Healing Touch Chiropractic

♦ General Information

Last Name: _____ First Name: _____ Middle Initial: _____

What do you prefer to be called? _____ Employer/Occupation: _____

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

Home Phone ( ) _____-_____ Work Phone ( ) _____-_____ Ext: _____

Cell phone ( ) _____-_____ Email Address: _____

Would you like to receive occasional health care related emails? **Y / N** *You may opt out at any time*

Sex: M F Date of Birth: _____/_____/_____ Age: _____ SSN : _____-_____-_____

Marital status: M S W D Spouse's name_____ # of children: _____

Nearest relative (Not living with you):_____ Phone number ( ) _____-_____

Name of your primary physician: _____Phone number ( ) _____-_____

Have you ever seen a chiropractor before? Y N If yes, who and when: _____

When did you last have x-rays? _____ How were you referred to our office?_____

♦ ***For Women Only***: Are you pregnant? Y N If yes, how far along? _____ Are you nursing? Y N

Who is your OB/GYN? _____ Are you taking birth control? Y N

♦ **Health Information**

Where specifically is the majority of your pain? _____

What recent activity/event caused your pain? _____ Date of event: _____ / _____ / _____

Please list any other areas of complaint: _____

Please rate your pain by circling the number below that best describes your pain ***today and at its worst.***

Today: (mild pain) 1 2 3 4 5 6 7 8 9 10 (severe)

Worst: (mild pain) 1 2 3 4 5 6 7 8 9 10 (severe)

In the past week on average how often have your symptoms been present?

(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

What activities or positions seem to make your pain **worse** (I.E. walking, sitting, standing, etc.)?

_____

What makes your pain **better** (I.E. sitting, walking, lying, etc.)?

_____

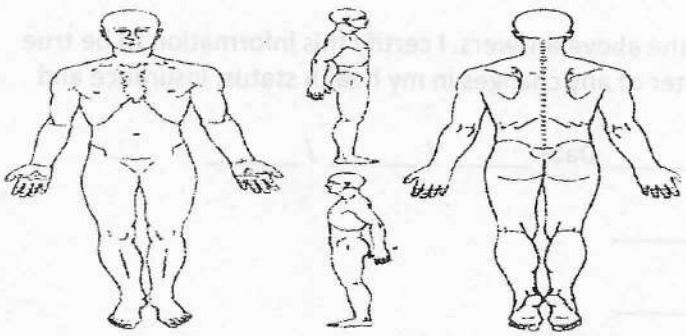
Which of the treatments listed below have decreased your level of pain:

☐ Physical Therapy ☐ Chiropractic Treatments ☐ Muscle Relaxants ☐ Pain Medications (specify)_____

☐ Epidural Steroid Injections ☐ Anti-Inflammatory Medications ☐ Massage Therapy ☐ Other: _____

Please mark the areas you are currently experiencing pain by using the letters that are appropriate.

A = ACHE **P** = PAIN **B** = BURNING **S** = STABBING **N** = NUMBNESS **O** = OTHER



Social Health History (EHR)

1. **Demographics** ☐ Unknown / Prefer not to answer
   Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other: _____
   Preferred Language: ☐ English ☐ Spanish ☐ Other: _____
   Race: ☐ White/Caucasian ☐ African American ☐ Native American ☐ Hawaiian/Pacific Islander
   ☐ Other: _____
2. **Would you like access to your health records electronically?** ☐ YES ☐ NO
   *_____ (please initial) ***I hereby give my consent to have my health records available to me via a secure, web-based portal.*** Email address: _____
3. **Are you taking medications?** ☐ YES ☐ NO
   If yes, please list medications (BE SPECIFIC) you are currently taking along with dosage. *If you have a med list, we can copy it for you instead.
   _____ _____
   _____ _____
   _____ _____
4. **Are you allergic to medication(s)?** ☐ YES ☐ NO
   If yes, please list medications you are allergic to and the problem experienced:
   _____ _____
5. **Do you smoke now?** ☐ YES ☐ NO
   Have you ever been a smoker? ☐ YES ☐ NO
   Do you use any other form of tobacco? ☐ YES ☐ NO *If yes, please complete the following:*
   What type: _____ How much: _____
   Have you tried to quit? _____ What methods did you use? _____
6. **Do you exercise?** ☐ YES ☐ NO
   How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
   What type? _____
7. **Do you drink alcohol?** ☐ YES ☐ NO
   Alcohol quantity ☐ 1-2 per week ☐ 1-2 per day ☐ 2 or more per day ☐ Other: _____

Past Medical History

List all operations/hospitalizations and dates: _____
_____
List all major accidents and traumas and dates: _____
_____

I have read all the information on this sheet and have completed the above answers. I certify this information to be true and correct to the best of my knowledge. I will notify Dr. Poindexter of any changes in my health status, insurance and any above information.

Patient's Signature: _____ Date: ____ / ____ / ____

Parent/Guardian's Signature: _____

Doctor's Signature: _____

Financial Responsibility

I agree to be financially responsible of all charges incurred at this clinic including my insurance deductible, co-payment and any services rejected by my insurance company. A no-show fee will be assessed to any massage patient who does not give the office a minimum of a 24 hour notification for cancellation. This charge is set at $40.00 per occurrence. A fee of $25.00 will be charged to your account for all returned checks to this office. This will be in addition to the amount of the original payment. We will not send the check to the bank more than once. If additional checks are returned for insufficient funds we will no longer accept a check as payment from you. A collection fee of $40.00 will be charged to your account if it is forwarded to a collection agency.

Signature/Parent of minor/Guardian _____ Date _____

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic 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 by this clinic.

Signature/Parent of minor/Guardian _____ Date _____

Release of Information

I authorize this clinic to release any information pertinent to my case to my insurance company, adjustor and attorney involved in this case; and hereby release this clinic of any consequences thereof.

Signature/Parent of minor/Guardian _____ Date _____

Acknowledgement of Receipt of HIPAA Privacy Notice

I hereby give my consent for Healing Touch Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right and had the opportunity to review the Notice of Privacy Practices prior to signing this consent. I understand Healing Touch Chiropractic reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Erin Schachterle 4744 Beckley Road Battle Creek, MI 49015.

With this consent, Healing Touch Chiropractic may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Healing Touch Chiropractic may mail to my home or other alternative location any items that assist the practice in carrying out TPO.

With this consent, Healing Touch Chiropractic may e-mail or text message to me any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, practice newsletter, and educational information. I have the right to request that Healing Touch Chiropractic restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Healing Touch Chiropractic to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Healing Touch Chiropractic may decline to provide treatment to me.

Signature/Parent of minor/Guardian _____ Date _____

Informed Consent for Treatment

I understand that the treatment I receive at this clinic is from a licensed Doctor of Chiropractic. Chiropractic scope of practice includes a wide range of services but if the doctor determines the services I need cannot be provided by this office, then he/she will direct me to the appropriate health care provider.

Within the service provided by this office, chiropractic treatment almost always includes the chiropractic adjustment, a specific type of joint manipulation. Spinal manipulation is done to ease pain and help the body function better. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **The following are the potential risks:**

- ☐ **Temporary soreness or increased symptoms or pain** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- ☐ **Dizziness, nausea, flushing** These symptoms are relatively rare. It is important to notify the doctor if you experience these symptoms during or after your care.
- ☐ **Fractures** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your doctor if you have been diagnosed with a bone weakening disease or condition. If your doctor detects any such condition while you are under care, you will be informed, and your treatment plan will be modified to minimize risk of fracture.
- ☐ **Disc herniation or prolapse** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your doctor if symptoms change or worsen.
- ☐ **Stroke** According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. Regarding neck pain and headache symptoms, there is an association between stroke and visits to all provider-types, including primary care medical visits, which may occur before or during the provider visit.
- ☐ **Other risks** associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.
- ☐ **Bruising** Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.
- ☐ **Alternatives** to manipulation discussed through a shared decision-making process include: Medicines, Physical therapy, Massage, Mobilization, Acupuncture, and/or Cognitive-behavioral therapy. You can do these whether or not you are doing spinal manipulation.
- ☐ **Refusing Care** may carry a risk to future capabilities in regard to performing activities of daily living or progression towards chronic pain.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. The material risks have been disclosed to me, including a description of those material risks; and after consideration, I agree to the procedures understanding any material risks which are inherent to that procedure.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print)_____ DATE OF BIRTH: _____

PATIENT GUARDIAN/REPRESENTATIVE (PRINT) _____

_____ _____ _____ _____

(PATIENT GUARDIAN/REPRESENTATIVE SIGNATURE) (DATE) (TRANSLATOR | INTERPRETER SIGNATURE) (DATE)

CLINICIAN ONLY

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

☐ OF LEGAL AGE ☐ APPEARS UNIMPAIRED ☐ CONSENT GIVEN THROUGH GUARDIAN/PATIENT REPRESENTATIVE

☐ ORIENTED X3 ☐ FLUENT IN ENGLISH ☐ ASSISTED BY A TRANSLATOR OR INTERPRETER

_____, D.C. _____

(DR. STEPHANY POINDEXTER) (DATE)

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 - Personal Care

A I do not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain I am unable to do some washing and dressing without help.
F Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

SECTION 4 - Walking

A I have no pain on walking.
B I have some pain on walking but it does not increase with distance.
C I cannot walk more than one mile without increasing pain.
D I cannot walk more than 1/2 mile without increasing pain.
E I cannot walk more than 1/4 mile without increasing pain.
F I cannot walk at all without increasing pain

SECTION 5 - Sitting

A I can sit in any chair as long as I like.
B I can sit only in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than 10 minutes.
F I avoid sitting because it increases pain straight away.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain on standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get pain in bed but it does not prevent me from sleeping well.
C Because of pain my normal night's sleep is reduced by less than 1/4.
D Because of pain my normal night's sleep is reduced by less than 1/2.
E Because of pain, my normal night's sleep is reduced by less than 3/4.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life, and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Travel

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get ext ra pain while traveling, which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

A My pain is rapidly getting better.
B My pain fluctuates but overall is definitely getting better.
C My pain seems to be getting better but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

SIGNATURE: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

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

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

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMMENTS: _____

NAME: _____ DATE: _____ SCORE: _____

Healing Touch Chiropractic 4744 Beckley Road Battle Creek, MI 49015 Phone 269-979-7814 Fax 269-979-7815

PATIENT REVIEW OF SYSTEMS

Please check the **"PRESENT"** box for all conditions that you are now experiencing and mark the **"PAST"** box for any conditions or symptoms experienced at any time in your life.
*IF YOUR PARENTAL HISTORY IS UNKNOWN PLEASE CHECK HERE: ☐

	PRESENT	PAST
Allergic/ Immunological		
Sinus issues	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cardiovascular		
Heart problems	☐	☐
Shortness of breath	☐	☐
Blood clots	☐	☐
Varicose veins	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Chest pain	☐	☐
Palpitations	☐	☐
Ears, Nose & Throat		
Hearing loss	☐	☐
Ringing in the ears	☐	☐
Nose bleeds	☐	☐
Pain w/ swallowing	☐	☐
Ear infections	☐	☐
Endocrine		
Hypothyroid	☐	☐
Hyperthyroid	☐	☐
Diabetes	☐	☐
Reproductive issues	☐	☐
Heat intolerance	☐	☐
Cold intolerance	☐	☐
Excessive hunger	☐	☐
Excessive thirst	☐	☐
Eyes		
Glasses/contacts	☐	☐
Blurry vision	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐

	PRESENT	PAST
Gastrointestinal		
Digestion issues	☐	☐
Acid reflux	☐	☐
Hernia	☐	☐
Nausea/vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Gallbladder disease	☐	☐
Hemorrhoids	☐	☐
Ulcer	☐	☐
Genitourinary		
Difficulty urinating	☐	☐
Painful urination	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Urinary infections	☐	☐
Increased urination	☐	☐
Decreased urination	☐	☐
Menstrual issues	☐	☐
Bed wetting	☐	☐
Kidney stones	☐	☐
Hematological/ Lymphatic		
Anemia	☐	☐
Prolonged bleeding	☐	☐
Integumentary		
Rash	☐	☐
Bruising	☐	☐
Hair loss	☐	☐
Sores	☐	☐
Constitutional		
Fatigue	☐	☐
Stress	☐	☐
Difficulty sleeping	☐	☐

	PRESENT	PAST
Musculoskeletal		
Neck pain	☐	☐
Back pain	☐	☐
Jaw pain	☐	☐
Pain in arms/hands	☐	☐
Pain in legs/feet	☐	☐
Stiffness	☐	☐
Arthritis	☐	☐
Joint swelling	☐	☐
Muscle tenderness	☐	☐
Muscle cramp	☐	☐
Fractures	☐	☐
Dislocations	☐	☐
Neurological		
Headaches	☐	☐
Numbness/tingling	☐	☐
Twitches/tics	☐	☐
Tremors	☐	☐
Stroke	☐	☐
Seizures	☐	☐
Dizziness/vertigo	☐	☐
Neuropathy	☐	☐
Poor balance	☐	☐
Weakness in limbs	☐	☐
Psychological		
Depression	☐	☐
Anxiety	☐	☐
Emotional stress	☐	☐
Sleep walking	☐	☐
Respiratory		
Difficulty breathing	☐	☐
Chronic cough	☐	☐
Sleep apnea	☐	☐
Wheezing	☐	☐

	PRESENT	PAST	
Conditions			
Osteoporosis	☐	☐	
Osteopenia	☐	☐	
Multiple sclerosis	☐	☐	
Parkinson's	☐	☐	
Cancer/tumor	☐	☐	type/location:_____
Polio	☐	☐	
Alcoholism	☐	☐	*Other:_____
Gout	☐	☐	_____

FAMILY MEDICAL HISTORY

Mother Deceased **Y / N** Mother medical history _____
Father Deceased **Y / N** Father medical history _____
Family medical history _____

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 269-979-7814