John W. Moore, D.C.
Seth R, Moore, D.C.

Muncie Spine & Rehab

Appointment Time _____ Date_____
Name_____
Age_____ D.O.B_____ M / F
M S W D Email _____
Mobile Phone _____
Address _____
Referred By_____ Dr. Preference_____

Patient #_____
Description of pain and onset:

_____

_____

In Case of Emergency, Notify:_____ Phone_____

Do you have insurance? Y / N Insurance Company_____

INSURANCE INFORMATION

I authorize Muncie Spine & Rehab to release information regarding my care and treatment to my insurance company, benefit plan administrator, or attorney. This authorization is only for the evaluation and or settlement of a claim made on my behalf. This authorization is for the term coverage of the policy of settlement of any outstanding balance incurred at this office. I agree that a photocopy of this authorization is as valid as the original.

X Signature_____Date_____

ASSIGNMENT OF BENEFITS/ FINANCIAL DISCLOSURE

I assign any insurance benefits that would be paid to me for expenses incurred in this office to Muncie Spine & Rehab. I understand that any and all charges that are denied are my responsibility for immediate payment. I also understand that my deductible, co-payments, and noncovered services are due and payable at time of service. Muncie Spine & Rehab reserves the right to charge 8% interest per year on an outstanding account. We also reserve the right to recover any expenses incurred in collecting such debt, including but not limited to use of a collection agency or attorney.

X Signature_____Date_____

CONSENT TO TREAT A MINOR

I hereby authorize Muncie Spine & Rehab to administer treatment as deemed necessary to my son/ daughter.

Parent's Name _____

Signature_____Date_____

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Muncie Spine & Rehab

Patient Privacy Practices

Acknowledgement of Receipt

I acknowledge that I have been offered a copy of the Muncie Spine & Rehab Notice of Privacy Practices.

Signature_____

Date_____

Name_____ Patient # _____ Date_____

CHECK ALL THAT APPLY

☐ Neck pain	☐ Headache	☐ Chest pain	☐ Face flushed	☐ Irritability
☐ Neck stiff	☐ Light Bothers eyes	☐ Shortness of breath	☐ Feet cold	☐ Dizziness
☐ Back pain	☐ Loss of taste	☐ Fever	☐ Hands cold	☐ Fatigue
☐ Back stiff	☐ Loss of smell	☐ Diarrhea	☐ Swelling	☐ Fainting
☐ Numbness in toes	☐ Ears ringing	☐ Nausea	☐ Weakness	☐ Depression
☐ Numbness in fingers	☐ Buzzing in ears	☐ Constipation		☐ Memory loss
☐ Tingling in _____	☐ Loss of balance	☐ Cold sweats		

1. What are your symptoms and when did they first appear?

2. What incident or activity do you feel may have caused your symptoms?

3. Have you ever had similar symptoms? **Y / N** If so, when?

4. Have you seen other doctors for this condition? **Y / N**

If so, when?_____ Who?_____

Were any images (X-ray, CT, MRI) taken?

5. List activities or movements that aggravate your condition:
(*Be specific*. Examples: bending, lifting, walking, computer usage, sitting)

1. 2.

3. 4.

6. This condition is progressively getting
☐ worse
☐ better
☐ remains the same

7. List daily activities that are affected by your condition:
(*Be specific*. Examples: sleeping, work, walking, self care, sports)

1. 2.

3. 4.

8. What percentage of your day do you feel affected by your pain (circle one)

0-25% 26-50% 51-75% 76-100%

Name_____

PATIENT'S MEDICAL CONDITIONS: (please add any not listed)

⬜ High Blood Pressure	⬜ Heart Disease	⬜ Anxiety	⬜ Depression
⬜ High Cholesterol	⬜ Pacemaker/Stent	⬜ ADHD	⬜ Arthritis
⬜ Hyperthyroidism	⬜ Diabetes (DMII)	⬜ Asthma	⬜ _____
⬜ Hypothyroidism	⬜ Epilepsy	⬜ _____	⬜ _____
⬜ Stroke	⬜ Cancer	⬜ _____	⬜ _____

9. CURRENT MEDICATIONS:

10. PREVIOUS SURGERIES/ PROCEDURES (include dates)

11. FAMILY HISTORY OF MEDICAL CONDITIONS:
Mother: Father:

13. LIFESTYLE/ WORK

Occupation:
Hours worked weekly:
Hours exercised weekly

Alcohol consumption:
Smoker: **Y / N** If yes, how long?
If quit, how long?

14. OTHER SYMPTOMS:
Bowels:
Urination:
Digestion:

WOMEN ONLY:
Number of pregnancies: _____ 1st day of last cycle_____
Menstruation issues:
Is there any possibility you may be pregnant? **Y / N** *If YES, be sure to notify Doctor or staff*

****

For staff use only

B/P_____ HR_____ WT_____ HT_____0_2%_____

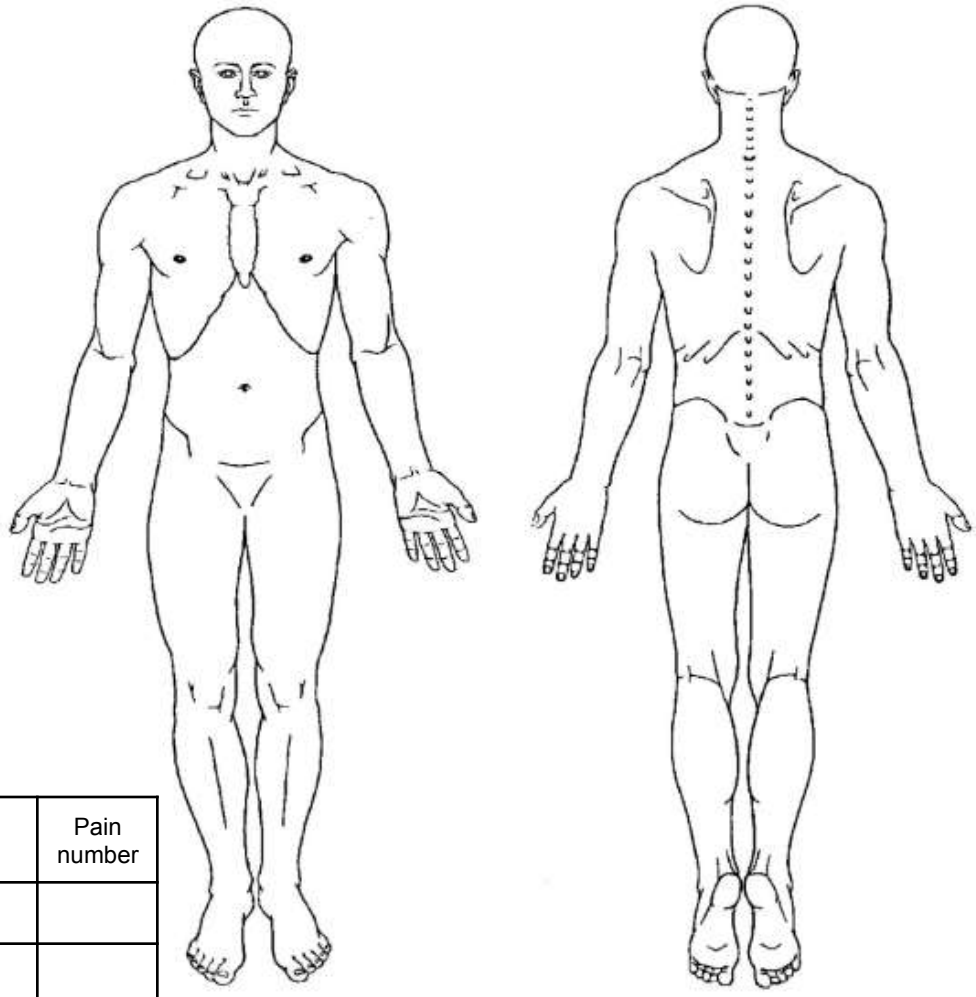
Information Taken By_____Date_____

PAIN DRAWING

Name_____ Date_____

Directions:

Mark areas on the body with an **X** where you feel your symptoms. Include all affected areas. If the pain radiates, use an arrow from where it starts and extend the arrow as far as the pain travels.



Name the areas where you are having pain and give a number 1-10 and be sure to use the ***Muncie Spine and Rehab pain scale.***	Area	Pain number

Describe your symptoms (mark all that apply)

- ☐ Aching
- ☐ Dull
- ☐ Stiff
- ☐ Tight
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Sharp
- ☐ Numb
- ☐ Tingling
- ☐ Radiating

Neck Index

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 care 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.

Neck Index Score

Back Index

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

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score

John W. Moore, DC - Seth R. Moore, DC
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Patient Acknowledgement of Appointment Cancellation Policy

Muncie Spine and Rehab has instituted an Appointment Cancellation Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

To remain consistent with our mission, we have instituted the following policy:

1. Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left on our answering machine to avoid a cancellation fee being charged.
2. A “No-Show”, “No-Call” or missed appointment, without proper 24-hour notification, may be assessed a $40 fee.
3. This fee is not billable to your insurance.
4. If you are 15 or more minutes late for your appointment, you may be asked to reschedule.
5. As a courtesy, we make reminder texts, for appointments, one day in advance. Please note, if a reminder text is not received, the cancellation policy remains in effect.
6. Repeated missed appointments may result in termination of the chiropractor/patient relationship.
7. **Implementation of this policy is at the discretion of the doctor and office management.**

_____

Patient Name

_____ _____

Patient Signature Date