Patient Name: _____ **Date:** _____.

Welcome to Back Pain Relief Chiropractic!

Please print and fill out the following pages to the best of your ability.

It would be REALLY HELPFUL if you **printed these out as one side only.** Thank you.

If you have had recent X-rays, CT scan or MRI please bring the reports or films with you for your office visit.

If you are under 18 you must be accompanied by a parent or legal guardian.

Depending on your symptoms and health status there will probably be a few more papers you will need to fill out when you get to the office, but this is a Great Start. Thank you.

Due to Privacy Concerns (HIPPA) DO NOT fax or email these forms back to us.

We are a Walk-In clinic, but we request you schedule an appointment for your First Visit. Our office phone number is 575-746-6375.

Welcome to the office. We look forward to serving you.

Dr. Andrews

Patient Name: _____ **Date:** _____.

The ChiroTrust Pledge:

"To the best of my ability, I agree to provide my patients convenient, affordable, and mainstream Chiropractic care. I will not use unnecessary long-term treatment plans and/or therapies."

NO SURPRISE BILLING ACT

This office participates in the No Surprise Billing Act. Below you will find a Fee Schedule of our most utilized charges, as well as an explanation of these charges. If we are contracted with your insurance company, you may receive an in-network discount; that will depend on your insurance company and individual policy.

Consultation / Examination:	$27	Usually covered by general insurance companies but is not covered by Medicare. This charge may be for an initial examination (first visit with the doctor) or for a reexamination at various intervals during care.
Chiropractic SPINAL Adjustment/s	$40	This fee includes any single area of the spine or a combination of multiple areas of the spine including head, neck, upper/mid/low back, ribs and pelvis. This does not include Extremity Adjustments.
Chiropractic EXTREMITY Adjustments:	$26	If there is a specific complaint involving a specific area/joint/muscle etc. OUTSIDE of the spinal column (as described above) each area will be evaluated as a separate and distinct complaint and will be billed accordingly. Example: knee issues, shoulders, elbow, wrist, etc.
Spinal X-rays, (only if needed):	$45	per Area. Specifically: Neck is one Area; low back would be another Area. X-rays are taken in this office only when deemed medically necessary. X-rays are generally covered by most commercial insurance companies but unfortunately, not by Medicare.

Additional THERAPY: At times various therapies may be recommended and/or utilized to accelerate your recovery. These therapies are recommended and used only when necessary.

Intersegmental Traction (Roller Table)	$20.	No longer covered by insurance as of 2020-2021
Electrical Muscle Stimulation	$15	Covered by insurance at times, generally short term only
Spinal Decompression Table	$50	The Spinal Decompression Table is generally reserved for patients that have documented or suspected disc issues, such as disc bulge, herniations, etc. Unfortunately, this device is not covered by any insurance plans that we are aware of.
Dry Needling: 1-2 muscle groups	$75	Dry Needling is not covered by any insurance or Medicare
Radial Pulse Wave:	$50	Radial Pulse Wave is not covered by any insurance or Medicare.

Patient Signature / Initials: _____

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Phone: (575)746-6375 Fax: (575)746-6799

Patient Name: _____ **Date:** _____.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You (the patient) give us (the office) permission to disclose and discuss any and all aspects of your case with the following person/s:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative **Date**

For minors only: _____ _____ _____
Representatives Relation to Patient **Printed Name of Representative** **Date**

Patient Name: _____ **Date:** _____.

BASIC PATIENT INFORMATION

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Sex: _____ Marital Status: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____lbs.

Emergency Contact Name and Phone Number: _____

Have you ever received Chiropractic Care? ____ Yes ____ No

If yes, Doctors name/s: _____ When did you see them last? _____

How did you hear about our office? _____

WORKERS COMP / ON THE JOB INJURIES
This office does NOT currently treat active on the job injuries. If you are here due to a recent on the job injury notify us immediately and we will make the proper referral for you.
My Initials here certifies my symptoms are NOT work related: _____

MOTOR VEHICLE / CAR ACCIDENTS
Motor Vehicle Injuries / Car Accidents are accepted on a case-by-case basis. If you are here due to a recent car accident inform our staff immediately. Do NOT fill out any further paperwork until speaking with our staff.
My Initials here certifies my symptoms are NOT related to a motor vehicle injury: _____

FINANCIAL RESPONSIBILIIY AND INSURANCE ASSIGNMENT
I acknowledge that my bill in this office is ultimately my responsibility regardless of possible insurance coverage or not.
Patient or Representative Initials: _____

INSURANCE BILLING
If you want us to bill your insurance, give your insurance card and driver's license to our office staff to be copied. By doing so, you authorize this office to take assignment of your insurance benefits. If my insurance will be billed, I authorize payment of medical benefits to Back Pain Relief Chiropractic, P.C. Dr. Thomas M. Andrews, D.C. for services performed.
Patient or Representative Initials: _____

If you have insurance and your coverage is through another person such as your spouse, guardian, etc.:
Policy Holder Name: _____ Policy Holder Date of Birth: _____

CELL PHONE USE
Please have the courtesy to step outside to make or take phone calls. Thank you. Seriously. Thank you.
Patient or Representative Initials: _____

Patient Name: _____ **Date:** _____ .

BASIC INTAKE INFORMATION

1. Past Health History:

A. Surgeries:

Date Type of Surgery

_____ _____

_____ _____

_____ _____

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

2. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases

□ Adopted/Unknown □ Cardiac disease below age 40

□ Psychiatric disease □ Diabetes □ Other _____ □ None of the above

A. Deaths in immediate family:

Cause of parents' or siblings' death Age at death

_____

_____

_____

3. Social and Occupational History:

A. Employer: _____ Job description: _____

B. Work schedule: □ Days □ Nights □ Shift Work □ Variable □ N/A

C. Do you have any specific Recreational Activities or Hobbies? _____

D. Lifestyle:

Level of Exercise: On average, I Exercise 1 2 3 4 5 6 7 times per week

Alcohol Use: On average, I consume _____# drinks per week.

(a 'drink' is considered one beer or one shot or equivalent)

Tobacco Use: __ None __ snuff or chewing tobacco __ smoker # packs/canisters per day:____

Drug Use?: ___ None Other: _____

Do you follow a Specific Diet Plan?: _____

4. Medications:

Medication Reason for taking

_____

_____

_____

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Patient Name: _____ **Date:** _____.

REVIEW OF SYSTEMS

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain
□ Irregular heartbeat □ Aneurysm □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures
□ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors
□ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Loss of Bladder or Bowel Control
□ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements
□ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal Calculi/Kidney Stones □ Hematuria (blood in the urine) □ Incontinence (can't control)
□ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia
□ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease
□ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ GERD/heartburn □ None of the above
□ Other _____

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
□ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes
□ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots
□ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **Oncological (cancer-related)** issues?
□ Fevers/chills/sweats/unexplained weight loss □ Abnormal Bleeding/Bruising
Current oncology disease: _____ Past Oncology disease: _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture
□ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants
□ Ankylosing Spondylitis □ Severe Osteoporosis □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder
□ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

If there is anything else in your past medical history that you feel is important for us to know, please list it here:

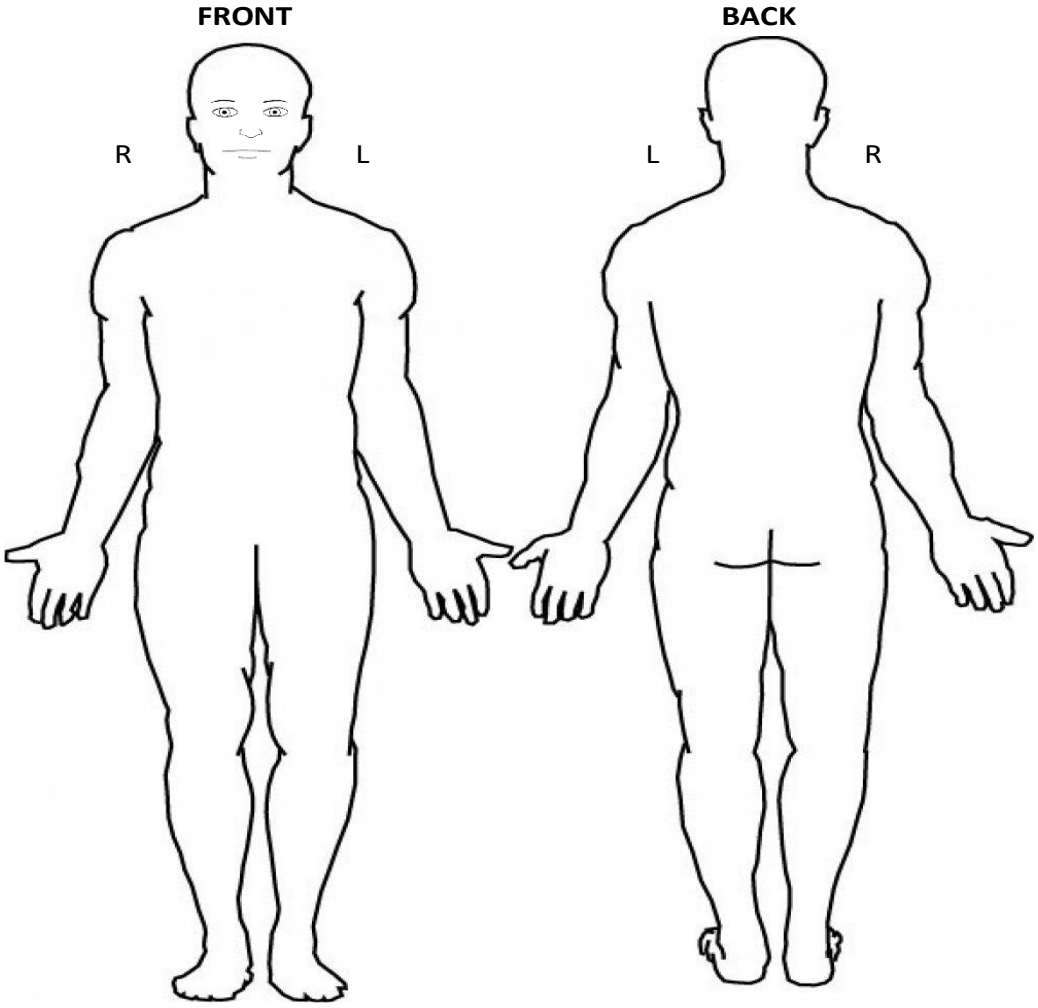
Patient Name: _____ **Date:** _____.

SYMPTOM DIAGRAM

Use the diagram below to identify the **Primary 3 or 4 Area/s** that are a priority to you for us to evaluate today.

Mark these areas with an X or by Circles.

***** Each area identified below must have an associated Symptom Form *****



_____ _____

Signature of Patient or Representative **Date**

For minors only: _____ _____ _____

Representatives Relation to Patient **Printed Name of Representative** **Date**

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Patient Name: _____ **Date:** _____.

SYMPTOM FORM
Each area identified on the Pain Diagram needs a Symptoms Form filled out

Symptom _____

- On a scale from 0-10, with 10 being the worst, circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- How long ago did you FIRST notice this symptom? _____
  - Did something happen to cause this symptom to occur? Yes No
  - If Yes, what happened? _____

- What makes the symptom worse? (circle or underline all that apply):
  nothing, any movement,

  bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right,

  bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist,

  driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed,
  other (please describe): _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff
    Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (circle all that apply)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit? (circle all that apply)

Nothing	Anti Inflammatory Meds	Pain Medication	Muscle Relaxers	
	Trigger Point Injections	Cortisone Injections	Massage	Surgery
	Physical Therapy	Chiropractic	Other: _____	

- Are you pregnant? ___ Yes If Yes, due date: _____ _____No

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Patient Name: _____ **Date:** _____.

SYMPTOM FORM
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  bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right,

  bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist,

  driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed,
  other (please describe): _____

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff
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  - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (circle all that apply)
  - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit? (circle all that apply)

Nothing	Anti Inflammatory Meds	Pain Medication	Muscle Relaxers
	Trigger Point Injections	Cortisone Injections	Massage Surgery
	Physical Therapy	Chiropractic	Other: _____

- Are you pregnant? ___ Yes If Yes, due date: _____ _____No

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