Berven Chiropractic
6534 Gunn Hwy., Tampa, FL 33625
813-968-3500

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Date- / /

PATIENT NAME

First Name- Last Name- DOB- / /

CONTACT INFORMATION

Address- City- State- Zip-

Home ( ) Work ( ) Cell ( ) Email-

Preferred Contact-Home/Work/Cell/Email Emergency Contact Name- Phone-( )

PERSONAL INFORMATION

Gender- M F Marital Status- Single/Married/Widowed/Divorced/Legally Separated

Spouse Name- Preferred Language- English/Spanish/Other

Race- African American/Asian/Caucasian/Hispanic/Other- Hispanic or Latino Ethnicity? Yes/No

INSURANCE INFORMATION

Name of Primary Insured- DOB- / / SSN-

Phone Number- ( ) Relationship to Patient-

Employer Name- Work Phone- ( )

Work Address- City- State- Zip-

Insurance Company Name- Phone- ( )

Group Number- Employer Number- Deductible Met? Y / N

Do you have additional insurance (secondary)? Y / N If yes, please complete the following.

Insurance Company Name- Phone- ( )

Group Number- ID Number- Deductible Met? Y / N

SIGNATURES

Name of the Insured-

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand an agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable

Patient's Signature- Date-

Spouse or Guardian Signature- Date-

REASON FOR VISIT

In your own words, please answer the following questions.

What is your reason for visiting us today?

When did your symptoms start?

What were you doing when they started?

Does any movement or position make you feel BETTER?

Does any movement or position make you feel WORSE?

Can you put what you're feeling into words? (sharp, stabbing, aching, etc.)

Does the feeling radiate to any other areas? Where?

Are your symptoms worse at any point in the day? (morning, evening, middle of night, etc.)

Have you ever experienced symptoms like this before? When?

Have you noticed any OTHER symptoms that seem to be related?

Please use the following scale to rate your symptom 0-10. 0 being no pain at all and 10 being the worst pain you can imagine.

What are your symptoms RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10
What are your symptoms AT THEIR WORST?	0	1	2	3	4	5	6	7	8	9	10
What are your symptoms AT THEIR BEST?	0	1	2	3	4	5	6	7	8	9	10

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Patient Name_____

MEDICAL HISTORY

Medications:

Name	Dosage (mg?)	Frequency	Duration (how long?)	Known Side Effects?

Major Traumas:

Type (check all that apply)		Date of Injury	Description including short-term and long-term effects
Car Accident	O		
Broken Bones	O		
Struck Unconcious	O		
Sprains/Strains	O		
Other: _____	O		
Other:	O		

Surgeries:

Date	Type of Surgery	Results of Surgery (fully recovered/continued symptoms?)

Hospitalizations:

Date	City	Hospital	Reason

Major Illness:

Date	Illness	Results of Illness (fully recovered/continued symptoms?)

Allergies:

Type	Reaction	Date of last episode

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Patient Name_____

Medical History Continued

Recent Testing:

Date	Type (X-Ray,CT,MRI,Labs,etc.)	Reason	Results	Testing Location

Family History:

Relationship	Age	Medical Condition(s)	Deceased?	Cause of Death
Father				
Mother				

Social History:

Lives With- Parents/Spouse/Alone **Smoking Status-** Never Smoked/Former Smoker/Current Smoker ___cigarettes/day

Alcohol- None/Casual/Moderate/Heavy **Caffeine-** ___drinks/day **Recreational Drugs-** None/Casual/Addict

___drinks/day or week **Exercise-** Never/Daily/Weekly **Type of Exercise-** Walk/Run/Swim/Gym/Other

Occupational History:

Employment Status- Employed/Unemployed/Retired/Student **Employer or School Name-** _____

Employment History

Company Name	Start Date	End Date	Description of Duties

ADDITIONAL INFORMATION

Have you ever suffered from: (check all that apply)

O Alcoholism	O Constipation	O Hemorrhoids	O Nosebleeds	O Thyroid Condition
O Allergies	O Cramps	O High Blood Pressure	O Pacemaker	O Tuberculosis
O Anemia	O Depression	O Hot Flashes	O Polio	O Ulcers
O Arteriosclerosis	O Diabetes	O Irregular Heart Beat	O Poor Posture	O Varicose Veins
O Arthritis	O Digestion Problem	O Irregular Cycle	O Prostate Trouble	O Venereal Disease
O Asthma	O Dizziness	O Kidney Infection	O Sciatica	O OSTEOPOROSIS
O Back Pain	O Ears Ringing	O Kidney Stones	O Scoliosis	O RHEUMATOID ARTHRITIS
O Breast Lump	O Excessive Menstruation	O Loss of Memory	O Shortness of Breath	O ABDOMINAL AORTIC ANEURYSM
O Bronchitis	O Excessive Thirst	O Loss of Balance	O Sinus Infection	O Other _____
O Bruise Easily	O Eye Pain/Problem	O Loss of Smell	O Sleep Trouble/Insomnia	
O Cancer	O Fatigue	O Loss of Taste	O Stroke	
O Chest Pain	O Frequent Urination	O Neck Pain/Stiffness	O Swelling of Ankles	
O Cold Arms/Legs	O Headaches	O Nervousness	O Swollen Joints	

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Financial Policies

I understand this office will process my insurance forms as a courtesy, to me, and will provide sufficient information to the carrier to obtain payment for my treatment. In some instances insurance companies may deny or reduce payment despite best efforts to demonstrate the necessity for care. I understand that my insurance policy is a contract between myself and the insurance carrier. I agree to assume all financial responsibility once these limitations have been satisfied and no further insurance coverage is available. I understand that services are payable when rendered, unless previous financial arrangements have been made.

Neuromuscular massage therapy, stress relief massage, rehabilitative exercises, as well as maintenance/preventive chiropractic treatment, are usually considered outside covered insurance benefits, therefore, my financial responsibility. Some insurance companies exclude the therapy modalities (EMS, Ultrasound, Diathermy, Traction, etc.). While the doctor may recommend this treatment to you as medically necessary and beneficial for my particular condition, I understand that it is my financial responsibility.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____(insurance company) and assign directly to Dr. Berven 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. Berven may use my health care information and may disclose such information to the above-named insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ / _____

Signature of Patient, Parent Guardian or Personal Representative — Please print name

_____/ _____

Date — Relationship to patient

Notice: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Berven Chiropractic **6534 Gunn Hwy., Tampa, FL. 33625** **(813) 968-3500**

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations.
Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.
A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-Rays), and laboratory testing.
The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.
In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.
Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.
I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. BERVEN TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ _____

Patient Signature Date

BERVEN CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
(45 CFR 164.520)

PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice describes how medical information about you may be used and disclosed and you can get access to that information as required by 45 CFR 164.520.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. This Notice may be amended or revised at which time you will be provided the revised or amended Notice to review.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

- (a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

- (b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

- (c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) Any information is deleted that would identify you.

(b) To a company or person who is not employed by the practice to provide a service such as billing insurance and/or electronic records. These persons/companies are called "Business Associates." Only that information necessary to perform the service will be submitted to the business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

(c) To a person that you designate as a personal representative who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Appointment reminders are used by the Practice. The Practice will use those methods which you designate at the end of this Notice, such as: a) a postcard mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone; or sending you an email or text message.

DIRECTORY/SIGN-IN LOG-NOT USED AT OUR PRACTICE

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850 414-3300 if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Lisa Johnson, at 813-968-3500 or via email at office@bervenchiropractic.com

PRACTICE'S REQUIREMENTS

1. The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:

  Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases, Section 456.057 relating to patient records ownership, control and disclosure and Section 501.171 relating to protecting your personal information, Social Security and driver license numbers, credit or debit card information, financial accounts information, email address, and medical information.

- (c) Is required to abide by the terms of this Privacy Notice.

- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below whom is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is Lisa Johnson.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE

This Notice is in effect as of 10/03/2016.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:
Mail_____;
Email_____; at email address_____;
I ACKNOWLEDGE THAT EMAIL WILL NOT BE ENCRYPTED_____;
Telephone numbers_____;
By voice mail_____;
By text message-N/A;

By checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by;
Mail_____;
Email_____; at email address_____;
I ACKNOWLEDGE THAT EMAIL WILL NOT BE ENCRYPTED_____;
Telephone numbers_____;
By voice mail_____;
By text message-N/A;

By checking the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition.
Mail_____;
Email_____; at email address_____;
I ACKNOWLEDGE THAT EMAIL WILL NOT BE ENCRYPTED_____;
Telephone numbers_____;
By voice mail_____;
By text message-N/A;

_____ _____
Patient Name (please print) Date

_____
Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

Berven Chiropractic
6534 Gunn Hwy.,
Tampa, FL. 33625
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Berven Chiropractic

OFFICE POLICY

Welcome to Our Office

We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of restoring or maintaining your health. If we do not believe your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate. Our practice will strive to provide you with the finest quality chiropractic care. If you have any questions, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship.

We ask that all cell phones be turned off before you are brought back for your treatment.

Transferring Records

If you want to have copies of your records, you must authorize us to include all relevant information. If you want your records transferred from another doctor or organization to us, you authorize us to receive all relevant information.

Payment Options

You may choose to pay cash, check, credit or by debit on the day that the treatment is rendered.

Insurance

Insurance is a contract between you and your insurance company. We will provide you with the service of billing your insurance company for you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by your insurance.**

Verification of Benefits

We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what chiropractic coverage is available on your policy. You as the policy holder are primarily responsible to verify benefits. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Required Payments

Any co-payment, deductibles or coinsurance, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payments

Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Past Due Accounts

If your account becomes past due, we will take steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs. You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date

Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____

Patient Signature

_____

Date

BERVEN CHIROPRACTIC 6534 GUNN HWY, TAMPA, FL 33625

PATIENT NAME:_____

What is your **primary** complaint? _____

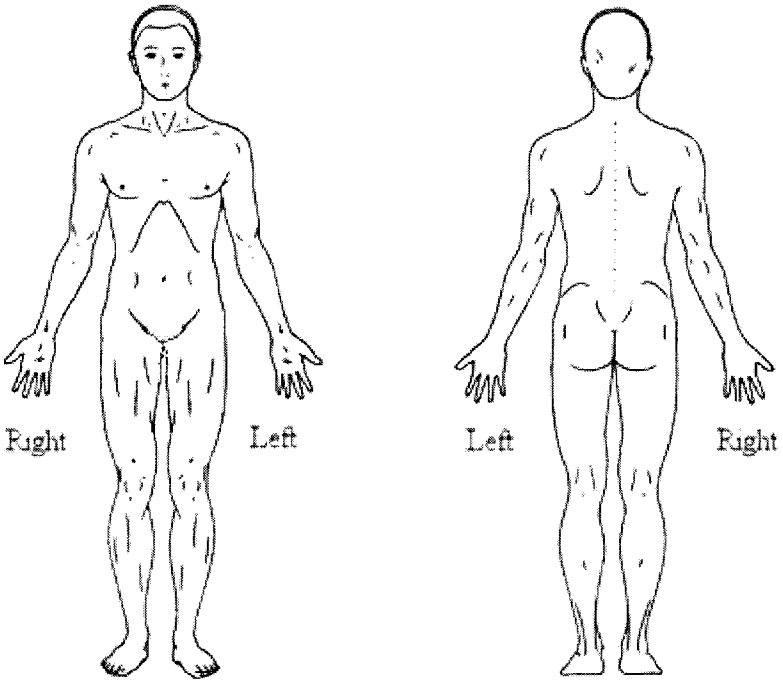
Do you have any additional symptoms that are related to this? _____

If yes, please list: _____

Since my last visit, I feel (circle one): worse__slightly worse__no change__slightly improved__improved

Please illustrate your symptoms below with the following letters at the site of pain.
Type of Pain: Stiff-(S) Burn-(B) Numb-(N) Tingling-(T) Ache-(A) Sharp-(X) Dull-(D) Pulsing/Throb-(P)

Pain Chart



1-Symptoms that do not affect life in any way

2-Symptoms that slightly affect life

3-Symptoms that don't affect daily activities

4-Symptoms that affect daily activities

5-Symptoms that prevent performing daily activities

6-Symptons that limit work schedule

7-Symptoms that prevent attending work

8-Symptoms that prevent work and all personal activities

9-Symptoms that keep me from leaving home

10-Symptoms that cause thoughts of suicide

Signature _____ Date_____

Notes:_____

_____

_____

Exam: 99202 99203 Re-Exam: 99212 99213 99214 X-rays: 72050 C spine 72110 L spine

Treatment: 98940 (1-2) 98941(3-4) G0283 (EMS) 97014 (EMS) 97530 (TA or Cox) 97140 (Man Tx)

97110 (Ther Ex) 97032 (Auriculo) Massage (30) or (60) 4000F 98942 98943

Return for care:_____ Amt paid:_____