Manchester Chiropractic
& Sports Injuries, PLLC

Patient name _____
DOB _____
Date _____

Dear Patient,

Thank you for your visit today. In order to provide you with complete chiropractic wellness care and address the root cause of your health concerns, we would like you to complete a detailed health questionnaire. Often there are conditions that could be contributing to your symptoms without your outward awareness. Therefore, your answers will help us provide better management strategies so you can experience better treatment results. The more you are willing to share with us, the better we can treat the root of your health conditions and symptoms.

We look forward to being your partners in health!

Patient Information

Name _____ Date _____
Address _____
City _____ State _____ ZIP _____
Home phone _____ Work _____
Mobile _____ E-mail _____

Date of birth _____ Age _____
Occupation _____ Employer _____
Marital status: S M D W Partner Spouse name _____
Emergency contact name _____ Phone _____

How would you like to be addressed by our staff? _____

Who may we thank for referring you to us? _____

What is the nature of your complaint? _____
_____
When did it first occur? _____
Other complaints? _____

Does your present condition involve a claim for:
A job injury (worker's comp)? YES _____NO_____ If yes, in which state? _____
An auto accident or other personal injury? YES _____ NO ____ If yes, in which state? _____

Have you lost time from work for this incident? YES_____NO____ Exact dates _____
Has an MRI been taken for this incident? YES_____NO ____ Previously? _____

Have you ever consulted a Doctor of Chiropractic before? YES____NO____
Name of chiropractor _____ Last visit _____

Do you have a primary care physician? YES____ NO____
Name _____ Location _____ Phone _____
Last physical examination date _____Reason_____
Did it include blood tests? _____
May we contact them to coordinate care and records? YES___ NO___

May we contact you at home and leave messages? YES___ NO___

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Past Medical History

Please mark any of the following illnesses you have had or currently have, and indicate when. (If not certain of dates, please give approximate dates.)

_____ High blood pressure	_____ Prostate disease	_____ Multiple sclerosis
_____ Heart disease	_____ Venereal disease/STI	_____ Ulcer
_____ Stroke	_____ Allergies	_____ Cancer
_____ Diabetes	_____ Scoliosis	_____ Serious injury/fall
_____ Kidney disease	_____ Mental/Emotional	_____ Auto accident
_____ HIV	_____ Seizures	Other: _____

Is there anything else in your medical history we should know? _____

_____

List times/reasons you have been hospitalized (do **not** list normal pregnancies):

Year **Reason** **Hospital**

_____

_____

_____

_____

Family History

Has anyone in your immediate family (father, mother, siblings, children) had any of the following illnesses? Please list which family members have had each.

High blood pressure _____
Heart disease _____
Stroke _____
Diabetes _____
Cancer _____
Other _____

Social History

Do you smoke tobacco? YES _____NO ___ If yes: ____ packs per day for ____ years

Do you consume alcohol? YES _____NO ___ If yes: ____ servings per week

What exercise do you regularly perform? _____
How frequently? _____

If you have children, how many? _____ How many live with you? _____

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Review of Systems

Please mark any medical problems you currently have or have had in the past.

Are you currently experiencing, or have you in the past year experienced:

□ Eyes □ Ears □ Nose □ Mouth/Throat

Lungs / Pulmonary and breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain/angina □ high blood pressure/hypertension □ irregular heartbeat/arrhythmia
□ heart attack/myocardial infarction □ heart murmur/ valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve pro lapse □ deep vein thrombosis
□ bleeding problems □ other: _____

Neurologic disorders

□ stroke or TIA □ MS □ other: _____
□ peripheral neuropathy □ cerebral palsy
□ Parkinson's □ polio

Bone & joint disorders

□ osteoarthritis □ lupus □ other: _____
□ rheumatoid arthritis □ osteomyelitis
□ gout □ ankylosing spondylitis

Gastrointestinal disorders

□ peptic ulcer/stomach ulcer □ irritable bowel syndrome □ GI bleed
□ acid reflux/GERD □ hepatitis – type _____ □ Inflammatory bowel disease
□ diverticulitis □ liver disease □ other: _____

Genitourinary disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & other disorders

□ diabetes – type _____ □ skin disorder □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____
□ Cancer – please specify type or location: _____

Other problems not included above: _____

_____

_____

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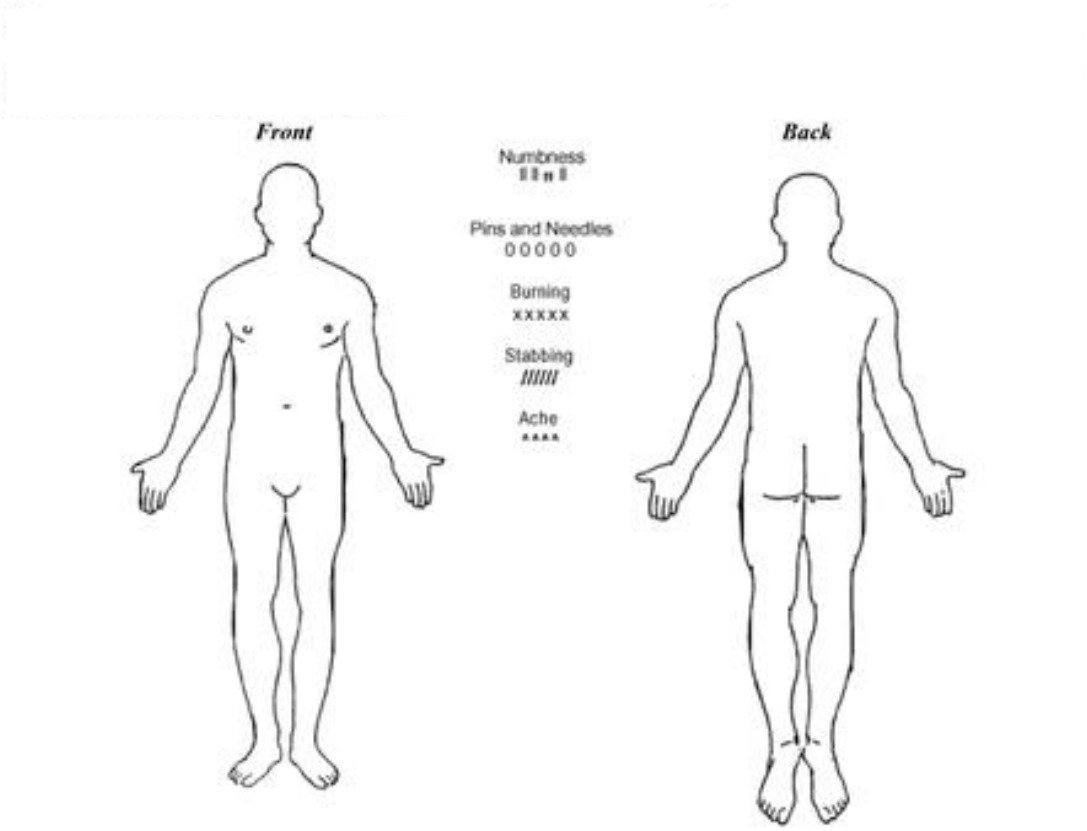
Pain Diagram



Patient-Specific Functional Scale

What are two important activities that you cannot do or are having trouble doing? (i.e., "I can't get dressed without help," "I can't play golf," "I can't go to work.")

Activity 1. _____

Please rate activity:

0 1 2 3 4 5 6 7 8 9 10

Unable to perform *Able to perform at same level as before problem*

Activity 2. _____

Please rate activity:

0 1 2 3 4 5 6 7 8 9 10

Unable to perform *Able to perform at same level as before problem*

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Outcomes Assessment

Over the past week, on average how would you rate your pain? (Circle only one number)

No pain — *Worst possible pain*

0 1 2 3 4 5 6 7 8 9 10

Based on all the things you do to cope, or deal with, your pain, on an average day, how much control do you feel you have over it? Please circle the appropriate number. (Circle only one number)

No control — *Some* — *Complete control*

0 1 2 3 4 5 6

Based on all the things you do to cope, or deal with, your pain, on an average day, how much are you able to decrease it? Please circle the appropriate number. (Circle only one number)

Can't decrease it at all — *Can decrease it somewhat* — *Can decrease it completely*

0 1 2 3 4 5 6

How confident are you in your ability to overcome your problem?

Total confidence — *No confidence*

0 1 2 3 4 5 6 7 8 9 10

The Keele STarT Back Screening Tool

Thinking about the last 2 weeks, mark your response to the following questions:

	Disagree (0)	Agree (1)
1. My back pain has spread down my leg(s) at some time in the last 2 weeks.	☐	☐
2. I have had pain in the shoulder or neck at some time in the last 2 weeks.	☐	☐
3. I have only walked short distances because of my back pain.	☐	☐
4. In the last 2 weeks, I have dressed more slowly than usual because of back pain.	☐	☐
5. It's not really safe for a person with a condition like mine to be physically active.	☐	☐
6. Worrying thoughts have been going through my mind a lot of the time.	☐	☐
7. I feel that my back pain is terrible and it's never going to get any better.	☐	☐
8. In general I have not enjoyed all the things I used to enjoy.	☐	☐

9. Overall, how bothersome has your back pain been in the last 2 weeks? (Circle one)

Not at all Slightly Moderately Very much Extremely

 Funded by Arthritis Research UK

Office use only
Total score (all 9): _____
Sub Score (Q5-9): _____

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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.
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 the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect 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 to 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 physician has the right to refuse to give care.

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

NAME OF PATIENT DATE

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CONSENT FOR TREATMENT

I consent to routine treatment deemed necessary or advisable by the health care provider responsible for my care. I also understand that I have the right to be informed about all treatments given me and the right to decline any specific treatment should I so choose. I further consent to x-rays being taken if deemed necessary by my healthcare provider and understand that it is my responsibility to disclose whether or not I may be pregnant (as applicable) or have any condition that may be affected by the use of radiographic imaging.

ACKNOWLEDGEMENT AND CONSENT

The Manchester Chiropractic & Sports Injuries, PLLC Notice of Privacy Practices, describes the ways in which Manchester Chiropractic & Sports Injuries, PLLC use and disclose protected health information.

- I acknowledge that I have received and signed the Manchester Chiropractic & Sports Injuries, PLLC Notice of Privacy Practices (required by federal law) and that a copy of my signed notice will be furnished on request.
- I consent to Manchester Chiropractic & Sports Injuries, PLLC use and/or disclose of my health information as necessary to treat me, to obtain payment for services, and to conduct internal health care operations as described in the Notice of Privacy Practices in accordance with federal and state law.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of medical information by Manchester Chiropractic & Sports Injuries, PLLC relating to services rendered by Manchester Chiropractic & Sports Injuries, PLLC to any insurance company, having coverage on me, attorney who may be representing me, or case manager related to my treatment as necessary for processing of my insurance claims or co-managing my healthcare.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer Manchester Chiropractic & Sports Injuries, PLLC all benefits payable under my insurance policy(s). I hereby authorize Manchester Chiropractic & Sports Injuries, PLLC to bill my insurance carrier(s) directly for services rendered, and I authorize the insurance carrier(s) to pay directly to Manchester Chiropractic & Sports Injuries, PLLC all benefits due from said policy for services rendered.

RESPONSIBILITY FOR PAYMENT OF SERVICE (refer also to Office Financial Policy)

I agree to be financially responsible for services provided in the event that:

- My health insurance coverage is not in effect at the time of service for any reason.
- My health insurance plan deems the services to be non-covered benefit
- I have not obtained the appropriate referrals required by my health insurance plan, and coverage is denied as a result.
- I do not have chiropractic coverage under my policy.
- I have a deductible that I must meet prior to my insurance company making payments according to my plan.

I have read and understand the above disclosures and consent:

_____ _____

Signature of Patient/Parent/Authorized Representative Date

Manchester Chiropractic
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OFFICE FINANCIAL POLICY/DOCTOR'S LIEN

All patients must notify this office within 24 hours of appointment for cancellations or rescheduling. *There will be a $30.00 charge for all missed appointments.* Any charges for missed appointments must be paid prior to receiving additional care.

Patients will no insurance: Patients are expected to make payment in full at the time of service.

Patients with insurance: Patients must provide their insurance card on the first date of service, or services must be paid for at the time of visit until such time as the insurance card is provided. Patients with insurance must pay co-payments at the time of service. Our office will qualify your insurance coverage in an effort to help you determine exactly what chiropractic coverage is available under your policy, however, the ultimate responsibility for insurance verification rests with the patient. As a courtesy, this office will file your insurance claims with your primary insurance carrier. Patient authorizes and directs the insurance carrier to pay provider directly. If your carrier has not paid a claims within 60 days of submission, you are responsible for taking an active part in the recovery of your claim. After 90 days, you will responsible for payment in full for any outstanding balance. Payment of co-insurance and deductibles established by patient's insurance company are due within 30 days of receipt of statement from this office. This office does not promise that an insurance company will pay for usual and customary charges of this office, nor will this office enter into any dispute with an insurance company regarding reimbursement. We do not own your policy. If we have difficulty with your insurance company, we may terminate your assignment privilege. There may be certain procedures that your insurance company will not cover, in this event, you, the patient is liable for these charges. If your insurance coverage is exhausted during the course of your treatment, you are responsible for full payment of your account.

Personal Injury or Workers Comp Cases: Patients must provide the name, address and phone number of the attorney, insurance company, and/or workers comp carrier and claim number on the first date of service or all services must be paid for at time of visit until such information has been provided. Our office must verify representative/case prior to rendering treatment. Patient is liable for the complete balance of the account if the case is denied. Personal Injury or Workers Comp patients are directly and full responsible to Manchester Chiropractic & Sports Injuries, PLLC for all services rendered, and acknowledge the responsibility to pay for those services regardless of any insurance coverage. Patient obligation to pay for said services is not contingent upon any recovery by judgement, settlement or otherwise against any responsible third party. I understand that if settlement on my personal injury case is not sufficient to cover the amounts owed for treatment, then I will personally become liable for the balance.

Recovery: In the event a patient has a balance and collection efforts including small claims court action is taken, patient will be liable for the balance on the account plus any and all filing fees; attorney fee and court administration fees.

Doctor's Lien: Personal Injury patients do hereby give a lien to Manchester Chiropractic & Sports Injuries, PLLC on any settlement, claim, judgement or verdict as a result of said accident/illness, and authorize my attorney/ insurance carrier to pay directly to Manchester Chiropractic & Sports Injuries, PLLC such sums as may be due and owing for services rendered to me. These sums should be withheld from such settlement, claim, judgement or verdict as may be necessary to protect Manchester Chiropractic & Sports Injuries, PLLC adequately. Manchester Chiropractic & Sports Injuries, PLLC does not accept a reduction in payment at the time of settlement, and the patient is to inform their attorney (if applicable) of such.

I have read and understand the terms as outlined in this financial policy.

_____ _____

Patient Signature Date