GATEWAY CHIROPRACTIC CENTER

702 N. Beers Street, Suite 8, Holmdel, NJ 07733

Phone: (732) 739-0040 ♦ Fax: (732) 739-0539

Stephen J. Loihle, DC

Patient: ______________________

Employer: ______________________

Claim Group: ______________________ SS #: ______________________

I hereby instruct and direct ______________________ Insurance Company to pay a check made payable and mailed to:

Gateway Chiropractic Center,
702 N. Beers Street, Suite 8
Holmdel, NJ 07733

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make the check payable to me and mail to GATEWAY CHIROPRACTIC CENTER.

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for this profession services rendered, THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed by indebtedness to the above mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment.

A copy of this agreement shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Holmdel, this ________ day of ______________________, 20___

______________________ ______________________

Signature of Policyholder Witness

____

Signature of Claimant, if other than Policyholder

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AUTHORIZATION & PRIVACY

AUTHORIZATION CARE

I authorize and allow Stephen J. Loihle, DC to work with my spine through the use of spinal adjustments, Gateway Chiropractic Center techniques and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I understand I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. Dr. Loihle, DC will not be held responsible for any health conditions or diagnoses which are pre-existing given by another health care practitioner or are not related to the spinal structural conditions diagnosed at this clinic. I also understand clearly that if I do not follow the doctor's specific recommendations that I will not receive full benefit from these programs. I authorize the assignment of all insurance benefits to be directed to the doctor for all services rendered.

____________________________ ______ ________________________

Minor's Name (Please Print) Date Guardian's Signature

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES GATEWAY CHIROPRACTIC CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOOWING SPECIFIC AUTHORIZATIONS:

I give permission to Gateway Chiropractic Center to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages and treatment alternatives or other health related information.

By signing the following you are giving Gateway Chiropractic Center permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I, ______________________________ understand and have been provided with a notice of information practices that provides me a more complete description of information and disclosures. I understand that I have the following right and privileges:

The right to review the notice prior to signing this consent

The right to object to the use of my health care information for directory purposes

The right to request restrictions as to how my health care information may be used or disclose in this office to carry out treatment, payment or health care operation.

________________________ ________________________ ____________________

Patient Name Patient Signature Date

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CONFIDENTIAL HEALTH HISTORY

Please take a minute to fill this form out completely.

We look forward to assisting you on your journey back to optimal health.

Patient Information

Name ______________________________ SS# ____________________

Address ____________________ City __________ State ____ Zip Code __________

Sex M / F Age ____ DOB ___/___/___ Single ____ Married ____ Divorced ___ Widowed ___

Employer ____________________________ Occupation ____________________

Employer's Address ____

Home Phone ____________ Work Phone ______________Cell Phone ______________

Whom may we thank for referring you? ____________________________________

Have you ever seen a chiropractor? ___ When? _______ Why? ____________________

Email Address ________________________

Primary Insurance

Responsible Party______________________ Relation to Patient ________________

DOB ___/___/___ SS# ______________ Address ______________________________

Employer__________________________ Occupation _______________________

Employer's Address ________________________ Business Phone ______________

Insurance Company____________________ Address ________________________

Phone __________________ Group #____________ ID# ______________________

Health Information

Briefly describe your complaint, how it began, and rate it on a scale from 0-10.

(0 = no pain   10 = severe pain)

____

____

It is: constant ______ frequent ______ occasional ______ intermittent ______

It is: getting better ______ staying the same ______ getting worse ______

What makes it better? ____

What makes it worse? ____

Please See Reverse Side

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History

Previous medical conditions:

1. ______________________________
2. ______________________________
3. ______________________________

Previous falls, accidents, injuries:

1. ______________________ Date ____________
2. ______________________ Date ____________

Surgeries: (Please list all)

1. ______________________ Date ____________
2. ______________________ Date ____________
4. ______________________ Date ____________

Please list all medications:

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Additional Information:

____
____
____

Authorizations

I have reviewed the information on this questionnaire and it is true to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to Gateway Chiropractic Center all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Loihle to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature ______________________ Date ____________

Payment is due at the time of service unless prior arrangements have been made.

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NECK DISABILITY INDEX

Name______________________________ Date_____/_____/_____ File #__________
(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - 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.

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, I 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 gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are coveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - 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 with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 - 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.

From Vernon H, Mior S. JMPT 1991; 14(7): 409-415

SECTION 6 - 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.

SECTION 7- 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.

SECTION 8 - 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 can't 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 can't drive my car at all.

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

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

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REVISED OSWESTRY DISABILITY

Name ______________________________ Date ___/___/___ File # ____________
(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - 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.

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

- ☐ 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 increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives 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.

SECTION 4- Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on 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 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain immediatley.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal nights sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no 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, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - 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 alternative 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 that done lying down.

SECTION 10 - 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.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Form by N. Hudson- Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR. Eds. Back Pain. Manchester University Press 1989: 187-204

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