Meitz Family Chiropractic PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____ Occupation: _____

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

List any **Allergies**:

z Animals z Aspirin z Bees z Chocolate z Dairy z Dust z Eggsz Latex z Molds z Penicillin z Ragweed/Pollen

z Rubber z Seasonal Allergies z Shellfish z Soaps z Wheat z X-Ray Dye z Other: _____

List any **Surgeries**:

z Back z Brain z Elbow z Foot z Hip z Knee z Neck z Neurological z Shoulder z Wrist z Other: _____

List **ALL Past Medical History** conditions:

z Ankle Pain z Arm Pain z Arthritis z Asthma z Back Pain z Broken Bones z Cancer z Chest Pain z Depression

z Diabetes z Dizziness z Elbow Pain z Epilepsy z Eye/Vision Problems z Fainting z Fatigue z Foot Pain

z Genetic Spinal Condition z Hand Pain z Headaches z Hearing Problems z Hepatitis z High Blood Pressure

z Hip Pain z HIV z Jaw Pain z Joint Stiffness z Knee Pain z Leg Pain z Menstrual Problems z Mid-Back Pain

z Minor Heart Problem z Multiple Sclerosis z Neck Pain z Neurological Problems z Pacemaker z Parkinson's

z Polio z Prostate Problems z Shoulder Pain z Significant Weight Change z Spinal Cord Injury z Sprain/Strain

z Stroke/Heart Attack z Other: _____

List Type of **Medications** you are taking:

z Anxiety z Muscle Relaxors z Pain Killers z Insulin z Birth control z Cardiovascular z Allergy z Seizure

z Other: _____

List your **Family History**:

z Arthritis z Asthma z Back Pain z Cancer z Depression z Diabetes z Epilepsy z Genetic Spinal Condition

z High Blood Pressure z Heart Problems z Multiple Sclerosis z Neurological Problems z Parkinson's z Polio

z Prostate Problems z Stroke/Heart Attack z Other: _____

Have you had any auto or other accidents? z No z Yes

Describe: _____

Please tell us how you Heard about our office

_____

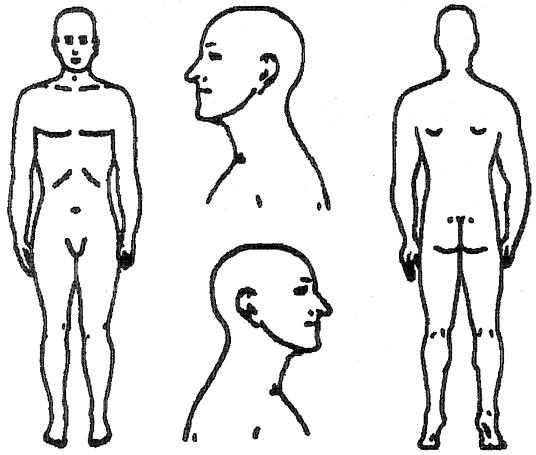
Date of last physical examination: _____ Do you smoke? z No z Yes

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

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

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

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

z Become pain free
z Explanation of my condition
z Learn how to care for my condition
z Reduce symptoms
z Resume normal activity level

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? z GETTING BETTER z GETTING WORSE z NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

z Constantly (76-100% of the day) z Frequently (51-75% of the day)

z Occasionally (26-50% of the day) z Intermittently (0-25% of the day)

Describe the nature of your symptoms: z Sharp z Dull z Numb z Burning z Shooting z Tingling z Radiating Pain

z Tightness z Stabbing z Throbbing z Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your SECOND complaint? _____Date problem began?

_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? z GETTING BETTER z GETTING WORSE z NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

z Constantly (76-100% of the day) z Frequently (51-75% of the day)

z Occasionally (26-50% of the day) z Intermittently (0-25% of the day)

Describe the nature of your symptoms: z Sharp z Dull z Numb z Burning z Shooting z Tingling z Radiating Pain

z Tightness z Stabbing z Throbbing z Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) z 1 z 2 z 3 z 4 z 5 z 6 z 7 z 8 z 9 z 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Meitz Family Chiropractic

Activities of Daily Living Assessment

Rate your current difficulties by placing the appropriate number in the box.

If an activity does not cause pain or if pain does not affect an activity, leave box blank.

[1] This activity causes some pain, but it is only a minor annoyance.
[2] This activity causes a significant amount of pain, but I can do it.
[3] I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

[ ] bathing/showering [ ] brushing teeth [ ] putting on shoes [ ] eating [ ] doing laundry
[ ] grooming hair [ ] making the bed [ ] putting on pants [ ] dishes [ ] going to toilet
[ ] washing face [ ] putting on shirt [ ] cooking [ ] taking out trash

Physical Activities

[ ] standing [ ] walking [ ] reaching [ ] bending right [ ] twisting right
[ ] sitting [ ] squatting [ ] bending forward [ ] bending left [ ] twisting left
[ ] reclining [ ] kneeling [ ] bending back [ ] looking left [ ] looking right

Functional Activities

[ ] carrying small objects [ ] lifting weights off table [ ] pushing/pulling while standing
[ ] carrying large objects [ ] climbing stairs/incline [ ] exercising upper body
[ ] carrying briefcase/purse [ ] pushing/pulling while seated [ ] exercising lower body
[ ] lifting object off floor

Social and Recreational Activities

[ ] bowling [ ] jogging [ ] swimming [ ] golfing [ ] dancing
[ ] biking [ ] hunting/fishing [ ] competitive sports [ ] gardening
[ ] walking [ ] horse riding [ ] other:

_____

Difficulties with Traveling

[ ] driving in car [ ] driving for long periods of time
[ ] riding as passenger [ ] riding as passenger for long periods of time

Other activities

Use this scale for the following activities:
[1] This activity is slightly affected by my condition
[2] This activity is moderately affected by my condition
[3] This activity is severely affected by my condition
[4] I cannot perform this activity due to my condition

[ ] concentrating [ ] listening [ ] reading [ ] studying [ ] writing [ ] using computer
[ ] sleeping [ ] sexual relations

Patient Name: _____ Date of Birth: _____ Doctor Signature: _____

BQ PRE-TREATMENT (Baseline)

This questionnaire is about the pain complaint you have presented for treatment at this clinic. We want to evaluate your treatment and therefore need to ask you now and in the future about your painful complaint and how you are doing. Please answer every question in order. The information you give will be treated in complete confidence. For EACH question, please tick ONE box only unless instructed otherwise.

Q1 **PATIENT: START HERE: YOUR SURNAME:**

Q2 TODAY'S date:

Q3 Age (years):

Q4 Are you?

Male ☐ Female ☐

Q5 What place(s) do you feel most pain? (more than one box allowed)

Low back ☐ Headache ☐
Leg ☐ Shoulder/arm ☐
Neck ☐ Other ☐

Q6 If your pain is in your back or neck, does it go down into your leg(s) or your arm(s)?

Yes ☐ No ☐

Q7 Have you had this SAME or a similar complaint anytime in the PAST?

Yes ☐ No ☐

Q8 Have you had a WHOLE MONTH in the past 6 months WITHOUT any pain from a similar complaint?

Yes ☐ No ☐

Q9 How long has this PRESENT EPISODE of your painful complaint lasted?

Less than 1 week ☐ Between 1 and 3 months ☐
Between 1 and 4 weeks ☐ More than 3 months ☐

Q10 How would you describe this PRESENT EPISODE of your pain?

Comes and goes ☐ There constantly ☐

Q11 Has this PRESENT EPISODE of your painful complaint been bad enough to limit your usual activities or change your daily routine for MORE THAN ONE DAY?

Yes ☐ No ☐

Q12 Are you taking medication ON A DAILY BASIS, either bought over-the-counter at a pharmacist or prescribed by your GP, for this PRESENT EPISODE of your painful complaint?

Yes ☐ No ☐

Q13 Have you sought help from ANY OTHER PRACTITIONER, such as your GP or another healthcare professional, for this PRESENT EPISODE of your painful complaint?

Yes ☐ No ☐

Q14 How do you expect your condition to RESPOND TO TREATMENT in the next few weeks?

Recover/ improve ☐ Stay about the same ☐
Get worse ☐

Q15 Are you currently in PAID EMPLOYMENT?

Yes ☐ No ☐

Q16 Have you taken any time OFF WORK for this PRESENT EPISODE of your painful complaint?

Not in paid employment ☐ Yes, 1-2 days ☐
Yes, 3-7 days ☐
In paid employment but not taken any time off work ☐ Yes, 1-3 weeks ☐
Yes, more than 3 weeks ☐

Q17 Do you smoke?

Yes ☐ No ☐

Q18 Compared with people of a similar age and in a similar position, how would you rate your OVERALL PHYSICAL ACTIVITY?

More/about the same ☐ Less ☐

Q19 Apart from this complaint, how would you rate your GENERAL HEALTH and WELL-BEING?

Excellent/Good ☐ Fair/Poor ☐

CONTINUED OVERLEAF

Put a CROSS **X** in ONE box for EACH of the following statements that best describes your painful complaint and how it is affecting you NOW. Please read each question carefully before answering.

Q17 Over the past few days, on average, how would you rate your pain on a scale where '0' is 'no pain' and '10' is 'worst pain possible'?

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

Q18 Over the past few days, on average, how has your complaint interfered with your daily activities (housework, washing, dressing, lifting, walking, reading, driving, climbing stairs, getting in/out of bed/chair, sleeping) on a scale where '0' is 'no interference' and '10' is 'completely unable to carry on with normal daily activities'?

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

Q19 Over the past few days, on average, how much has your painful complaint interfered with your normal social routine including recreational, social and family activities, on a scale where '0' is 'no interference' and '10' is 'completely unable to participate in any social and recreational activity'?

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

Q20 Over the last few days, on average, how anxious, (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling, on a scale where '0' is 'not at all anxious' and '10' is 'extremely anxious'?

	0	1	2	3	4	5	6	7	8	9	10
Not at all anxious	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q21 Over the past few days, how depressed (down-in-the dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling, on a scale where '0' is 'not at all depressed' and '10' is 'extremely depressed'?

	0	1	2	3	4	5	6	7	8	9	10
Not at all depressed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q22 Over the past few days, how do you think your work (both inside the home and/or employed work) have affected your painful complaint, on a scale where '0' is 'make it no worse' and '10' is 'make it very much worse'?

	0	1	2	3	4	5	6	7	8	9	10
Makes it no worse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q23 Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your pain on your own, on a scale where '0' is 'I can control it completely' and '10' is 'I have no control whatsoever'?

	0	1	2	3	4	5	6	7	8	9	10
I have complete control over my pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature_____Date_____

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

Meitz Family Chiropractic, LLC.
Dr. Tom Meitz
450 S. Trooper Road, Norristown, Pennsylvania, 19403
Phone (610) 539-5000
Fax (610) 539-8350

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Tom Meitz and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Tom Meitz and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient: To be completed by the patient's representative, if necessary, (eg: if the patient is a minor or is physically or mentally incapacitated.

_____ _____
Printed Patient Name Date

_____
Signature of Patient

_____
Printed Name of Representative

_____
Signature of Representative

Meitz Family Chiropractic, LLC.
Dr. Tom Meitz
450 S. Trooper Road, Norristown, Pennsylvania, 19403
Phone (610) 539-5000
Fax (610) 539-8350

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, which will be added to the account at the time it is referred to collections, along with all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

_____ _____

Signature Date