

**Gillis Chiropractic Clinic
PERSONAL HISTORY**

Date: _____

Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Birthdate: _____ Age: _____ Sex: _____ Height/Weight: _____

Name of your Employer: _____ Type of Work: _____

Type of Insurance: _____ Marital Status: _____ Name of Spouse: _____

Spouse's Employer: _____ Spouse's Social Security #: _____

Type of Insurance: _____ Are you covered by this insurance?: _____

Name and Phone Number of Nearest Relative (Outside of your Home): _____

Who is responsible for your bill? (circle): Insurance Workman's Compensation Medicaid Medicare Self
Auto Insurance Other: _____

Referred by (circle): TV Yellow Pages Previous Patient Internet Facebook

Friend: _____ Other: _____

PAST HEALTH HISTORY

SURGERIES: (Spinal or joint) _____

ACCIDENTS OR FALLS: (Please Describe) _____

FRACTURES OR DISLOCATIONS: _____

HABITS: Sleep (hours): _____ Coffee: _____ Alcohol: _____ Exercise: _____
Tea: _____ Tobacco: _____

Are you taking any medications? (Please explain for what): _____

Are you Pregnant (circle): Yes No If yes, how far along: _____ Pacemaker (circle): Yes No

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Gillis Chiropractic to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third payers and/or health practitioners. I authorize and request my insurance company to pay directly to Gillis Chiropractic or chiropractic group insurance benefits otherwise payable to me. A fee schedule is available upon request. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

Patient Signature

Date

Name _____ Date of Birth _____ Date _____

WHEN DID SYMPTOMS APPEAR? _____

WAS THIS WORK OR AUTO RELATED? _____

HOW DID SYMPTOMS OCCUR? _____

SYMPTOMS

Please Circle All the Following Symptoms you have NOW.

	Side	Pain Type	Side	Pain Type	
Headaches			R / L		Sinus Trouble
Neck Pain	R / L		R / L		Difficult Breathing
Stiff Neck	R / L		R / L		Asthma
Fainting/Dizziness			R / L		Previous heart attack
Pins/Needles in arms, hands, fingers	R / L				Joint Swelling
Numbness in arms, hands, fingers	R / L		R / L		Stomach Pain
Pain in arms, hands, fingers	R / L		R / L		Bowel Changes
Mid Back Pain	R / L		R / L		Bladder Changes
Low Back Pain	R / L		R / L		Epilepsy
Hip Pain	R / L				Cancer

Other _____

Type of Pain (Circle): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling
Cramps Stiffness Swelling Other

What aggravates your symptoms? _____

What gives you relief of your symptoms? _____

Are you presently being treated for any other condition? Yes No If yes, what? _____
By who? _____

Have you ever had prior Chiropractic Care? Yes No If yes, who? _____

(For Doctor's Use Only)

ONSET: _____ ETIOLOGY: _____

HX OF BP: _____ PRIOR TX: _____

GILLIS CHIROPRACTIC CLINIC
Family Chiropractic Care Center, Inc
1905 Latham Avenue, Lima, Ohio 45805

NAME _____ DATE _____

AUTO ACCIDENT / ACCIDENTAL INJURY QUESTIONNAIRE

Date of Accident _____ Location of accident _____

Auto / Other _____ How did it occur: _____

In what exact area did you feel pain immediately? _____

List extent of injuries as you know them : _____

Did you require post accident care or hospitalization? Yes / No

Date: _____ Type of Treatment received: _____

Treating Physician _____

Did you receive any cuts / bruises ? Yes / No Where? _____

Was it hard for you to use any part of your body? Yes / No Where? _____

Check symptoms you have noticed since the accident:

- | | | |
|----------------------------|------------------------|---------------------------|
| _____ Headache | _____ Fainting | _____ Loss of Smell |
| _____ Neck Pain | _____ Dizziness | _____ Loss of Taste |
| _____ Stiff Neck | _____ Low Back Pain | _____ Ears Ring |
| _____ Pins/Needles in Arms | _____ Nervousness | _____ Sleeping Problems |
| _____ Numbness in Fingers | _____ Head Seems Heavy | _____ Shortness of Breath |
| _____ Mid back Pain | _____ Loss of Memory | _____ Chest Pain |
| _____ Numbness in Toes | _____ Loss of Balance | |
| _____ Pins/Needles in Legs | _____ Other _____ | |

Have you lost any days off work? Yes / No Dates: _____

Any previous surgeries? _____

Any previous injuries? _____

DETAIL OF AUTO ACCIDENT:

Were You : Driver Passenger Pedestrian

Were you struck: yes / no

Were you struck from: Behind Rt Side Left Side Front Parked

Was Seat Belt ON? Yes / No

Headrest Position? Up / down / none

Loss of Consciousness? Yes / No

Brake : On / Off Air Bag: Yes / No

Estimate of Vehicle Damage: _____

Did you strike other car? Yes / No

Seat Belt have shoulder harness? Yes / No

Body position in Vehicle? _____

Did you anticipate accident? Yes / No

Did it inflate? Yes / No

INSURANCE INFORMATION

Policy# _____

Driver of other Vehicle _____ Driver of your vehicle _____

Insurance Co: _____ Adjuster Name: _____

Gillis Chiropractic Clinic

Family Chiropractic Care Center, Inc

John A. Gillis, DC

(419) 228-0000

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

PRIVATE AND GROUP ACCIDENT / HEALTH INSURANCE / ATTORNEY

I hereby instruct and direct the _____ to pay by check made out and mailed directly to:

Family Chiropractic Care Center, Inc
Dbas GILLIS CHIROPRACTIC CLINIC
1905 Latham Avenue
Lima, OH 45805

Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows

Family Chiropractic Care Center, Inc
Dbas GILLIS CHIROPRACTIC CLINIC
1905 Latham Avenue
Lima, OH 45805

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee. I fully understand that in Personal Injury claims I am directly and fully responsible to said doctor for all medical bills submitted by him. I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

DATED: _____

SIGNATURE OF PATIENT

WITNESS

SIGNATURE OF ATTORNEY (if applicable)

*Please sign and return – Keep a copy for your records.

FAMILY CHIROPRACTIC CARE CENTER, INC
Dba Gillis Chiropractic Clinic

INFORMED CONSENT- CHIROPRACTIC OFFICE

Patient Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The primary treatment we use as a Doctor of Chiropractic is spinal manipulation therapy. We will use that procedure to treat you. The doctor may use his hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Activator instrument spinal/extremity adjustment	palpation
Orthopedic testing	range of motion testing	vital signs
Basic neurological exam	muscle strength testing	hot/cold therapy
Postural analysis testing	x-ray/radiographic studies	electrical stimulation
Rehabilitation/core strengthening	manual traction adjustment	ultrasound
Cold laser therapy	spinal segmental traction	trigger point therapy

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation (CMT) and therapy. However studies have shown that any observed association between vertebral artery dissection (VAD) and stroke with CMT is likely attributed to patients with an undiagnosed VAD who seek care for neck pain and headache before the onset of a stroke.(i) As a result we examine our patients thoroughly before initiating any treatment to be sure that treatment is appropriate. The doctor, will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform the doctor.

The probability of those risks occurring. Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is indentified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you experience after exercise.

Fracture: Fractures caused from spinal manipulation are extremely rare, so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation are utilized for this type patient.

TIA/Stroke Overview: Spinal manipulation is clearly one of the safest forms of treatment for cervical spine pain. The incidence of serious events, strokes, or death very rare.(ii) **Researchers found no evidence of excess risk of VBA stroke associated chiropractic care compared to primary care.**(iii) The risk was a low as 1 adverse events per 10,000,000 manipulations.(iv) The risk of artery dissection was a low as 1 per 5,846,381 cervical manipulations(v)

What about NSAIDS and Tylenol: To put it in perspective, non steroidal anti-inflammatory drugs (NSAIDS) kill approximately 16,500 people per year annually in the US.(vi) And Tylenol toxicity is now the leading cause of liver failure in the US.(vii,viii) Spinal manipulations is safer than NSAIDS by a factor of several hundred times. (ix)

Note: Screening tests are performed when necessary to rule out high risk patients. Alternative spinal adjusting is utilized when necessary to minimize potential risks.

Ruptured/Herniated Disc: There have been some reports of herniated or ruptured discs caused by spinal manipulation. Alternative spinal adjusting methods are utilized to minimize the risk and help the patient recover from serious disc-related pain.

Other complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The availability and nature of other treatment options:

Other treatment options for your condition may include:

Self administered, over-the-counter may include:

Medical care and prescriptions drugs such as anti-inflammatory, muscle relaxants and pain killers

Hospitalization

Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated or undertreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. Early intervention to restore normal function and compliance with the treatment program are both essential in an effort to prevent the condition from progressing to a chronic pain state.(x,xi,xii,xiii,xiv,xv)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. I will discuss it with Dr. Gillis, if I have any questions regarding the above information. **signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

Patient Name: _____

Patient Signature: _____ Date _____

Signature of Doctor: _____ Date _____

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 Family Chiropractic Care Center, Inc. 1905 Lathem Ave. Lima, OH 45805.

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: \$40.00, \$45.00
Examinations: \$30.00, \$55.00, \$75.00
Therapy: \$15.00-\$20.00/each, Decompression \$30.00
X-rays: \$40-\$105 each
Forms/Copies: \$5.00-\$20.00
Supports/Brace: Prices Vary

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

Back Index

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/15/89

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

- 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 very severe and does not vary much.

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 sleep is reduced by less than 25%.
- Because of pain my normal sleep is reduced by less than 50%.
- Because of pain my normal sleep is reduced by less than 75%.
- Pain prevents me from sleeping at all.

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 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain immediately.

Standing

- I can stand as long as I want without pain.
- I have some pain while standing but it does not increase with time.
- I cannot stand for longer than 1 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 pain immediately.

Walking

- I have no pain while walking.
- I have some pain while walking but it doesn't increase with distance.
- I cannot walk more than 1 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.

Personal Care

- I do 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 increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases 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.

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 can manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.

Traveling

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

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 affect 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.

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.
- My pain is neither getting better or worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Calculate Score

Back
Index
Score

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

Neck Index

ChiroCare of Wisconsin, Inc.

ChiroCare use Only rev 1/15/99

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

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain comes and goes and is moderate.
- 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.

Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I cannot read as much as I want because of moderate neck pain.
- I can hardly read at all because of severe neck pain.
- I cannot read at all because of neck pain.

Concentration

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

Work

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

Personal Care

- 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 I 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.

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, but I can manage if they are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything at all.

Driving

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

Recreation

- I am able to engage in all my recreation activities without neck pain.
- I am able to engage in all my usual recreation activities with some neck pain.
- I am able to engage in most but not all my usual recreation activities because of neck pain.
- I am only able to engage in a few of my usual recreation activities because of neck pain.
- I can hardly do any recreation activities because of neck pain.
- I cannot do any recreation activities at all.

Headaches

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

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

Calculate Score

Neck
Index
Score