

# Patient Information

Date \_\_\_\_\_ Patient # \_\_\_\_\_ Doctor \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address: \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Race \_\_\_\_\_ Marital: M S W D How many children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ Office Phone \_\_\_\_\_

Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Name of Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Purpose of this appointment \_\_\_\_\_

Date symptoms appeared or accident happened \_\_\_\_\_

Have you had previous chiropractic care?  Yes  No Date of Last Adjustment \_\_\_\_\_

Reasons for Previous Chiropractic Care \_\_\_\_\_

Family Medical Doctor (include location) \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

What surgeries have you had? (Include dates) \_\_\_\_\_

Serious illnesses (include dates) \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year?  Yes  No

If yes, describe: \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

What vitamins or supplements are you taking? \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case.

- Major Medical  Worker's Compensation  Medicaid  Medicare  Auto Accident  Other  
 Medical Savings Account & Flex Plans

Name of Primary Insurance Company \_\_\_\_\_

Name of Secondary Insurance Company (if any) \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

### SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:  
OFTEN= "O"    SOMETIMES= "S"    NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify)_____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	

### FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

**Patient's Signature** \_\_\_\_\_

PATIENT PERSONAL HISTORY

Patient \_\_\_\_\_ Date \_\_\_\_\_

Childhood Diseases: Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Others \_\_\_\_\_

Unusual Childhood Diseases: \_\_\_\_\_

Adult Illnesses or Conditions: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Fractures: \_\_\_\_\_

Are you allergic to any drugs or medications? \_\_\_\_\_

Describe Your Symptoms

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date symptoms appeared \_\_\_\_\_

Have you ever had the same or similar condition? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when and describe \_\_\_\_\_

What other treatment have you had for this condition? \_\_\_\_\_

Is the condition due to injury or sickness arising out of employment? \_\_\_\_\_

Is the condition due to injury or sickness arising out of an auto or other accident? \_\_\_\_\_

Date accident happened \_\_\_\_\_ Days lost from work? \_\_\_\_\_

Have you had or do you now have any of the following symptoms? Please indicate with the letter **N** if you have these conditions now or **P** if you have had these conditions previously.

**N** = Now

**P** = Previously

Headaches _____ Frequency _____	Loss of Balance _____
Neck Pain _____	Fainting _____
Stiff Neck _____	Loss of Smell _____
Sleeping Problems _____	Loss of Taste _____
Back Pain _____	Unusual Bowel Patterns _____
Nervousness _____	Feet Cold _____
Tension _____	Hands Cold _____
Irritability _____	Arthritis _____
Chest Pains/Tightness _____	Muscle Spasms _____
Dizziness _____	Frequent Colds _____
Shoulder/Neck/Arm Pain _____	Fever _____
Numbness in Hands/Fingers _____	Sinus Problems _____
Numbness in Feet/Toes _____	Diabetes _____
High Blood Pressure _____	Indigestion Problems _____
Difficulty Urinating _____	Joint Pain/Swelling _____
Weakness in Extremities _____	Menstrual Difficulties _____
Breathing Problems _____	Weight Loss/Gain _____
Fatigue _____	Depression _____
Lights Bother Eyes _____	Loss of Memory _____
Ears Ring _____	Buzzing in Ears _____

**Women: Are you pregnant?** \_\_\_\_\_

Name \_\_\_\_\_ No. \_\_\_\_\_ Date \_\_\_\_\_

*Please read carefully:*

Mark the areas on your body where you have symptoms, using the appropriate symbols below. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops, extending the arrow as far as the pain travels.

Ache >>>>>

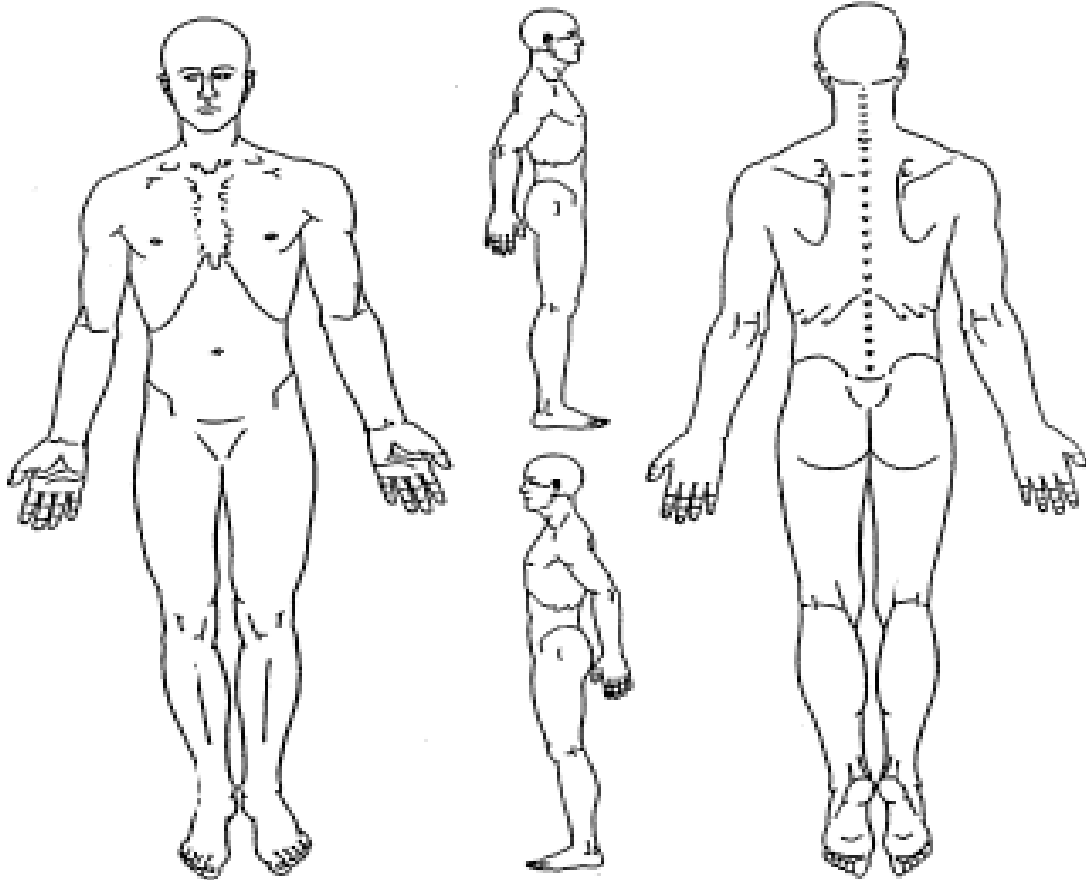
Burning x x x x x

Numbness = = = = =

Stabbing // // //

Pins & Needles ° ° ° ° °

Throbbing ~ ~ ~ ~ ~



# **PATIENT AUTHORIZATION FORM**

## **Authorization to Release Information to Family Members**

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**I authorize Greer Chiropractic & Rehabilitation to release my records and any information requested to the following individuals.**

1. \_\_\_\_\_ Relationship: \_\_\_\_\_
2. \_\_\_\_\_ Relationship: \_\_\_\_\_
3. \_\_\_\_\_ Relationship: \_\_\_\_\_
4. \_\_\_\_\_ Relationship: \_\_\_\_\_

## **Authorization Regarding Messages**

**(please check all that apply)**

\_\_\_ I authorize you to leave a detailed message on my home or cell number regarding appointments

\_\_\_ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

\_\_\_ I authorize you to leave a message with anyone who answers the phone

\_\_\_ Messages may only be left with \_\_\_\_\_

\_\_\_\_\_  
Patient Name (PLEASE PRINT)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

**Greer Chiropractic & Rehabilitation  
456 Washington Avenue  
Bridgeville, PA 15017**

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

*For further information regarding this notice, please contact our Doctor at 412-914-8965*

## **Back Oswestry Disability Index**

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

### **Section 1 – Pain Intensity**

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### **Section 2 – Personal Care (washing, dressing, etc.)**

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

### **Section 3 - Lifting**

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### **Section 4 – Walking**

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

### **Section 5 – Sitting**

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

### **Section 6 – Standing**

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

### **Section 7 – Sleeping**

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

### **Section 8 – Sex life (if applicable)**

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

### **Section 9 – Social Life**

- My social life is normal and cause me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

### **Section 10 – Traveling**

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

### **Section 11 - Previous Treatment**

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No
- Yes (if yes, please state the type of treatment you have received)

Name and ID#: \_\_\_\_\_

Date: \_\_\_\_\_

Reserved for Office Use:

Score: \_\_\_\_\_

## Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

### Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

### Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

### Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

### Section 4 – Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

### Section 5 – Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

### Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

### Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

### Section 8 – Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

### Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

### Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

Name and ID#: \_\_\_\_\_

Date: \_\_\_\_\_

Reserved for Office Use:

Score: \_\_\_\_\_