WELCOME TO ELMBROOK CHIROPRACTIC

Patient Information

Thank you for choosing Elmbrook Chiropractic for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help!

Name: _____ SS/HIC/Patient ID #: _____

Sex: Female ___ Male___ Birthdate: _____ Email: _____

Home Phone: (_____) - _____ Cell Phone: (_____) - _____ Work Phone: (____) - _____

Address: _____ City _____ State____ Zip Code: _____

Do you prefer to receive calls at: Home ___ Work ___ Cell ___ No Preference ___

Married ___ Widowed ___ Single ___ Minor ___ Separated ___ Divorced ___ Partnered for ____ Years

Patient Employer/School _____ Occupation: _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: (___) - _____

Emergency Contact: _____ Phone: _____ Relation: _____ Referral: _____

Responsible Party

Name of person responsible for this account: _____

Birthdate: _____ Relationship to patient: _____

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

Symptoms

Reason for Visit: _____

When did you first notice symptoms? _____ Where is the problem located? _____

Progression since onset: **Worse** ____ **Better** ____ **Same** ____ Is the pain constant or does it come and go? _____

Type of Pain (Ex. Sharp, Burning, Tingling, Stiffness, Aching, Shooting, Etc.) _____

Rate the severity of your pain. (1 = mild pain or discomfort, 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you received for your condition? Medication ____ Surgery ___ Physical Therapy ___ Other ___

Name and Address of other doctor(s) who have treated you for your condition:

_____

Daily Habits

Daily exercise: None ___ Moderate ___ Heavy ___ Daily work habits? _____

Do you smoke? Yes ___ No ___ How much per day? _____ How much liquor do you consume weekly? _____
How many caffeinated beverages do you consume daily? _____

WELCOME TO ELMBROOK CHIROPRACTIC

Health History Check only those conditions which are applicable:

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chicken Pox
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other _____

Date(s) of last exams: _____

WOMEN: Are you pregnant? **Yes** ___ **No** ___ Nursing? **Yes** ___ **No** ___ Taking Birth Control? **Yes** ___ **No** ___

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

_____

Please list any vitamins or nutritional supplements: _____

Allergies: _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

and assign directly to Dr. Nichole Schultz, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Nichole Schultz may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient/Parent/Guardian _____ Date_____

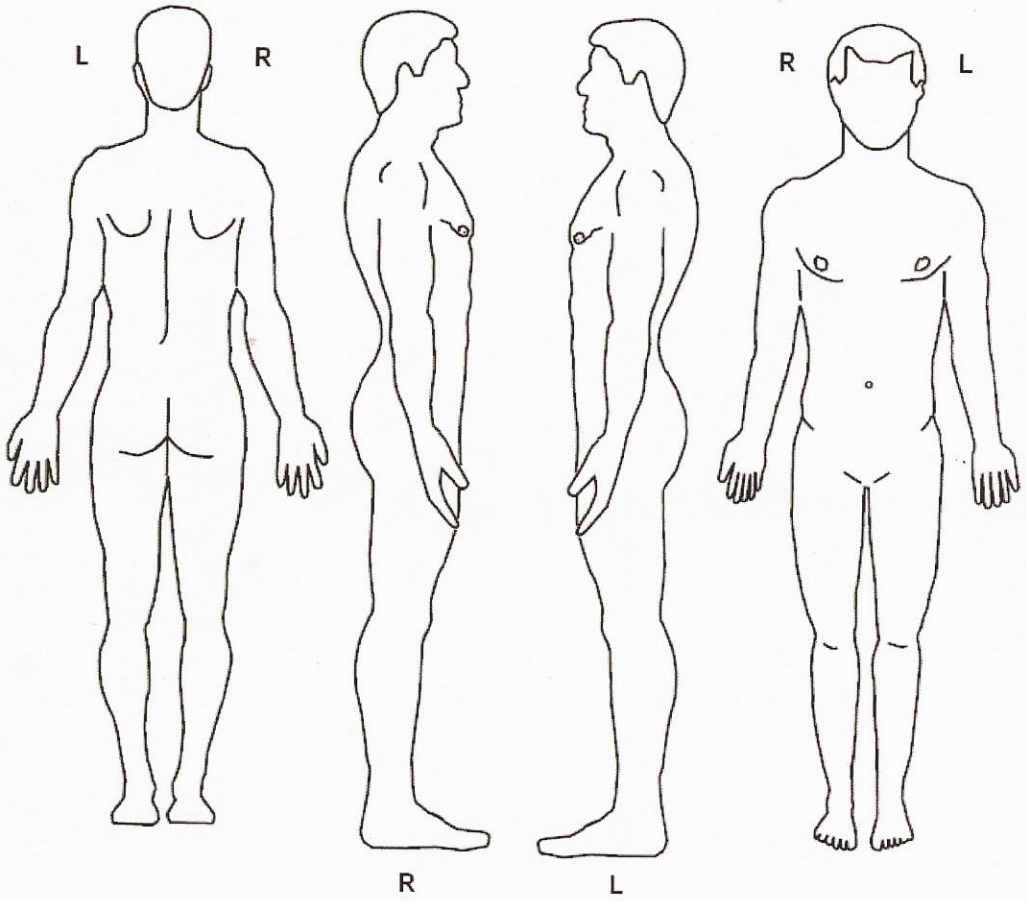
Printed Name of Patient/Parent/Guardian _____ Relationship_____ Date _____

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate letter(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness = N Pins & Needles = P Burning = B Stabbing = S Aching = A Stiffness = F



VISUAL ANALOGUE SCALE

Please circle the pain level that most accurately represents your pain.
0 = no pain and 10 = unbearable pain.

a) Right Now:----	0	1	2	3	4	5	6	7	8	9	10
b) Average Pain	0	1	2	3	4	5	6	7	8	9	10
c) At Best ------	0	1	2	3	4	5	6	7	8	9	10
d) At Worst-------	0	1	2	3	4	5	6	7	8	9	10

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

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 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

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.

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

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

ELMBROOK CHIROPRACTIC

Patient Policies

Thank you for trusting us with your health. We will do everything we can to assist you in getting and staying well. The following policies are established so that we can provide you with the best possible service.

Definition: Chiropractic is a system of gently adjusting segments of the spinal column to remove nerve interference and correct the symptoms of disease.

Patient Education: We welcome the opportunity to provide you with information about your health. We offer many diverse books and pamphlets, in addition to complimentary monthly newsletters and wellness tips on our website. To sign up for the newsletter, go to our website or notify our staff. If you have a special concern or topic area in which you would like additional information, please let us know.

Referrals: Our office is built on referrals from our patients and friends, and they are always welcome. Family members are encouraged to get their spines checked regularly.

Returns: All pillows, supplements, exercise equipment, supports and custom-made items are not returnable unless there is a material defect.

Financial Obligations: We want you to get the care you need in our office and will work with you so that finances are not a barrier to your treatment. Our fee consideration is confidential and should not be discussed with other patients.

(1) All deductibles and copays MUST be made at the time of service or at the end of each week. Patient balances may not exceed $200 at any time.

(2) You are considered to be a "cash patient" until our office qualifies your coverage and receives a determination of benefits and eligibility from your insurance.

(3) Should you discontinue care for any reason other than discharge from the doctor, any balances due will become immediately payable in full, regardless of any outstanding claims submitted.

(4) This office does not guarantee that your insurance company will reimburse you for the usual and customary charges submitted, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

(5) Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month.

(6) Copies of x-ray films can be provided upon request at a copy charge of $10 per film with a 24-hour notice.

ELMBROOK CHIROPRACTIC

Appointments: Please note that it is the frequency of weekly visits that make the difference in your care, not the days on which you receive the service.

If you experience a new injury, please notify the doctor and staff as soon as possible so that we may better schedule you. Please make every effort to maintain your appointments and our schedule of care.

We reserve the right to charge a $25 missed appointment fee for those cancelled **without *24 hours notice***. This fee is the patient's responsibility and is **NOT** covered by insurance. A fee of $50 will be charged for all missed Saturday appointments without a 24-hour courtesy notice.

I have read the above and understand and accept this policy and payment arrangement.

Patient Signature:_____Date:_____

ELMBROOK CHIROPRACTIC

Acknowledgement and Understanding

I hereby acknowledgement that I am receiving (or am about to receive) heath care services at Elmbrook Chiropractic, and that I will have been advised that the doctors(s) providing the services is/are willing to wait for payment of these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for the services of if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or

2. If a liability exists, and my attorney refuse to agree to protect the interest of the doctor(s), or if I have not engaged the services of an attorney:

Then payment for the services rendered by the doctor(s) at the Elmbrook Chiropractic will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of 60 days from my last treatment, whichever occurs first. Upon release from care, a monthly interest rate of 1.5% will be added to any remaining unpaid charges on my account.

_____ _____

Patient Signature Date

_____ _____

Witness Date

ELMBROOK CHIROPRACTIC

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have and always will respect the privacy of your health information. We may have to use or disclose your healthcare or billing information when:

1. It is necessary to refer you to another healthcare provider or hospital for the diagnosis, assessment, or treatment of your health condition.
2. Another party, such as a health insurance company, is responsible for payment of your services.
3. We need the information within our practice for quality control or other operational purposes.

Along with this consent form you will be given, at your request, a copy of our privacy notice that describes our privacy policy in detail. You have the right to review the notice before you sign this consent form. We reserve the right to change our privacy practices as described in this notice. If we make changes, we will notify you in writing.

Your chiropractor and members of the staff may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages as described above.

We do not give or sell patient information to any outside marketing organizations. All marketing services are by those staff members in our practice.

YOU HAVE THE RIGHT TO LIMIT USES OF DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. Although we are not required to agree to your restrictions, if we choose to do so, the restrictions are binding on us.

YOU HAVE THE RIGHT TO REVOKE AUTHORIZATION

You may revoke any authorization at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released health information prior to receiving your request. If you are required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if we decide to contest any of your claims.

I have read the consent policy and agree to its terms. I also acknowledge that I have been offered and/or received a copy of this consent form and a copy of the privacy notice (Notice of Privacy Practices for Protected Health Information).

Printed Name _____ Date _____

Signature of Patient _____ Relationship to Patient _____

ELMBROOK CHIROPRACTIC

Informed Consent to Chiropractic Treatment

Patient Name: _____

I, hereby, request and consent to the performance of procedures which are within the scope of practice of chiropractic, including but not limited to, chiropractic adjustments, various modes of physical therapy, and diagnostic X-rays, on me (or the patient named above, for whom I am legally responsible) by Dr. Nichole Schultz and/or any other licensed doctor or chiropractor who will now or in the future treat me while being employed by, working or associated with, or serving as a back-up for Dr. Nichole Schultz at Elmbrook Chiropractic.

I have had the opportunity to discuss with Dr. Nichole Schultz and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that there are some risks to chiropractic treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains/strains. I do not expect the doctor to anticipate and explain all the risks and complications. I wish to rely on the doctor to exercise judgement during the procedure which the doctor deems is in my best interest at the time and is based on the facts known.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about the content, and by signing below I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment

Print Name of Patient _____ Date _____

Signature of Patient _____ Relationship to Patient _____