

# GILLIS / Chiropractic Clinic

Dr. J. Scott Gillis  
Chiropractic Physician

Please present valid identification and your insurance card to the front desk staff. All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

## PATIENT DEMOGRAPHICS

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  Male  Female

What you prefer to be called: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_  
*Street*

\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip Code*

Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

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

Marital Status:  Single  Married  Divorced  Separated  Widowed

Race:  American Indian/Alaska Native  Asian  African American  Native Hawaiian  Other Pacific Islander  
 White  
Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Occupation: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

How did you hear about us?  Referred by (Name): \_\_\_\_\_

Other: \_\_\_\_\_

## INSURANCE INFORMATION

**Please present insurance card to the front desk staff.**

## REASON FOR VISIT

Have you ever been treated by a chiropractor before?  Yes  No

If so, please explain when and why: \_\_\_\_\_

The reason for this visit is a result of:  Work  Sports  Auto  Trauma  Chronic

Explain what happened: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PATIENT HEALTH HISTORY**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Are you taking any of the following medications?  Nerve Pills  Pain Killers (Including Aspirin)  Muscle Relaxers  Stimulants  Blood Thinners  Tranquilizers  Insulin  Other: \_\_\_\_\_

Have you ever had any of the following diseases/medical condition(s)?

<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Artificial Valves
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> STD	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> Shingles	<input type="checkbox"/> Cancer
<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Emphysema/Glaucoma	<input type="checkbox"/> Anemia
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Severe/Frequent Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Ulcers/Colitis
<input type="checkbox"/> Fainting/Seizures/Epilepsy	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes/ Tuberculosis	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Lower Back Problems	<input type="checkbox"/> Artificial Bones/Joints	<input type="checkbox"/> Arthritis

Please list any other serious medical condition(s) you have or ever had: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list anything you may be allergic to: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any previous surgeries/treatments with dates: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any past serious accidents with dates: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you smoke?  Yes  No      How much? \_\_\_\_\_      How Long? \_\_\_\_\_

Are you wearing any of the following?  Heels  Lifts  Sole lifts  Inner Soles  Arch Supports

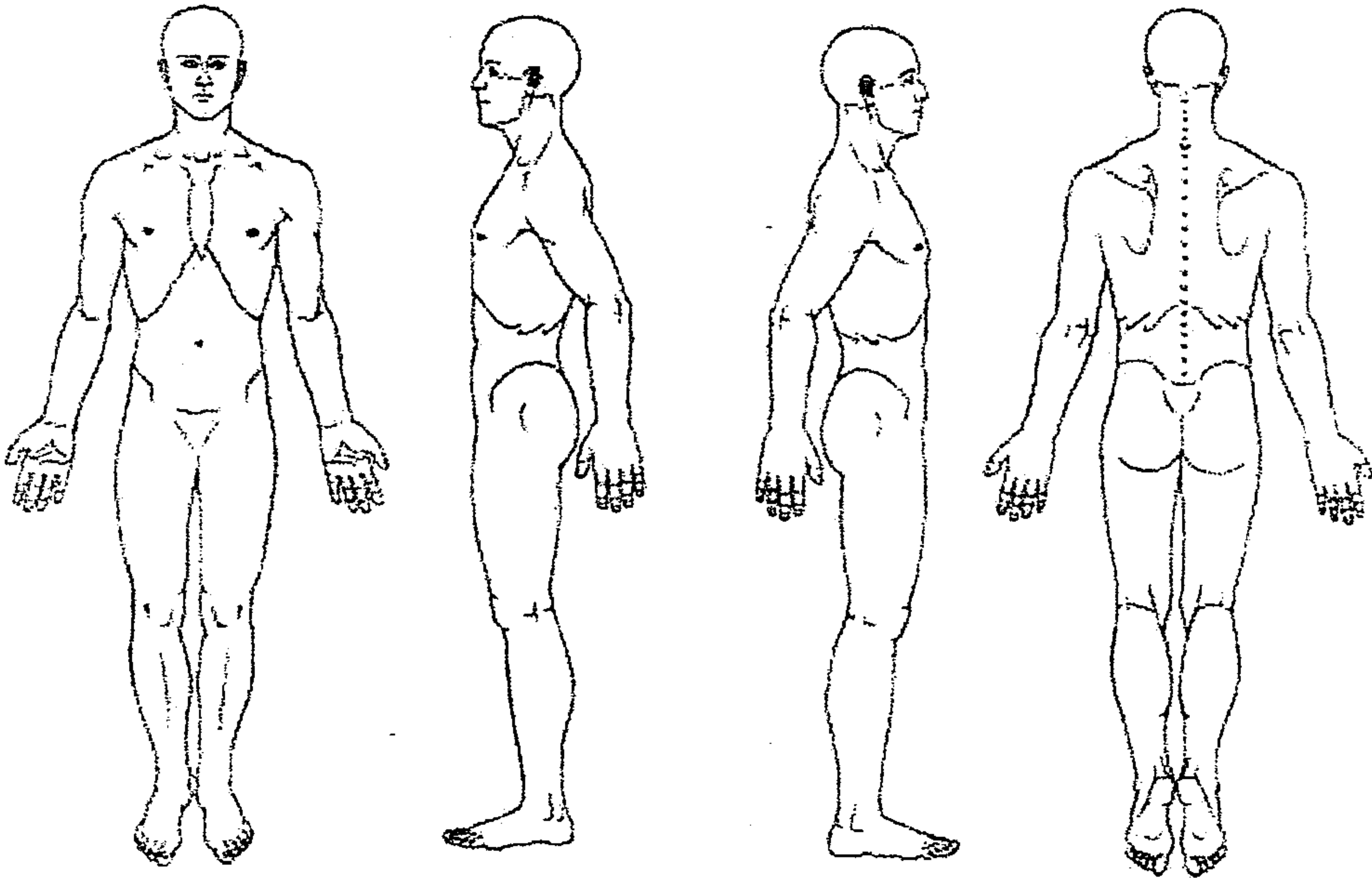
For Women:      Are you taking Birth Control?       Yes  No

Are you pregnant?       Yes  No      How Long? \_\_\_\_\_

**SHOW US WHERE IT HURTS**

Please mark area(s) of injury or discomfort. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description:    Numbness    Pins & Needles    Burning    Aching    Stabbing  
Symbol:            (N)            (P)            (B)            (A)            (S)  
Circle any area of pain not represented by a symbol



Patient Remarks: \_\_\_\_\_

\_\_\_\_\_

Doctor's Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Side / Back / Stomach Sleeper    Firm / Semi / Soft    W/ Pillow    Weather Bothers

Heat / Ice    Rx: \_\_\_\_\_    X/Day: \_\_\_\_\_

Worse Certain Time of Day / AM/PM    Positional / Lying / Sit / Stand / Walk

What Relieves Pain if Anything: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**PATIENT TREATMENT CONSENT FORM**

I authorize Gillis Chiropractic to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers or attorneys.

I authorize Gillis Chiropractic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

**Financial Responsibility / Assignment of Benefits**

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Gillis Chiropractic will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full from you.

I hereby request that my insurance carrier make payment directly to Gillis Chiropractic for all services rendered by this facility. If my current policy prohibits direct payment to Gillis Chiropractic, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Gillis Chiropractic.

If my insurance carrier makes a payment to me, I agree to immediately pay over these funds to Gillis Chiropractic. I also authorize Gillis Chiropractic to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker's Compensation injury shall be forwarded to the Worker's Compensation Insurance carrier. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

Charges related to Personal Injury shall be forwarded to my attorney, or my car insurance carrier for payment. However, be advised that if your Personal Injury Claim is denied, you will be held responsible. I direct all payments from my insurance carrier/attorney to pay directly to Gillis Chiropractic for services rendered. Upon settlement of my personal injury claim, Gillis Chiropractic will be paid, or I assume all responsibility on my account.

I, the undersigned, acknowledge that by signing this form I authorize Gillis Chiropractic to submit charges via mail or internet to my insurance carrier. This is a "Signature on File" authorization.

Patient recognizes that Policy quotes are not a guarantee of payment by carrier and the patient is responsible for obtaining actual Policy benefits, limits from the carrier and, if needed, any referrals from primary care physicians or pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring providers.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file be able to accept phone and/or text message. I authorize stating a detailed message to all phone numbers that I have given Gillis Chiropractic.

**List of prices (subject to change):**

Chiropractic Adjustment: \$55.00, Examinations: \$60.00/\$130.00, Therapy: \$35.00/each, X-rays: \$35-\$100 each

**Acknowledgement of Receipt of Notice of Privacy Practices / Patient Consent**

I certify that I was offered a copy of Gillis Chiropractic's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Gillis Chiropractic's health care operations. The Notice of Privacy Practices is also posted in the reception area.

Gillis Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requested a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, the undersigned, state that I have read all the above and agree to the terms and conditions set forth.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date



*Dr. J. Scott Gillis*  
Chiropractic Physician

**TCPA EXPRESS CONSENT FORM**

**I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or any other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# GILLIS CHIROPRACTIC III, LLC

5991 Chandler Court, Suite B Westerville, OH 43082

614-818-0000

## Patient Acceptance of Liability as Medicare Patient

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

Patient Name: \_\_\_\_\_

THE FOLLOWING ARE NON-COVERED SERVICES AND WILL BE PATIENT LIABILITY:

Exams: \$30.00

Therapy: \$20.00

Non-Spinal Adjustment: \$35.00

X-Rays: prices vary

Supports/Braces: prices vary

Supplements: prices vary

I, the above named patient, have received/purchased the above named service/item from Gillis Chiropractic III, LLC. If applicable, Gillis Chiropractic III, LLC will bill my health insurance. I fully understand that if my insurance company denies it as a "non-covered item/service" and/or it states on my explanation of benefits "not patient's responsibility" it will be completely my responsibility for payment.

The above services and items are the doctor's recommendation and I understand it is my choice to receive/purchase and maybe completely my RESPONSIBILITY FOR PAYMENT

ALL ITEMS ARE NON-REFUNDABLE.

X \_\_\_\_\_

Patient Signature/Date



# 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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

- ① 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

# 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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

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