MEDICARE HISTORY FORM

FISHER CHIROPRACTIC

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____ Employer/Occupation: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Gender: Male -- Female

Marital Status: M S W D How many children? _____ Name of Spouse: _____

Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

Referred by: _____

Please inform us if you have a secondary, supplemental or replacement policy

Yes No Are you covered by a Group Health Plan through your current or former employment?

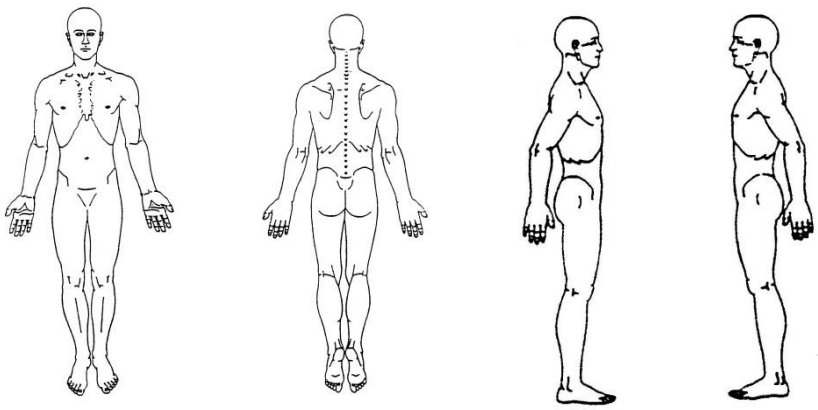
Yes No Are you covered by a Group Health Plan through your spouse or other family member's current or former employment?

Yes No Are you receiving Workers' Compensation (WC) benefits?

Yes No Are you filing a claim with a no-fault insurance or liability insurance?

Yes No Are you being treated for an injury or illness for which another party has been found responsible?

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main Reason for consulting the office:

- Become Pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity

Main Problem:

What pain has brought you to our office? _____

What caused this pain? _____

How bad is the pain? ☐ Mild ☐ Moderate ☐ Severe ☐ Intolerable

When did the pain start? _____ How long does it last? _____

How often does the pain occur? ☐ Occasionally ☐ Frequent ☐ Constant

Does this pain travel to any other area? _____

What best describes the pain? ☐ Cramping ☐ Aching ☐ Dull ☐ Sharp ☐ Deep
☐ Throbbing ☐ Shooting ☐ Stinging ☐ Burning ☐ Pressure

What makes the pain better? _____

What makes the pain worse? _____

What have you done to treat the pain? _____

Secondary Problem(s): _____

List any Allergies: _____

Mark any Surgeries:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist

Other: _____

Mark ALL Past Medical History:

☐ Ankle Pain
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Eye/Vision Problems
☐ Foot Pain
☐ Headaches
☐ Menstrual Problems
☐ Multiple Sclerosis
☐ Pacemaker
☐ Prostate Problems
☐ Spinal Cord Injury
☐ Arm Pain
☐ Back Pain
☐ Chest Pain
☐ Dizziness
☐ Fainting
☐ Genetic Spinal Condition
☐ Hearing Problems
☐ Mid-Back Pain
☐ Neck Pain
☐ Parkinson's
☐ Shoulder Pain
☐ Sprain/Strain
☐ Arthritis
☐ Broken Bones
☐ Depression
☐ Epilepsy
☐ Fatigue
☐ Hand Pain
☐ Leg Pain
☐ Minor Heart Problems
☐ Neurological Problems
☐ Polio
☐ Significant Weight Change
☐ Stroke/Heart Attack

Other: _____

_____

What Medications are you taking? (we can make a copy if you have a list)

_____

_____

Mark your Family History: Please indicate who in your family has the condition

	Mother	Father	Sibling	Maternal G. Mother	Maternal G. Father	Paternal G. Mother	Paternal G. Father	Aunt	Uncle	Other
☐ Arthritis										
☐ Back Pain										
☐ Cancer										
☐ Depression										
☐ Diabetes										
☐ Spinal Condition										
☐ Headaches										
☐ High blood Pressure										
☐ Heart Problems										
☐ Stroke/Heart Attack										

Other: _____

Additional Questions

Have you had any auto accidents or injuries? Yes No

Describe:_____

_____

Date of last Physical Examination: _____/_____/_____

Have you been hospitalized recently? No Yes

If yes, please explain _____

Have you had any illness in the past? _____

Do you smoke? No Yes **Do you drink alcohol?** No Yes --- **how many per day**?_____

Do you drink caffeine? No Yes --- how many per day?_____

Do you exercise? No Yes (What forms and how often): _____

I certify that the information that I have given here is true and accurate to the best of my knowledge.

X _____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

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 more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
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.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only 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.

Personal Care

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 I 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.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

FISHER CHIROPRACTIC

Privacy and HIPAA

_____ Initial **-This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at any time from the front desk. Please initial and sign at the bottom to indicate you have been made aware of its availability. *I also understand there is a possibility my conversations may be overheard since there are no doors on the exam rooms. I may request, prior to my appointment, to have time set aside to discuss matters in a more private manner.***

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other therapy procedures to be performed on myself by the doctor. I also consent to the procedures performed by his trained staff assistants under direct instruction and supervision.

I have had an opportunity to discuss with the doctor or other office personnel the nature and purpose of chiropractic adjustments and other therapy procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee to results has been made to, nor relied upon by, me, and I wish to rely on the doctor to exercise judgment during the course of the procedures which he feels at the time, based upon the facts then known, is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic procedures is very low, anyone undergoing chiropractic adjustments, physical therapy services or joint manipulation procedures should know of possible complications, which have been alleged. These include, but are not limited to; burns, fractures, disc injuries, strokes, dislocations, sprains, increase or worsening of symptoms and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had the opportunity to ask questions about its' contents, and by signing below, acknowledge my understanding of its contents.

_____

Please print name of Patient

X

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**

Patient-Doctor Agreement

Initial **ONE** CORRECT FORM OF PAYMENT

The purpose of this agreement is to make sure we are able to best serve you. The scheduled appointments are made for a reason, they attempt to keep patient wait times down and allow for the best patient care possible.

_____Initial **CASH PATIENT FINANCIAL POLICY –** All fees are due at the time of service unless pervious arrangements have been made with this office. For your convenience, future payments may be arranged at the first visit of each week. We are happy to **accept** cash, check, MasterCard, Visa, Discover, and American Express. We **do not** accept Care Credit.

_____Initial **MEDICARE –** Original Medicare covers 80% of approved services after the deductible is met. Medicare **does not** pay for evaluations, re-exams, or x-rays. Medicare **will not** pay for maintenance care, but episodes of care where notable progress is being made.

_____Initial **MAJOR MEDICAL/GROUP INSURANCE –** Payment is expected at time of visit, whether it is a co-pay or towards a deductible. Please give all insurance information (secondary policies included) to the Front Desk C.A. along with a copy of your card(s). Also, any payment sent to your home by the insurance company that is owed to Fisher Chiropractic must be brought to our office within three days.

_____Initial **AUTO ACCIDENT/PERSONAL INJURY –** Fees are **usually** covered 100% for these injuries; however, YOU are ultimately responsible for any balance on your account. When using PIP, personal injury protection, you are responsible for providing this office with the name of your insurance company and the adjustor's name and contact information. You are also responsible for reporting the accident to your insurance company/agent.

Phone Consent

! **I give Fisher Chiropractic my permission** to leave voice messages regarding my appointments, medical care and/or billing information on this number: _____

! **I give Fisher Chiropractic my permission <u>to discuss</u>** my medical care and/or billing information with the person(s) listed below:

Authorized Contact:_____ Relationship: _____

Authorized Contact:_____ Relationship: _____

X _____ _____

Signature of Patient, Parent, Guardian, or Personal Representative **Date**