APPLICATION FOR CARE AT NO LIMITS CHIROPRACTIC

Today's Date: _____ **Acct. #:**_____

PATIENT DEMOGRAPHICS

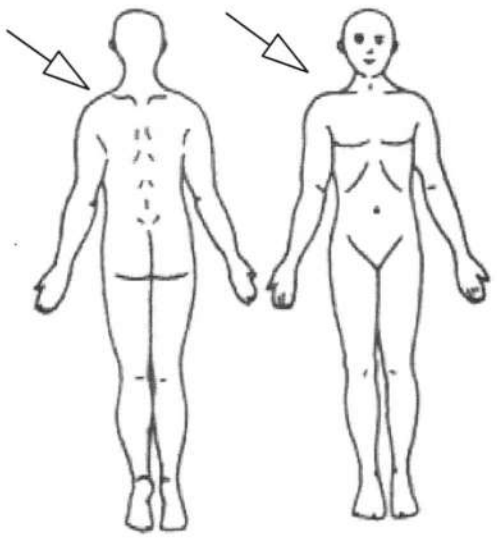
Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female
Name you wish to be called in our office: _____
Address: _____ City:_____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Name of Spouse: _____ Spouse's Employer:_____
Occupation: _____
Names and Ages of your children:_____
Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT(s)

Primary Problem: _____ **When did problem begin?** _____
What relieves your symptom? Rest Ice Heat Movement Stretching Other:_____
What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other_____
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?**_____
How long does this problem last? _____ **# of prior episodes?** _____
Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today:
(**Circle the number**): 0 1 2 3 4 5 6 7 8 9 10

Secondary Problem: _____ **When did problem begin?** _____
What relieves your symptom? Rest Ice Heat Movement Stretching Other:_____
What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other_____
Frequency: Off & On / Constant **Does the pain radiate?** No / Yes **Where?**_____
How long does this problem last? _____ **# of prior episodes?** _____
Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today:
(**Circle the number**): 0 1 2 3 4 5 6 7 8 9 10

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull
A = Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



Do your symptoms cause you to feel worse in the ☐AM ☐PM ☐ mid-day ☐ late PM
Have these Problems ever been treated by anyone in the past? ☐No ☐Yes
If yes, Who provided: _____
How long ago? _____What **type** of treatment did you receive? _____
What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:_____
List any **medications** taken to treat these conditions:_____
Did they help? ☐ No ☐ Yes If you still take them how often? _____
Have you ever been under chiropractic care? ☐ No ☐ Yes
If yes, how long ago: _____ Name of Previous Chiropractor: _____
Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes
If yes, How long ago? _____ Please explain what type of accident:

_____

PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past, C** for **Currently** have and **N** for **Never** have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___Diabetes ___ Other_____

2. PLEASE, **identify** ALL PAST **and any** unrelated current **conditions you feel may be contributing your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS			
ADULT DISEASES			
SURGERIES			
CHILDHOOD DISEASES			

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes **If yes whom**:
❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister(s) ❑ Brother(s) ❑ Son(s) ❑ Daughter(s)
2. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
3. Any other hereditary conditions the doctor should be aware of ❑ No ❑Yes _____

What health goals do you hope to accomplish in our office?
Short Term: _____
Long Term: _____

Whom may we thank for referring you into our office today? _____

How do you plan to take care of your charges today? ❑ Cash ❑ Check ❑ Credit Card

For Women Only: Are you pregnant? (circle one) **Yes** **No**

Reserved for doctor's use only → Systems reviewed with patient:
❑Musculoskeletal
❑Neurological

Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include, sprain/strain injuries, irritation of a disc condition, and - although rare- minor fractures. One of the rarest complications associated with Chiropractic cares (occurring at a rate between one instance per one million to one instance per two million) is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted by the doctor(s) in practice. This form was not signed until all my questions regarding treatment were answered to my complete satisfaction, and I conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor discussed with me that he/she deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Completed

Reviewed by: _____ _____
Reviewer Initials Doctors Initials

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only 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.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only 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.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

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 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra 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.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

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 the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Notice of Privacy Practices – HIPPA

NO LIMITS CHIROPRACTIC
109 Church St.
O'Fallon, MO 63366

Patient Name: _____ Date: _____

May we leave personal medical information on your answering machine or cell phone?
YES NO

Who do you give us permission to discuss your medical information with?

No one _____ (please initial)

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
My signature below indicates that I have read and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Privacy Practices).
Pamphlets available in reception area.

Patient or Responsible Party Signature: _____ Date: _____

No Limits Office Policy

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up-to-date. This will allow you to obtain the health care you need and handle your fees in a convenient manner.

Insurance

We shall assist in all possible ways in helping you process and obtain all of the benefit for which you are eligible; but financial obligation is yours. For your own information, please check with your insurance company as to the policy benefits for which you are eligible. We will advise you to pay any amount due for the "deductible" or any other "non-covered" charges.

Personal Payment

For your convenience, we accept: cash, personal checks, ApplePay, MasterCard, Visa, and Discover. We will be happy to discuss your financial charges. Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay for any deductible amount, co-insurance or any other balance not paid by your insurance. **IN ORDER TO CONTROL YOUR COST OF COPAYS AND COINSURANCE, ALL SERVICES MUST BE PAID AT THE TIME OF SERVICE.**

No Show Policy

Your health is important to us and it is important for you to keep your scheduled appointments. When patients miss appointments without calling the office to cancel, we lose the ability to offer those appointment times to other patients. We require a 24 hour notice to change or cancel a scheduled appointment. **If you fail to show or cancel your appointment without a 24 hour notice you will be charged $40.00.** These charges will be the **patient's responsibility** and cannot be billed to your insurance company.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. I am aware that if my account is past due by 30 days, there will be a 1.5% finance charge added to my balance monthly. Should collection of services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required.

Security Video

This office is under video surveillance. I understand that video material will only be used for security and educational purposes in an educational setting intended for healthcare professionals only.

Consent

I hereby authorize and release the doctor and whomever he may designate as his assistant to administer treatments, physical examinations, x-ray studies, chiropractic care, or any clinic services that he deems necessary in my case.

I agree that if I discontinue my care for any reason: 1) Any time of service or other house discounts will be voided. 2) I will pay the balance in full at the time.

_____ _____

Patient/Guardian Signature Date