MAYSVILLE / GEORGETOWN
Family Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip: _____

E-mail address:_____Fax # _____ Cell Phone:_____ Age:_____

Birth Date:_____ Race:_____ Marital: M S W D Occupation: _____

Employer:_____ Employer's Address:_____

Office Phone:_____ Spouse:_____ Spouse Occupation:_____ Spouse Birth Day:_____

How many children?_____ Names and Ages of Children:_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____ When doctors work together it benefits you.

May we have your permission to update your medical doctor regarding your care at this office? _____ YES _____ NO

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto_____ Work_____ Other_____

Have you ever had the same or a similar condition? □ Yes □ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken/Fractured Bones	__Osteoarthritis	__Eating Disorder	__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder	__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Ulcers	__ Coughing Blood			

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No If yes, describe: _____

_____

What medications or drugs are you taking?_____

Do you have any allergies to any medications? □ Yes □ No If yes, describe: _____

Do you have any allergies of any kind? □ Yes □ No If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____ Do you use any tobacco products?_____ Do you smoke?_____
If so, packs per day: _____ Do you take vitamin supplements?_____ If so, please list:_____

_____

Do you consume caffeine?____ If so, how much per day:_____ Do you exercise?_____ If yes, what is the frequency and type of exercise? ____

_____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting_____ sitting_____ bending_____ working at a computer_____

FAMILY HISTORY:

Parents:

Father: living ___ deceased___ Current age if still living:_____ Cause of /age at death if deceased:_____

Mother: living___ deceased___ Current age if still living:_____ Cause of /age at death if deceased:_____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____
_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

___Tuberculosis ___Cancer ___Mental Illness ___Diabetes ___Asthma ___Heart Disease ___Lung Disease ___Arthritis
___Kidney Disease ___Stroke ___Liver Disease ___Other _____

Please check any and all insurance coverage that may be applicable in this case:
□ Major Medical □ Medicaid □ Medicare □ Worker's Comp □ Auto Accident □ Medical Savings Account & Flex Plans
□ Other _____

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.
____INITIAL

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment. 2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions. 3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services. 4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. 5. Patients have the right to file a formal complaint with our privacy official about any suspected violations. 6. This office has the right to refuse treatment if the patient does not accept the terms of this policy. **_____INITIAL**

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor. **_____INITIAL**

By initialing and signing this form, the patient states to the best of their knowledge there is no pregnancy, neither confirmed nor suspected at the time this service was rendered. **_____INITIAL**

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time. **_____INITIAL**

Patient understands that they are responsible for payment to Family Chiropractic and that they are responsible for any and all collection costs in addition to their bill that may arise, including collections fees, court costs and reasonable attorney fees should action be taken. Accounts 90 days past due are subject to interest of 1 ½% per month on the unpaid balance. Patient hereby releases and forever discharges the aforesaid Doctor of Chiropractic from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment.
____INITIAL

By initialing and signing this form, the patient gives their permission to be contacted via Telephone, Text Message and/or Email for Appointment Reminders, Promotions and Well-Wishes. We will keep this information private for the sole use of Healing Hands, Inc.
_____INITIAL

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

ASSIGNMENT OF MEDICAL BENEFITS & INFORMED CONSENT

I understand that **my doctor is submitting my x-rays to Midwest Radiology Consultants for radiological evaluation**. I also understand that the fee for such services will be submitted to my insurance company, workers' compensation carrier, or my attorney.

I authorize my insurance company to **pay directly to Midwest Radiology Consultants for services rendered.**

In the event my insurance company, attorney, or workman's compensation carrier does not reimburse for the fee in full, or if I do not have insurance coverage, **I agree that I am directly responsible for the charges or any unpaid portion.** Returned checks for insufficient funds will be assessed a $20.00 service charge. ***Accounts delinquent by 90 days from the time of my 1st billing statement may be placed with a legal collection agency. I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.***

I understand that Dr. Doran L. Nicholson is not a participating provider in my insurance plan and that his services may not be covered by my insurance. ***I also understand that this service is not covered by Medicare or Medicaid.***

In the event that my insurance company sends payment directly to me, I agree to promptly remit such payments to Midwest Radiology Consultants.

Patient Signature:

_____

(Patient, Parent or Guardian)

Date: _____

MIDWEST RADIOLOGY CONSULTANTS
706 NE Langsford Rd.
Lee's Summit, MO 64063
Phone: 816 525-2822
800-454-2822
Doran L. Nicholson, D.C., D.A.C.B.R.

MIDWEST
RADIOLOGY
CONSULTANTS

706 N.E. LANGSFORD RD. (P.O. BOX 1122)
LEE'S SUMMIT, MO 64063
PHONE: 816 525-2822 FAX: 816 525-4540

Doctor Information:

Maysville Family Chiropractic

Dr. Rita Goldman

1335 Southgate Plaza

Maysville, KY 41056

Trauma? Y ☐ N ☐ Explain:

Malignancy? Y ☐ N ☐ Explain:

Areas of Concern:

Results Requested: ☐ Phone: 606-564-4213

☐ Fax: 606-564-4406

☐ E-Mail _____

Payment: ☐ Payment Enclosed ☐ Bill Patient ☐ Insurance ☐ Work Comp ☐ PI ☐ Auto Accident
(Date of Accident: ____/____/____)

CONFIDENTIAL

PATIENT INFORMATION		INSURED PARTY
Name:		Name:
Street:		Street:
City/State/Zip:		City/State/Zip:
Phone:	M ☐ F ☐	Phone:
Soc. Sec. #	Date of Birth:	Relation to insured: ☐Self ☐Spouse ☐Child ☐Other

INSURANCE INFORMATION		SECONDARY INSURANCE	
Company & Adjustor Name:		Company & Adjustor: Name:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone #	Claim #	Phone #	
Group #	Policy / ID #	Claim #	Group#

ATTORNEY INFORMATION		WORKER'S COMPENSATION CARRIER	
Name		Company Name:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone:		Phone	Claim#

Patient Name: _____Date:_____

LOW BACK INDEX- OSWESTRY REVISED

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than 1/2 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing
A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from sleeping at all.

SECTION 9--Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms off travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: %_____

Maysville Family Chiropractic
1335 Southgate Plaza
Maysville, KY 41056

Georgetown Family Chiropractic
100 East Side Drive
Georgetown, KY 40324

PATIENT NAME: _____DATE:_____

NECK DISIBILITY INDEX (REVISED)

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

DISABILITY INDEX SCORE: %_____

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

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