

Date \_\_\_\_\_ File \_\_\_\_\_

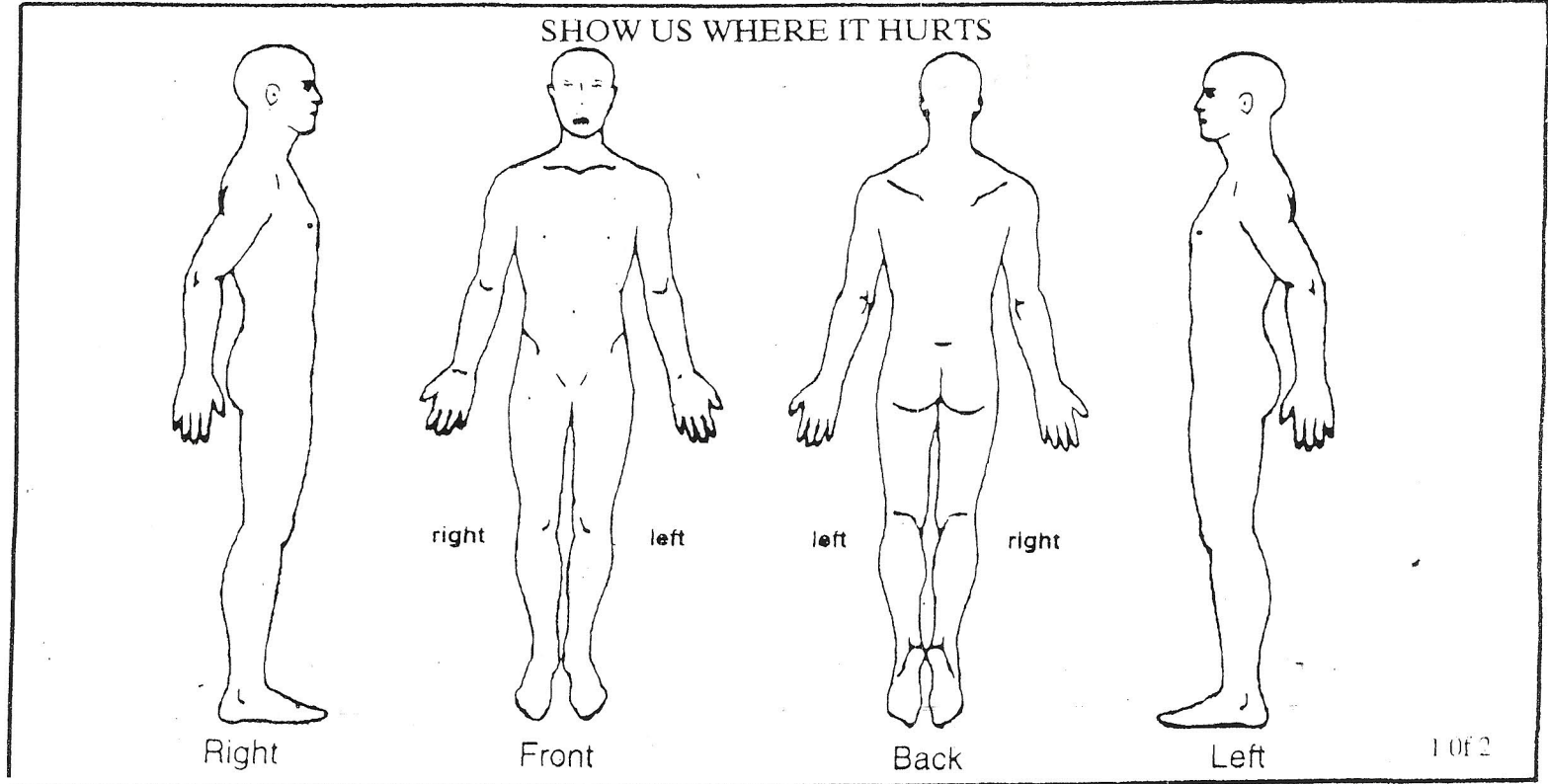
**PERSONAL**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_  
What do you prefer to be called? \_\_\_\_\_ SS# \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Number of children \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ How long? \_\_\_\_\_ Employer address \_\_\_\_\_  
Occupation \_\_\_\_\_ How long? \_\_\_\_\_  
Spouse \_\_\_\_\_ Spouse's employer \_\_\_\_\_  
Referred by \_\_\_\_\_ In case of emergency notify \_\_\_\_\_

**CURRENT CONDITION**

Please describe the principal health problems for which you came to this office. \_\_\_\_\_  
How and when did symptoms first occur? \_\_\_\_\_  
List any other doctors seen for these problems \_\_\_\_\_  
List any diagnosis (es) and type of treatment \_\_\_\_\_  
Are you taking any medications for the current condition? Yes \_\_\_\_\_ No \_\_\_\_\_ Have they helped? A lot \_\_\_\_\_ Some \_\_\_\_\_ Not at all \_\_\_\_\_  
Type of medications? Pain killers \_\_\_\_\_ Muscle relaxers \_\_\_\_\_ Anti-inflammatory \_\_\_\_\_ Other \_\_\_\_\_  
Have you lost any days of work? Yes \_\_\_\_\_ No \_\_\_\_\_ Dates \_\_\_\_\_  
Have you had similar symptoms before? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_

Check if you currently have or recently had any of the following.  
Trauma \_\_\_\_\_ Fever \_\_\_\_\_ Infection \_\_\_\_\_ Weight loss \_\_\_\_\_ Loss of bladder control \_\_\_\_\_ None \_\_\_\_\_



# HEALTH HISTORY

Check the following conditions/procedures you have/had

- |   |   |  |   |  |   |
|---|---|--|---|--|---|
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Arteriosclerosis       | <input type="checkbox"/> Colitis               | <input type="checkbox"/> Endometriosis        |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Rheumatoid Arthritis     | <input type="checkbox"/> Bone Fracture           | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Gallbladder Condition | <input type="checkbox"/> Hormone Replacement  |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Thyroid Condition        | <input type="checkbox"/> Bone Fusion             | <input type="checkbox"/> Heart Attack/Stroke    | <input type="checkbox"/> Gastric Reflux        | <input type="checkbox"/> Ovarian/Uterine Cyst |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Disc Herniation         | <input type="checkbox"/> Heart defect           | <input type="checkbox"/> Hemorrhoids           |   |
| <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Venereal Disease         | <input type="checkbox"/> Dislocations            | <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Kidney Condition      | <input type="checkbox"/> Prostate Condition   |
| <input type="checkbox"/> Gout               |   | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Liver Condition       | <input type="checkbox"/> Testicle Condition   |
| <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Sciatica                | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Rectal Polyps         |   |
| <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Scoliosis               | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Ulcers                |   |
| <input type="checkbox"/> Lupus              | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Tendon/Ligament Rupture |   |  |   |
| <input type="checkbox"/> Multiple Sclerosis |   | <input type="checkbox"/> TMJ Condition           |   |  |   |
|   |   | <input type="checkbox"/> Whiplash                |   |  |   |

Please Circle the appropriate letter for any of the following symptoms.

O-OCCASIONAL  
F-FREQUENT  
C-CONSTANT

## HEAD AND NECK

- ☐ O ☐ F ☐ C Severe/frequent Headaches
- ☐ O ☐ F ☐ C Jaw Pain
- ☐ O ☐ F ☐ C Eye Problems
- ☐ O ☐ F ☐ C Sinus Problems
- ☐ O ☐ F ☐ C Ear Problems
- ☐ O ☐ F ☐ C Nose Bleeding
- ☐ O ☐ F ☐ C Nose Discharge
- ☐ O ☐ F ☐ C Sore Throat
- ☐ O ☐ F ☐ C Dental Problems
- ☐ O ☐ F ☐ C Swollen Lymph Nodes

## GENITOURINARY

- ☐ O ☐ F ☐ C Bladder Trouble
- ☐ O ☐ F ☐ C Excessive Urine
- ☐ O ☐ F ☐ C Painful Urination
- ☐ O ☐ F ☐ C Discolored Urine
- ☐ O ☐ F ☐ C Urinary Infection

## RESPIRATORY

- ☐ O ☐ F ☐ C Difficulty Breathing
- ☐ O ☐ F ☐ C Coughing Blood
- ☐ O ☐ F ☐ C Coughing Phlegm
- ☐ O ☐ F ☐ C Chest Pain

## CARDIOVASCULAR

- ☐ O ☐ F ☐ C Pain over Heart
- ☐ O ☐ F ☐ C Rapid Heartbeat

## GASTROINTESTINAL

- ☐ O ☐ F ☐ C Weight Trouble
- ☐ O ☐ F ☐ C Excessive Thirst
- ☐ O ☐ F ☐ C Excessive Hunger
- ☐ O ☐ F ☐ C Poor Appetite
- ☐ O ☐ F ☐ C Heartburn
- ☐ O ☐ F ☐ C Abdominal Pain
- ☐ O ☐ F ☐ C Nausea/Vomiting
- ☐ O ☐ F ☐ C Diarrhea
- ☐ O ☐ F ☐ C Constipation
- ☐ O ☐ F ☐ C Black Stool
- ☐ O ☐ F ☐ C Bloody Stool

## MUSCULOSKELETAL

- ☐ O ☐ F ☐ C Back Pain
- ☐ O ☐ F ☐ C Neck Pain
- ☐ O ☐ F ☐ C Pain between Shoulders
- ☐ Pain or Numbness in:
- ☐ O ☐ F ☐ C Shoulders
- ☐ O ☐ F ☐ C Arms
- ☐ O ☐ F ☐ C Elbows
- ☐ O ☐ F ☐ C Hands
- ☐ O ☐ F ☐ C Hips
- ☐ O ☐ F ☐ C Legs
- ☐ O ☐ F ☐ C Knees
- ☐ O ☐ F ☐ C Feet
- ☐ O ☐ F ☐ C Swollen/Stiff Joints
- ☐ O ☐ F ☐ C Loss of Strength
- ☐ O ☐ F ☐ C Walking Problems

## NERVOUS

- ☐ O ☐ F ☐ C Seizures
- ☐ O ☐ F ☐ C Fainting
- ☐ O ☐ F ☐ C Dizziness
- ☐ O ☐ F ☐ C Paralysis
- ☐ O ☐ F ☐ C Loss of Feeling

## FEMALES ONLY

- ☐ O ☐ F ☐ C Vaginal Discharge
- ☐ O ☐ F ☐ C Irregular Vaginal Bleeding
- ☐ O ☐ F ☐ C Vaginal Pain
- ☐ O ☐ F ☐ C Breast Pain
- ☐ O ☐ F ☐ C Breast Lumps
- ☐ O ☐ F ☐ C Hot Flashes

## Please Answer

List any health conditions within the last year

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List any medications not listed previously that you currently use.

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## DO YOU:

- Wear heel lifts, arch supports, sole lifts, or inner soles? ☐ Y ☐ N
- Smoke? ☐ Y ☐ N
- Exercise? ☐ Y ☐ N
- Take Vitamins? ☐ Y ☐ N

Allergies \_\_\_\_\_

Usual sleeping position? Back \_\_\_\_\_ Stomach \_\_\_\_\_ Right Side \_\_\_\_\_ Left Side \_\_\_\_\_

Mattress: Age \_\_\_\_\_ Type \_\_\_\_\_ Is it comfortable Yes \_\_\_\_\_ No \_\_\_\_\_

How would you rate your overall health? Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Received chiropractic care before? Yes \_\_\_\_\_ No \_\_\_\_\_

## FEMALES ONLY:

- Are you currently pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_
- If yes, due date? \_\_\_\_\_
- Are you currently menstruating? Yes \_\_\_\_\_ No \_\_\_\_\_

List approximate date of any other operations, diseases, serious illnesses or accidents you have had.

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## Doctor's Notes:

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PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

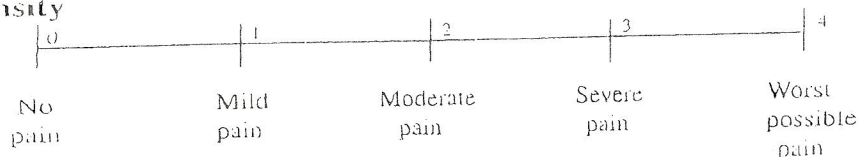
NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ FILE# \_\_\_\_\_

## Functional Rating Index

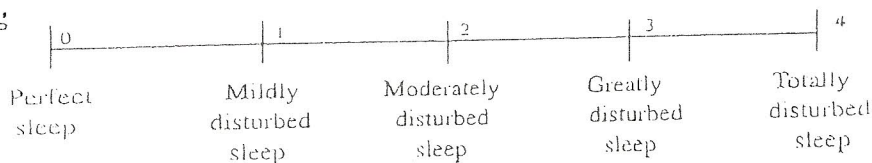
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

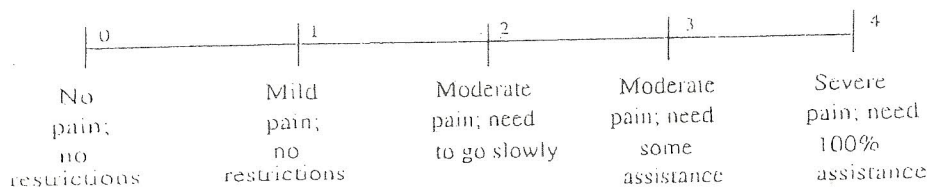
### 1. Pain Intensity



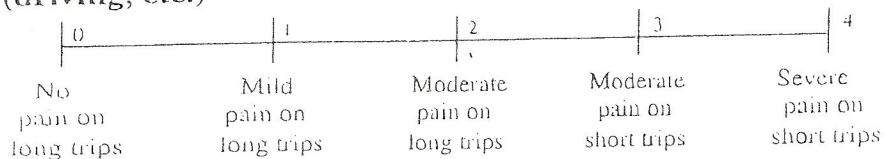
### 2. Sleeping



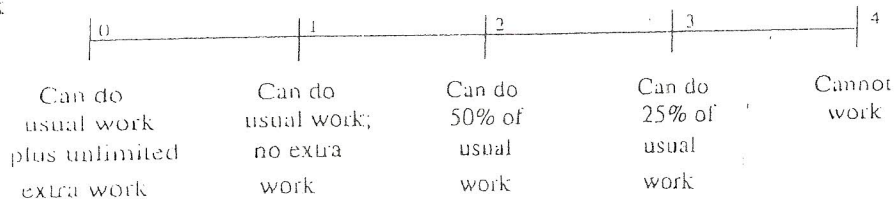
### 3. Personal Care (washing, dressing, etc.)



### 4. Travel (driving, etc.)

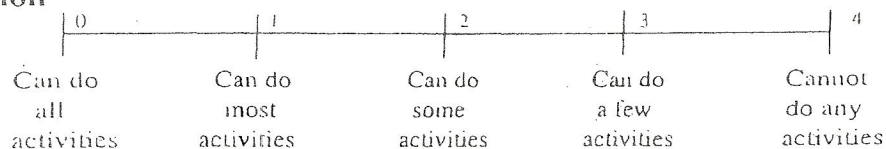


### 5. Work

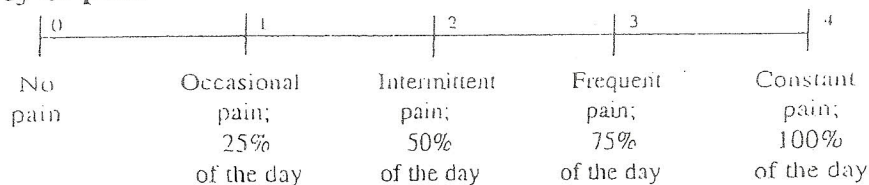


Please Turn Over

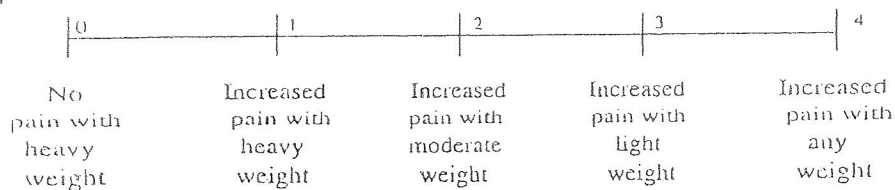
#### 6. Recreation



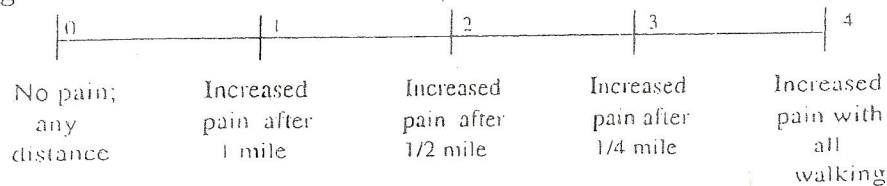
#### 7. Frequency of pain



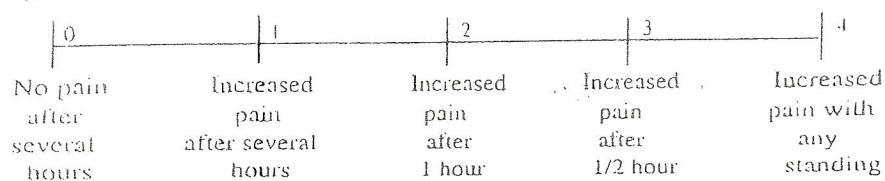
#### 8. Lifting



#### 9. Walking



#### 10. Standing



\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



Date: \_\_\_\_\_  
CA: \_\_\_\_\_

## PATIENT DATA SHEET

### General Information

First Name \_\_\_\_\_  
Middle Initial \_\_\_\_\_  
Last Name \_\_\_\_\_

Race (circle only 1)      American Indian      Alaska Native  
                                 Asian      White  
                                 Black or African American  
                                 Native Hawaiian      Other Pacific Islander  
                                 Declined to state

Ethnicity (circle only 1)      Declined to state      Hispanic or Latino  
                                 Not Hispanic or Latino

Preferred Language \_\_\_\_\_

Email Address \_\_\_\_\_

Smoking Status ( circle only 1)      Current Every Day Smoker  
                                 Current Some Day Smoker  
                                 Former Smoker  
                                 Never Smoker

Smoking Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

In an effort to quit smoking, I am currently taking: \_\_\_\_\_

Do you have any allergies to medication? Yes      No  
If yes, please indicate the following:

Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
End Date: \_\_\_\_\_

Allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_  
Start Date: \_\_\_\_\_  
End Date: \_\_\_\_\_

Are you currently taking any medications? Yes      No  
If yes, please indicate the following:

Medication: \_\_\_\_\_  
Route:      Oral  
                 Intravenous  
                 Other: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Began Use: \_\_\_\_\_  
Discontinued Use: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route:      Oral  
                 Intravenous  
                 Other: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Began Use: \_\_\_\_\_  
Discontinued Use: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route:      Oral  
                 Intravenous  
                 Other: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Began Use: \_\_\_\_\_  
Discontinued Use: \_\_\_\_\_

Medication: \_\_\_\_\_  
Route:      Oral  
                 Intravenous  
                 Other: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Began Use: \_\_\_\_\_  
Discontinued Use: \_\_\_\_\_

### For Office Use Only

Account Number \_\_\_\_\_  
Patient Height \_\_\_\_\_  
Patient Weight \_\_\_\_\_  
Patient BMI \_\_\_\_\_  
Patient Blood Pressure \_\_\_\_\_

**EASTMAN-KINGREY CLINIC  
CONSENT/RELEASE**

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_ FILE# \_\_\_\_\_

**PATIENT INFORMED CONSENT**

I hereby request and/or consent to the performance of chiropractic examinations and/or procedures on (or on the patient names above for who I am legally responsible) by Dr. Kenneth R. Eastman, Dr. Charles T. Kingrey, Jr. D.C. and/or Jana Kingrey D.C.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to strokes, sprains and strains, fractures, dislocations and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor will perform and examination in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its content, and by signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Doctor's Signature

**AUTHORIZATION TO RELEASE INFORMATION**

I authorize release of any medical information necessary to process any claims. I authorize payment of any medical benefits to be paid directly to Eastman-Kingrey Clinic for any medical services rendered to me. This authorization shall remain in effect until cancelled by me.

\_\_\_\_\_  
Patient Signature

**INSURANCE/PATIENT RESPONSIBILITY**

I have been informed and am aware that my health insurance coverage may have some limitations pertaining to chiropractic care. I am also aware that this could cause benefits to be denied or paid at a lower percentage rate due to such policy limitations as yearly maximum payment amounts, yearly number of visits limits, referral needed from primary care physicians, etc.

I am aware that my visits may not be covered by my insurance and that I will be fully responsible for payment of services rendered at such time that a denial is received from my insurance carrier.

\_\_\_\_\_  
Patient Signature

**CONSENT TO TREAT MINOR CHILD**

I hereby authorize:  
Dr. Kenneth R. Eastman, Dr. Charles T. Kingrey,  
Jr and/or Dr. Jana Kingrey and whoever he or  
she may designate as assistants to administer  
chiropractic care as deemed necessary to my  
\_\_\_\_\_ (indicate relationship  
to child).  
Name of child \_\_\_\_\_.

\_\_\_\_\_  
Parent/Guardian Signature

**VERIFICATION OF NON-PREGNANCY**

By my signature on this form, I hereby state that, to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time.

\_\_\_\_\_  
Patient Signature

## **EXPLANATION OF CHIROPRACTIC MEDICARE BENEFITS**

### **MEDICARE DOES NOT COVER CHIROPRACTIC CARE BUT WITH LIMITATIONS.**

The only service covered by Medicare is manual manipulation of the spine. These manipulations under some circumstances and with certain carriers are limited to 12 (twelve) per calendar year.

Your condition may require, in our judgment, more treatments than allowed by Medicare. We can apply for additional treatments by submitting a "medical necessity statement" on your behalf. Your case will be sent for review. We cannot guarantee or predict what the review board will decide in your case.

### **ANY VISITS OVER 12 (TWELVE) IN THIS CALENDAR YEAR, NOT APPROVED BY MEDICARE, WILL BE YOUR FINANCIAL RESPONSIBILITY.**

Medicare does not cover the cost of x-rays, examinations, therapy, supports, supplements or any other services offered in this office.

Any services other than spinal manipulation will be your financial responsibility.

I have read and understand the above statement.

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Patient Signature

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Date



Eastman-Kingrey Clinic

## Financial Policy

Eastman-Kingrey Clinic is happy to work with our patients to provide to provide the best quality of services. This letter is to acquaint you with our office billing procedures. Please read the following carefully and initial the appropriate method of payment. Your health insurance policy may have a deductible as well as a percentage (co-insurance or co-pay fee) for which you, the patient, are responsible for. Therefore, it is our policy to have all initial visit fees paid for, by the patient, at the time of his/her appointment.

Claims are sent out to insurance companies every Monday morning. Upon receipt of payment for services rendered, you will also receive statements from your insurance company, referred to as explanation of benefits (EOB's), which will inform you of any payments made. Since there are no guarantees of payment from the insurance company, you the patient are held liable for unpaid balances. **Health insurance is an agreement between the patient and the insurance company.** Insurance companies often send a payment directly to the clinic for services rendered to the patient and these funds are applied to your account balance for a specific day's service, on occasion the insurance company will send payment directly to the patient. If this occurs you can do 2 things, 1) endorse the payment and bring it to the clinic and the funds can be applied to the balance or 2) you keep the payment and are responsible for paying off the balance.

We encourage you to ask any questions you may have regarding our financial policy, so that you may have a clear understanding. Our goal is to concentrate on returning you to optimal health and establish overall well being, we have prepared the following checklist in order to help our patients determine their responsibility toward payment for chiropractic services please check the statement that applies to you:

\_\_\_\_\_ Private insurance: I understand that as a service to me, Eastman-Kingrey Clinic will bill my insurance company for services rendered, however; I fully understand that it is my financial responsibility to be liable for all healthcare expenses regardless of insurance coverage. I agree to assume all financial responsibility.

\_\_\_\_\_ Medicare: I am eligible for Medicare and I understand it reimburses only **for manipulation of the spine, it does not reimburse for therapy or x-rays.** I, the patient, am responsible for payment of spinal manipulation, therapy, and x-rays at the time of service. I understand that Medicare will only reimburse up to the 12<sup>th</sup> visit, they will not reimburse if there is no medical necessity or for maintenance care.

\_\_\_\_\_ Private Pay (Cash): As I have no insurance or third parties liable for my healthcare expenses, I agree to assume all payment responsibility and keep my account current. (Please be sure to talk with our office about pre-payment incentives and payment options.)

My signature gives this office permission to give out any pertinent information to any insurance company, attorney, or adjustor who needs this information to facilitate the payment of a claim. A photocopy of this shall be deemed valid.

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date



## CHIROPRACTIC ASSOCIATION OF LOUISIANA AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Chiropractic Association of Louisiana (CAL). This disclosure will be made if we need the CAL's assistance to receive reimbursement for your services or, we need the CAL's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the CAL this information. You are also giving the CAL authorization to re-disclose your information to the party responsible for the payment of your services, the CAL's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to whom your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we may send to the CAL at any time. (§164.524).

This notice is effective as of \_\_\_\_\_. This authorization will expire six years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal representative printed

\_\_\_\_\_  
Personal representative signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient.

Clinic Name

## CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

### Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

### Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

### Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

EASTMAN-KINGREY CLINIC  
902 Sampson Street  
Westlake, La 70669

(337) 436-3145

### **Consent to use PHI**

#### **Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

##### **Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Eastman-Kingrey Clinic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

##### **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. \_\_\_\_\_ Patient Initials

##### **Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

##### **Notice of Treatment in Open or Common Areas**

Describe and Notify private areas available upon request

##### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



## APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. If we are unable to reach you at home, we will leave a message at your worksite on an answering machine or with a co-worker.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of the date below. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Authorized provider representative

\_\_\_\_\_  
Personal representative (printer)

\_\_\_\_\_  
Personal representative signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient



# NECK DISABILITY INDEX QUESTIONNAIRE

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_ SCORE \_\_\_\_\_

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your 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 THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

<b>SECTION 1 - Pain Intensity</b> A. I have no pain at the moment. B. The pain is very mild at the moment. C. The pain is moderate at the moment. D. The pain is fairly severe at the moment. E. The pain is very severe at the moment. F. The pain is the worst imaginable at the moment.	<b>SECTION 6 - Concentration/</b> 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.
<b>SECTION 2 - Personal Care (Washing, Dressing, etc.)</b> A. I can look after myself normally 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.	<b>SECTION 7 - Work</b> 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.
<b>SECTION 3 - Lifting</b> A. I can lift heavy weights without extra pain. B. I can lift heavy weights, but it gives extra pain. C. Pain prevents me from lifting heavy weights off the floor, but I can manage 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.	<b>SECTION 8 - Driving</b> A. I can drive my car without any 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 at all because of severe pain in my neck. F. I cannot drive my car at all.
<b>SECTION 4 - Reading</b> 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 to with slight pain in my neck. C. I can read as much as I want to 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.	<b>SECTION 9 - Sleeping</b> 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)
<b>SECTION 5 - Headaches</b> A. I have no headaches at all. B. I have slight headaches which come infrequently. C. I have moderate headaches which come infrequently. D. I have moderate headaches which come frequently. E. I have severe headaches which come frequently. F. I have headaches almost all the time.	<b>SECTION 10 - Recreation</b> A. I am able to engage in all of my recreational activities with no neck pain at all. B. I am able to engage in all of my recreational activities with some pain in my neck. C. I am able to engage in most, but not all of my recreational activities because of pain in my neck. D. I am able to engage in a few of my 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 at all.

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely 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 very severe.
- ☐ The pain is severe and does not vary much.

#### SECTION 2 - PERSONAL CARE

- ☐ 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 causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I 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.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half hour
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

#### 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 straight away.

#### 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 night's 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 - TRAVELLING

- ☐ I get no pain whilst travelling.
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain whilst travelling but it does not compel me to seek alternative form of travel.
- ☐ I get extra pain whilst travelling 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 at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

#### Pain Severity Scale:

Rate your usual level of pain today by checking one box on the following scale

0	1	2	3	4	5	6	7	8	9	10
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No pain

Excruciating pain