK #: ________________

Assignment & Release - *By signing below, I authorize Chugach Chiropractic Clinic LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Chugach Chiropractic Clinic LLC. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any reasonable collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

Consent to Treatment - *By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.*

SIGNATURE: ______________________________ DATE: ____________________



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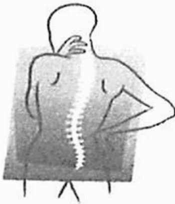
I authorize Chugach Chiropractic Clinic to discuss my medical information, to include financials, with the following individuals (Please list their name and relationship to you):

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

I understand that I may revoke this consent in writing at any time.

____________________ ____________________ ____________________

Print Name **Signature** **Date**



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Financial Policy

It is the policy of Chugach Chiropractic Clinic LLC to assess a *$25 missed visit fee to patients who cancel appointments with less than 24 hours notice or patients who miss their appointments without notifying our office.* One missed visit will be considered "grace"; however, all missed visits thereafter will be assessed the missed visit fee. Please understand that we attempt to serve as many patients as possible, and when a visit is missed, it represents time that could have been used to provide care for others.

In order to help our patients determine their responsibility toward payment for services, please read the following, and initial your preference for payment of your account:

Private Pay: (please initial)

A_____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C_____ Your health insurance policy most likely has a deductible amount as well as a percentage of your fees for which you, as the patient, are responsible. For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of the charges incurred. It is our policy to have the initial visit fees paid by the patient at the time of his/her appointment.

Our business office will contact your insurance company and inform you of your coverage for chiropractic care. We will then determine your eligibility.

Statements are sent out to a patient's insurance company on a regular basis. Your insurance company will inform you of benefits received and paid. Our office will notify you if there are any amounts unpaid or if there is a credit balance. We request that you clear up any and all balances that are due at that time.

If there is an overpayment at the time you have finished your series of treatments, the credit balance will be refunded. If any outstanding balances exist on any adjoining family accounts, your credit balance will be applied to that account or, if you wish, applied toward further care.

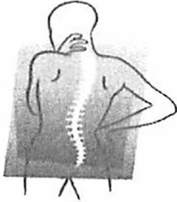
Supplies must be paid for when they are received.

Health policies are an arrangement between an insurance company and you, the insured. We will be happy to cooperate with you in the preparation of your insurance forms. Any amount paid directly to our office will be promptly credited to your account. If the insurance company should send you the check, please bring the check to our office.

IT IS IMPORTANT FOR YOU TO UNDERSTAND, HOWEVER, THAT ALL HEALTH SERVICES RENDERED TO YOU ARE CHARGED TO YOU AND ARE YOUR PERSONAL RESPONSIBILITY.

IF YOU HAVE ANY QUESTIONS, PLEASE LET US KNOW. WE WANT YOU TO HAVE A CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY SO THAT TOGETHER WE CAN CONCENTRATE ON RETURNING YOU TO GOOD HEALTH.

Patient/Responsible Party Signature________________________________ Date_______________



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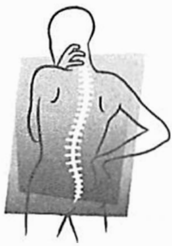
I have had an opportunity to review the Notice of Privacy Practices.

______________________	______________________
Patient's Printed Name	Date of Birth
______________________	______________________
Patient's Signature or that of Legal Representative	Today's Date
______________________	______________________
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Individual



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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:______________________________ **Last Name:**_____________________________

Email address: __________________@________________ **Date:**_________________________

How did you hear about our office? ____

Preferred reminder method (Circle one): Email / Phone / Mail **DOB:** ___/___/____

Gender (Circle one): Male / Female **Preferred Language:** __________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date: __________________

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any *medication* allergies?

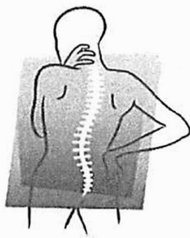
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ **Date:** _______________

For office use only

Height: ________ Weight:___________ Blood Pressure:_____ /_____ Pulse: _________



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SYMPTOM QUESTIONNAIRE

NAME: ____________________ DATE: ____________

REASON FOR TODAY'S VISIT: New Injury Old Injury Chronic Pain Wellness Visit

WOMEN: Pregnant? Y / N If yes, weeks? ______ ARE YOU WEARING: Shoe Lifts Inner Soles Arch Supports

DO YOU EXERCISE? Y/N If yes, times per week? _______ DIETING? Y/N If yes, for how long? ________

DO YOU SMOKE? Y/N How many per day? _______ DRINK? Y/N How many per day? _________

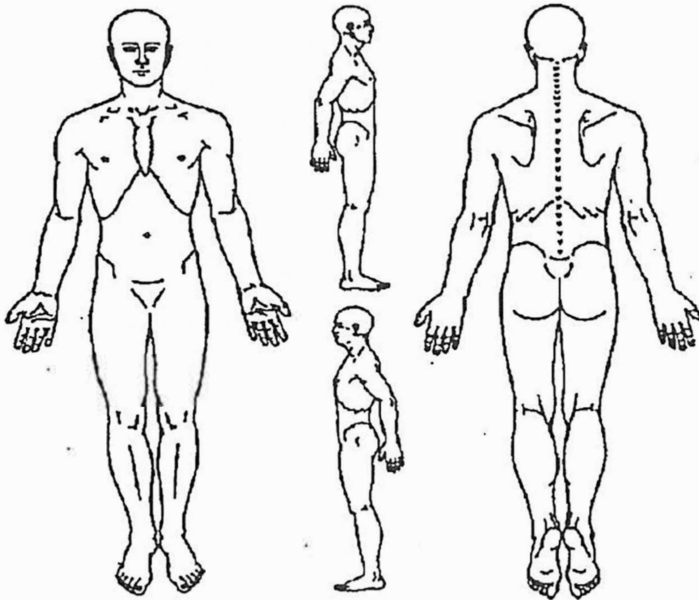
HAVE YOU BEEN TREATED BY A PHYSICIAN FOR THIS PAIN? Y/N IF SO, BY WHOM? ____________

FAMILY HISTORY OF MAJOR DISEASE/ILLNESS? ____________________

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
------	ooooo	^^^^	xxxx	⊗⊗⊗⊗
------	ooooo	^^^^	xxxx	⊗⊗⊗⊗
------	ooooo	^^^^	xxxx	⊗⊗⊗⊗



PLEASE RATE YOUR PAIN, 10 BEING WORST:

1 2 3 4 5 6 7 8 9 10

WHEN AND WHERE DID YOUR INJURY/ACCIDENT OCCUR? HOW DID IT HAPPEN?: ____________

IS YOUR CONDITION GETTING WORSE?

Yes No Constant Comes & Goes

HAS THIS OR SOMETHING SIMILAR HAPPENED IN THE PAST? Y/N

IF YES, PLEASE EXPLAIN: ____________

LIST PAST SERIOUS ACCIDENTS WITH DATES:

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? Y/N IF SO, BY WHOM? WHEN?

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS, AND IF SO, WHAT TYPES?

Pain Killers ____________

Muscle Relaxants ____________

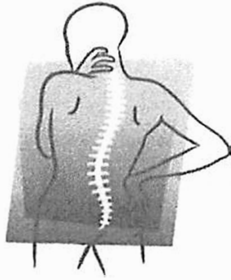
Insulin ____________

Supplements ____________

Other ____________

PLEASE CIRCLE ALL THAT APPLY DIRECTLY TO YOU:

Heart Attack/Stroke	Ulcers	Severe/Frequent Headaches
Heart Condition/Pacemaker	Cancer/Chemotherapy	Sinus Problems
Artificial Valves	Anemia/Diabetes	Emphysema/Asthma
Artificial Bones/Joints/Implants	Kidney Problems	Tuberculosis
Arthritis	Frequent Neck Pain	Difficulty Breathing
High/Low Blood Pressure	Lower Back Problems	Fainting/Seizures/ Epilepsy



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Oswestry Back Pain Scale Questionnaire

This questionnaire has been designed to give your doctor information as to how your back has affected your ability to manage in everyday life. Please answer every question by circling the **one** number that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please circle only the number which most closely describes your current condition**.

Question 1 - Pain Intensity
0. I can tolerate the pain I have without having to use pain medication.
1. The pain is bad but I can manage without having to take pain medication.
2. Pain medication provides me complete relief from pain.
3. Pain medication provides me with moderate relief from pain.
4. Pain medication provides me with little relief from pain.
5. Pain medication has no effect on my pain.

Question 2 – Personal Care
0. I can take care of myself normally without causing increased pain.
1. I can take care of myself normally, but it increases my pain.
2. It is painful to take care of myself, and I am slow and careful.
3. I need help, but I am able to manage most of my personal care.
4. I need help every day in most aspects of my care.
5. I do not get dressed, I wash with difficulty, and I stay in bed.

Question 3 – Lifting
0. I can lift heavy weights without increased pain.
1. I can lift heavy weights, but it increases pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently located.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Question 4 – Walking
0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than 1 mile.
2. Pain prevents me from walking more than 1/2 mile.
3. Pain prevents me from walking more than 1/4 mile.
4. I can walk only with crutches or a cane.
5. I am in bed most of the time and have to crawl to the toilet.

Question 5 – 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 for more than 1 hour.
3. Pain prevents me from sitting for more than 1/2 hour.
4. Pain prevents me from sitting for more than 10 minutes.
5. Pain prevents me from sitting at all.

Question 6 – Standing
0. I can stand as long as I want without increased pain.
1. I can stand as long as I want, but it increases my pain.
2. Pain prevents me from standing for more than 1 hour.
3. Pain prevents me from standing for more than 1/2 hour.
4. Pain prevents me from standing for more than 10 minutes.
5. Pain prevents me from standing at all.

Question 7 – Sleeping
0. Pain does not prevent me from sleeping well.
1. I can sleep well only by using pain medication.
2. Even when I take medication, I sleep less than 6 hours.
3. Even when I take medication, I sleep less than 4 hours.
4. Even when I take medication, I sleep less than 2 hours.
5. Pain prevents me from sleeping at all.

Question 8 – Social Life
0. My social life is normal and does not increase my pain.
1. My social life is normal but increases my level of pain.
2. Pain prevents me from participating in more energetic activities.
3. Pain prevents me from going out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of my pain.

Question 9 – Traveling
0. I can travel anywhere without increased pain.
1. I can travel anywhere, but it increases my pain.
2. My pain restricts my travel over 2 hours.
3. My pain restricts my travel over 1 hour.
4. My pain restricts my travel to short necessary journeys under 1/2 hour.
5. My pain prevents all travel except for visits to the physician/ therapist

Question 10 – Working
0. My normal homemaking/job activities do not cause pain.
1. My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2. I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities.
3. Pain prevents me from doing anything but light duties.
4. Pain prevents me from doing even light duties.
5. Pain prevents me from doing any job or homemaking chores.

Name: ________________________________ **Date:** ____________________

Lumbar (Lower Back)

The Neck Pain Disability Index Questionnaire

Instructions: Please circle **ONE NUMBER** in each section which 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, 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 with moderate pain in my neck.
3. I cannot 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 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.

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 cannot 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 cannot 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 cannot drive my car at all.

Section 9: Sleeping
0. I have no trouble sleeping.
1. My sleep is slightly disturbed (< 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 pain in my neck.
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 a few of my usual recreation activities because of pain in my neck.
4. I can hardly do any recreation activities because of pain in my neck.
5. I cannot do any recreation activities at all

Name: ______________________________ **Date:** ____________________

Cervical (Neck)