Robert W. Wilborn, D.C.

WELCOME!

Patient Information **(confidential)**

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(please print)

Name _____ SSN _____ Gender _____

Address _____ Home Phone _____

City _____ State _____ Zip Code ____ Work Phone _____

Birthdate _____ Marital Status _____ Email _____

Do you prefer to receive calls at: ☐ Home ☐ Work

Guarantor Information *(if patient is not guarantor, please complete this section)*

Name _____ SSN _____ Gender _____

Address _____ Home Phone _____

City _____ State _____ Zip Code ____ Work Phone _____

Birthdate _____ Marital Status _____ Email _____

_____

Guarantor relationship to patient (parent, guardian, etc.)

Primary Insurance Ins Company Name _____

Policy Holder Name _____ Birthdate _____ Group Name/# _____

ID Number _____ Ins Company Phone _____

Claims Address _____ City _____ State ___ Zip Code _____

Policy Holder Employer _____ Employer Phone _____

Employer Address _____ City _____ State ___ Zip Code _____

Secondary Insurance Ins Company Name _____

Policy Holder Name _____ Birthdate _____ Group Name/# _____

ID Number _____ Ins Company Phone _____

Claims Address _____ City _____ State ___ Zip Code _____

Policy Holder Employer _____ Employer Phone _____

Employer Address _____ City _____ State ___ Zip Code _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about us? _____

Name of referring physician, patient, etc. _____

Patient Signature _____ Date _____

I certify that the above information is accurate and I understand that I am responsible for payment of all charges to Dr. Robert W. Wilborn's office regardless of insurance benefits or eligibility determination.

NEED INSURANCE CARD COPY

Symptoms

1) Reason for visit _____
2) When did you first notice the symptom(s)? _____
3) How did it start? _____
4) Is this condition getting progressively worse? _____
5) Where specifically is the problem(s) located? _____
6) Which activities make it worst? ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other _____

7) Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Numb ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramping ☐Stiff ☐Swollen ☐Other _____

8) Rate the severity of your pain. *(1, mild pain or discomfort, to 10, severe pain)*: 1 2 3 4 5 6 7 8 9 10

9) Is the pain constant? ☐ Or Does it come and go? ☐
10) What treatment have you already received for your condition? ☐Chiropractic ☐Medication ☐Surgery ☐Physical Therapy ☐Other _____

11) Name and address of other doctor(s) who have treated you for your condition: _____
_____
_____
_____

Personal Health History

Check only those conditions which are applicable:

☐AIDS/HIV	☐Cataracts	☐Heart Disease	☐Osteoporosis	☐Suicide Attempt
☐Alcoholism	☐Chemical Dependency	☐Hepatitis	☐Pacemaker	☐Thyroid Problem
☐Allergy Shots	☐Chicken Pox	☐Hernia	☐Parkinson's Disease	☐Tonsillitis
☐Anemia	☐Depression	☐Herniated Disc	☐Pinched Nerve	☐Tuberculosis
☐Anorexia	☐Diabetes	☐Herpes	☐Pneumonia	☐Tumors, Growths
☐Appendicitis	☐Emphysema	☐High Cholesterol	☐Polio	☐Typhoid Fever
☐Arthritis	☐Epilepsy	☐Kidney Disease	☐Prostrate Problems	☐Ulcers
☐Asthma	☐Fractures	☐Liver Disease	☐Prosthesis	☐Vaginal Infection
☐Bleeding Disorder	☐Glaucoma	☐Measles	☐Psychiatric Care	☐Venereal Disease
☐Breast Lump	☐Goiter	☐Miscarriage	☐Rheumatoid Arthritis	☐Whooping Cough
☐Bronchitis	☐Gonorrhea	☐Mononucleosis	☐Rheumatic Fever	☐Other _____
☐Bulimia	☐Gout	☐Multiple Sclerosis	☐Scarlet Fever	_____
☐Cancer	☐Headaches	☐Mumps	☐Stroke	_____

12) Please list all medications you are currently taking: _____
13) Allergies: _____
14) Date of last examination _____
15) **WOMEN:**

Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No

Taking birth control pills? ☐Yes ☐No HRT? ☐Yes ☐No

List any types of surgeries which you have had and the dates on which they occurred: _____
_____
_____

Daily Habits

16) What type of exercise do you perform on a regular basis? _____ How often? _____
17) What do your daily work habits include? (Ex: sitting, standing, light labor, heavy labor, computer work)

_____

18) How many servings (1/2 cup) do you eat each day of dark, colorful fruits? _____ vegetables? _____
19) How many ounces of water (not including other fluids) do you drink each day? _____
20) What vitamins and/or other nutritional supplements do you currently take? _____
21) Do you smoke? ☐Yes ☐No How much per day? _____ How much alcohol per week? _____
22) On a daily basis, how much coffee _____ (☐regular ☐decaf) and soda _____ (type _____) do you drink?
23) What time do you go to bed? _____ Wake up? _____
When you wake up, do you feel rested? ☐Yes ☐No Or _____%

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Bob Wilborn to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Wilborn insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

Patient Signature _____ Date _____

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in the cause and prevention of disease."

-Thomas Edison-

Robert W. Wilborn, D.C.

Patient Health Information Consent Form

We want you to know how your Patient Health Information **(PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1) The patient understands and agrees to allow this chiropractic office to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2) The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3) A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4) The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5) For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6) Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7) If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physicians has the right to refuse to give care.

Patient Signature _____ Date _____

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Robert W. Wilborn, D.C.

Doctor-Patient Relationship in Chiropractic Informed Consent

Chiropractic

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions of the patient. It is important to understand what to expect from Chiropractic health care services.

Analysis

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic promise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

Diagnosis

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variable, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be answers to all problems. Both have made great strides in alleviating pain and controlling disease.

To The Patient

Please discuss any questions or problems with the Doctor ***before*** signing this statement of policy.

Patient Signature _____ Date _____

I have read and understand the foregoing.

Robert W. Wilborn, D.C.

Activities of Daily Living Assessment:

This questionnaire has been designed to give the doctor information as to how your symptoms have affected your ability to manage in everyday life.

Please check one item in each section which most closely applies to you.

SECTION 1: PAIN INTENSITY

☐I can tolerate the pain I have without using painkillers.

☐The pain is bad but I manage without taking painkillers.

☐Painkillers give complete relief from pain.

☐Painkillers give moderate relief from pain.

☐Painkillers give very little relief from pain.

☐Painkillers give no relief from pain and I do not use them.

SECTION 2: 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, wash with difficulty and stay in bed.

SECTION 3: 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, but I can manage if they are conveniently positioned (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 lift only very light weights.

☐I cannot lift or carry anything at all.

SECTION 4: 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 using a cane or crutches.

☐I am in bed most of the time and have to crawl to the toilet.

SECTION 5: SITTING

☐I can sit in any chair as long as I like.

☐I can only sit in my favorite chair as long as I like.

☐Pain prevents me from sitting for more than one hour.
☐Pain prevents me from sitting for more than 30 minutes.
☐Pain prevents me from sitting for more than 10 minutes.
☐Pain prevents me from sitting at all.

SECTION 6: STANDING

☐I can stand as long as I want without extra pain.
☐I can stand as long as I want but it causes extra pain.
☐Pain prevents me from standing for more than one hour.
☐Pain prevents me from standing for more than 30 minutes.
☐Pain prevents me from standing for more than 10 minutes.
☐Pain prevents me from standing at all.

SECTION 7: SLEEPING

☐Pain does not prevent me from sleeping well.
☐I can sleep well only by using ☐drugs ☐alcohol
☐How many hours do you sleep/night? _____
☐Pain awakens me. What time? _____

SECTION 8: SEX LIFE

☐My sex life is normal and causes no extra pain.
☐My sex life is normal and causes some extra pain. Where? _____
☐My sex life is nearly normal but is very painful.
☐My sex life is severely restricted by pain.
☐My sex life is nearly absent because of pain.
☐Pain prevents any sex life at all.

SECTION 9: SOCIAL LIFE

☐My social life is normal and gives me no extra pain.
☐My social life is normal but increases the degree of pain.
☐Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
☐Pain has restricted my social life and I do not go out as often.
☐Pain restricts my social life to my home.
☐I have no social life because of pain.

SECTION 10: TRAVELING

☐I can travel anywhere without extra pain.
☐I can travel anywhere but it gives me extra pain.
☐Pain is bad but I manage journeys over two hours.
☐Pain restricts me to journeys of less than one hour.
☐Pain restricts me to short necessary trips under a half hour.
☐Pain restricts me from traveling except to the doctor or hospital.

Patient Signature _____ Date _____