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

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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
6534 Gunn Hwy
Tampa, Florida 33625
PH: 813-968-3500

Notice of Patient Privacy Policy

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is: Lisa Johnson

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.bervenchiropractic.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of students.

  For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

  We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

  We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- *Disclosures of psychotherapy notes*
- *Uses and disclosures of Protected Health Information for marketing purposes;*
- *Disclosures that constitute a sale of Protected Health Information;*
- *Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then

your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of Protected Health Information to a health plan when you pay out of pocket in full for the healthcare delivered by our office.* You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may opt out of fundraising communications in which our office participates.*

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u>** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***<u>You have the right to be notified by our office of any breech of privacy of your Protected Health Information.</u>***

- **<u>Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.</u>**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:* https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Lisa Johnson. You may contact our Privacy Officer or any staff member, including , at the following phone number: 813-968-3500 or on our website: www.bervenchiropractic.com for further information about the complaint process.

This notice was published and becomes effective on November 1, 2022

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? ____

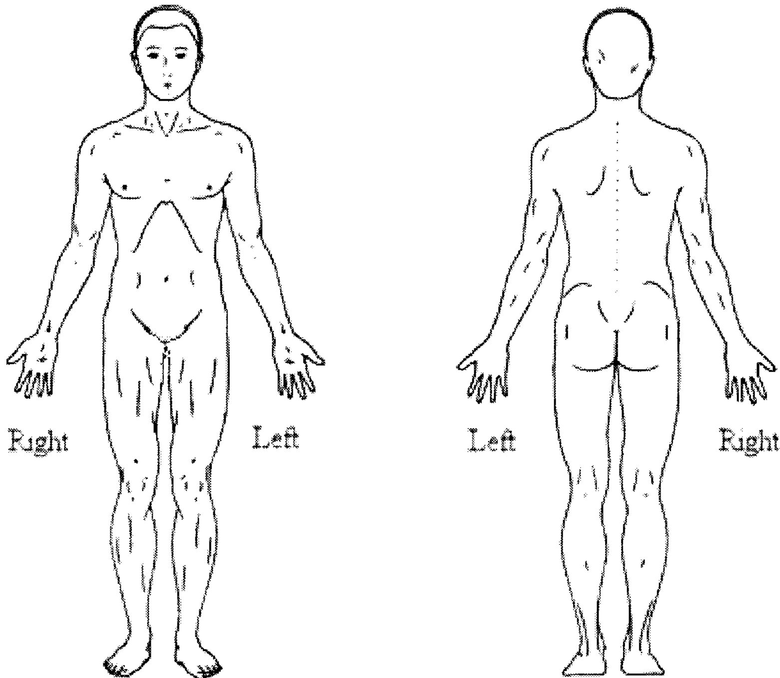
Do you have any additional symptoms that are related to this? ______________________________

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:_______________