INSPIRE chiropractic & wellness spa
In balance...In harmony...Inspire

PATIENT INFORMATION

Name_____Date_____
Address_____City_____State_____Zip_____
Phone (H)_____(C)_____ Email_____
Birthdate_____/_____/_____ Age _____ Male _____Female_____
Occupation_____Employer_____
Emergency Contact Name_____ Phone_____
How did you hear about our office?_____

COMPLAINT INFORMATION

Please circle all answers and fill in the blanks where appropriate to describe your complaint. This information is necessary to assist your health care provider to understand your health condition.

Describe your problem & how it began:_____

Date problem began _____/_____/_____

How bad is your pain? 0 1 2 3 4 5 6 7 8 9 10

How often are your symptoms present? Constantly Frequently Occasionally Intermittently

Describe your current pain/symptoms: Sharp/Stabbing Throbbing Aches Dull Soreness
Burning Weakness Tingling Numbness Shooting

Since it began is your problem: Improving Getting Worse No Change

What makes the problem better: Nothing Lying Down Walking Standing
Sitting Movement Exercise Inactivity/Rest

What makes the problem worse: Nothing Lying Down Walking Standing
Sitting Movement Exercise Inactivity/Rest

Can you perform your daily home activities: Yes Only with help Not at all

Do you exercise: Yes, almost daily Yes, occasionally Not at all

Describe your job requirements: Mainly sitting Light Labor Heavy Labor

Can you perform your work activities? Yes, all activities Only some Not at all

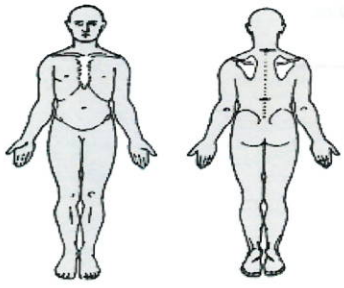
Describe your stress level: None to mild Moderate High

What treatment have you have had for this condition in the past? _____

_____

Have you had an X-ray, MRI or other tests for this condition? What, where & when?_____

_____



Mark an "X" on the picture where you have pain, numbness or tingling.

_____ _____

(patient signature) (date)

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ Date _____

If you have *ever* had a listed symptom in the past, please check that symptom in the Past Column.
If you are presently troubled by a particular symptom, check that symptom in the Present column.
KNOWLEDGE OF THESES CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT/THERAPY YOU RECEIVE.

Past	Present	
☑	☐	Neck Pain
☐	☐	Shoulder Pain (R___ L___)
☐	☐	Pain in Upper Arm or Elbow (R___ L___)
☐	☐	Hand Pain (R___ L___)
☐	☐	Wrist Pain (R___ L___)
☐	☐	Upper Back Pain
☐	☐	Low Back Pain
☐	☐	Pain in Upper Leg or Hip (R___ L___)
☐	☐	Pain in Lower Leg or Knee (R___ L___)
☐	☐	Jaw Pain
☐	☐	Swelling, Stiffness of Joint's)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headaches
☐	☐	Muscular In coordination
☐	☐	Tinnitus (Ear Noises)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pain
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Irregular Menstrual Flow
☐	☐	Profuse Menstrual Flow
☐	☐	Breast
☐	☐	Endometriosis
☐	☐	PMS
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular bowel habits
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash

Past	Present	
☐	☐	Depression
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack (date _____)
☐	☐	Stroke (date _____)
☐	☐	Asthma
☐	☐	Cancer, Explain _____
☐	☐	Tumor, Explain _____
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema (chronic lung disorder)
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver/Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Other erefredsf

If a family member has had any of the following, please mark the appropriate box:

☐ Cancer	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Chronic Back Problems
☐ Diabetes	☐ Chronic Headaches
☐ Heart Problems	☐ Lupus
☐ Lung Problems	☐ Other
☐ High Blood Pressure _____	

Yes	No	
☐	☐	Do you have a permanent disability rating?

Location _____
Date rating received _____
Rating Percentage _____%

Present Weight _____pounds
Height _____feet _____inches

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy, # of births _____
☐	☐	Birth Control Pills, type
☐	☐	Medications (list if not listed elsewhere)
☐	☐	Hospitalizations/Surgical Procedures (list if not described elsewhere)_____

Past	Present	
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health or health plan coverage in the future.

Patient's Signature_____ Date_____

INSURANCE INFORMATION:

Policy Holder Name_____Date of Birth_____

Is your condition due to an Employment related Injury? _____Yes _____No Date of Accident: _____

Is your condition due to an Automobile Accident? _____Yes _____No Date of Accident: _____

Your Personal Auto Insurance Carrier: _____Claim #_____

Adjusters Name: _____ PHN _____

☐ By checking this box I confirm that this is my auto insurance and not a third party involved.

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office prepares any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Inspire Chiropractic to administer treatment that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. In order to ensure that my healthcare providers function as a team, I hereby grant Inspire Chiropractic to communicate with and relay any information about condition to my other healthcare providers. I further authorize them to disclose all or part of patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies or insurance companies. I understand that if an insurance company initially pays for treatment and later requests reimbursement from Inspire Chiropractic for any reason, I will be responsible for payment of the outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

_____

Patient or Guardian's Signature Date

CONSENT TO TREAT A MINOR

I being the parent or guardian of the minor being _____, do hereby authorize, request & direct Inspire Chiropractic to perform any treatment that in their judgement, is deemed advisable or required.

It is the understanding of the undersigned that Inspire Chiropractic will have full authority from me as legal parent/guardian to continue with treatment as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I am fully responsible for all charges and payments due.

_____

Patient or Guardian's Signature Date

Financial Policies & HIPPA Acknowledgement

Read & Initial by each item

_____ Inspire Chiropractic will file insurance claims on your behalf as a courtesy to you. Any co-pays, coinsurance, or deductible amounts are determined by your insurance plan. We will make every attempt to clarify your portion of monies due by contacting your insurance carrier and inquiring about your plan. Please be aware that sometimes what we are told and what your insurance pays may not always be the same. If you have specific questions about what is and is not covered please contact your insurance directly by calling the number on your insurance card.

_____ In the event we are unable to verify your coverage prior to the end of your first visit it is the policy of this office to collect 50% of first day charges.

_____ Our office is a participating provider for Medicare and as such will assist you in filing your claims. If you have secondary insurance please provide us with that information.

_____ Payment is due at time of service, including co-pays and co-insurance.

_____ Assistance is available for patients who are not covered by any insurance and meet the criteria for a hardship exemption. Please inquire for details.

_____ Visits that are requested and services delivered on weekends or holidays are subject to a $50 weekend/holiday fee which is not payable by insurance.

_____ We ask for a 24 hour notice if you are unable to keep an appointment. In the event there is a missed appointment, a $30.00 fee will be charged payable before next service to be rendered.

_____ Returned checks will be charged a $25 fee.

_____ Accounts that are 90 days past due are subject to collections.

My signature below is acknowledgement that I have read and agree to the above policies. I understand that I am responsible for payment of services rendered to me or my dependents.

My signature below acknowledges I have read or been given the opportunity to receive a copy of the Notice of Privacy Practices.

Date _____ Name _____

Signature _____

INSPIRE chiropractic & wellness spa

Neck Index

Form N1-100

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

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.

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.

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).

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.

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.

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 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.

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.

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.

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.

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.

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

Neck Index Score _____

Back Index

Form BI100

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

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.

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

Back Index Score _____