

Chiropractic & Wellness Center, PC

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 DOB _____ SS# _____ Marital Status: S M D W Sex: M/F Age _____
 Occupation _____ Employer _____
 Work Address _____
 If applicable:
 Parents/Legal Guardians Name _____
 Address _____
 Home Phone _____ Work Phone _____
 No. of Children _____ How did you hear about our office? _____

Main Complaint

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. What is your treatment goal? _____
4. If this is a recurrence, when was the first time you noticed the problem? _____
5. How did it originally occur? _____
6. Has it become worse recently? Yes ___ No ___ Same ___ Gradually Worse ___
 If yes, when and how? _____
7. How frequent is this condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
8. How long does it last? All Day ___ Few Hours ___ Minutes ___
9. How many days have you lost from work due to these symptoms? _____
10. Are there any other conditions or symptoms that may be related to your major symptoms
 Yes ___ No ___. If yes, describe _____
11. Are there other related health problems? Yes ___ No ___ If yes, describe _____
 Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___ Burning ___
 Stabbing ___ Other _____
12. Is there anything you can do to relieve the problem? Yes ___ No ___
 If yes, Describe _____
 If no, what have you tried to do that has not helped? _____
13. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___ Lifting ___ Twisting ___
 Other _____
14. Have you had any broken bones? Yes ___ No ___. If yes, please list and give dates _____
15. List any major accidents you have had other than those that might be mentioned above _____
16. To you knowledge, have you had any disease, major illnesses, or injuries not indicated on this form either in past or the present? _____
17. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes ___ No ___ Uncertain ___
 Remarks: _____

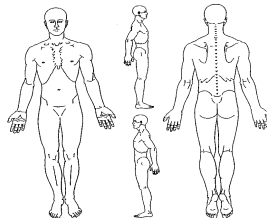
NO PAIN

Unbearable Pain

[_____]

Please place an "X" on the line above to indicate level of problem

Show area(s) of
pain, discomfort
or unusual
feeling



Medical History

Past Chiropractic care / doctor's name _____
 Family physician _____ Medications _____
 Surgeries / dates _____
 Illness / abnormalities _____
 Previous Injuries & accidents / dates _____

Do you have any difficulty with any of the following?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Low Blood pressure | <input type="checkbox"/> Menstrual cramps & pain |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Anemia | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Light bothers eye | <input type="checkbox"/> Nervous Stomach | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Asthma/allergies | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Tightness in throat | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Nerves & Nervousness | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Inflammation of throat | <input type="checkbox"/> Neuritis in shoulders & arms | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Pins & needles in hand | <input type="checkbox"/> Irritability | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Gall Bladder trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart pain | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Pains in legs & feet |
| <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weight loss | | |

Family Medical History

- | | | | |
|---------------|---------------|---------------------------|-----------|
| Breast Cancer | Other Cancers | Cardiovascular disease | Stroke |
| Osteoporosis | Alcoholism | Mental Illness/depression | Obesity |
| Alzheimer's | Diabetes | Arthritis | Allergies |

Please place an "F" for father or father's side or "M" for mother's side of the family in front of anything you marked in the section above

Lifestyle and Diet

Rate your current level of stress on a scale of 1 to 10 (1=low): 1 2 3 4 5 6 7 8 9 10

What are major causes? Work Family Finances Relationships Emotions
 Other _____

I eat the following: Sweets Sodas/Pop Ice Cream Fried Foods
 Cereals Legumes Fruits Vegetables

List your 4 favorite foods: _____

This applies to me: Diet frequently Skip meals Dine out regularly

Eat (0 1 2 3 4 5 6 more) meals a day

When do you eat? Morning Noon Night Constantly snacking

Do you:

-Use tobacco? YES or NO If yes, how much daily? _____
 If no, did you ever? YES or NO if yes how much? _____

-Have exposure to second hand smoke? YES or NO If yes, how much daily? _____
 If no, did you ever? YES or NO if yes how much? _____

-Drink Coffee? YES or NO If yes, how much daily? _____
 If no, did you ever? YES or NO if yes how much? _____

-Eat Chocolate? YES or NO If yes, how much daily? _____

-Drink Alcohol? YES or NO If yes, how many ounces a day/week? _____
 If no, did you ever? YES or NO if yes how much? _____

-Restrict your intake or avoid completely:
 How long did you drink before you stopped? _____

- | | | | |
|----------------|-----------------|------------------|-------|
| Fiber | Salt | Sugar | Fat |
| Dairy products | Animals protein | All animal foods | Other |

Exercise

Exercise weekly? YES or NO If yes, how many times per week? _____

I agree that the information I provided is correct _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

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Score**

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only 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.

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CHIROPRACTIC & WELLNESS CENTER (CWC) CONSENT FORM

For Use and Disclosure of Protected Health Information (PHI)

In signing this form, you consent to the use and disclosure of your protected health information by Chiropractic & Wellness Center, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You have the right to review our *Notice of Privacy Practices* prior to signing this consent. We encourage you to review our *Notice of Privacy Practices*. It provides more detail on how we may use and disclose your information. The *Notice of Privacy Practices* may change. A current copy may be requested when you are being seen as a patient, by contacting our facility at (317) 580-9867.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please ask for a separate form. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the *Notice of Privacy Practices* for further information.

By signing this form, I grant my consent for Chiropractic & Wellness Center to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Signature of Patient or

Surrogate Decision Maker: _____ **Date:** _____

Relationship to Patient/ Legal

Authority (if applicable): _____

For CWC Use Only:

Failure to obtain consent check the appropriate reason:

____ Indirect treatment relationship exists ____ Emergency treatment

____ Substantial barriers in communication ____ Refusal to sign

____ Other

Description:

CWC Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Financial Policy

Insurance Coverage

Welcome to Chiropractic and Wellness Center. Your insurance policy is an agreement between you and your insurer, not between your insurer and this office. Coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay a co-insurance, co-payment and/or deductible. For example: if you have a deductible of \$100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your \$100 at the beginning of the year. Our office will call your insurer to verify your benefits, however, this is NOT a guarantee of payment from your insurer.

Payments

In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

Private Pay: (please initial)

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B _____ I have insurance, but your office is OUT OF NETWORK, and I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

Health Insurance: (please initial)

C _____ I would like this clinic to bill my insurance. I understand I am responsible for the cost of treatment(s).

Missed Appointments

It is the policy of Chiropractic and Wellness Center to assess a \$ 10.00 missed visit fee to Chiropractic appointments, and one half the fee of all massage appointments, to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This office provides care for many individuals and missed office visits result in time lost that could have been used to provide care for others.

_____ My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.

Signature

Date