# Patient Information

Date: _____

First Name: _____ M.I.:_____

Last Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip code: _____

Date of birth:_____

Home phone :(_____) _____-_____

Cell phone :(_____) _____-_____

Text message reminders? : YES NO

If yes, please provide your cell phone carrier: _____

Email address: _____

Emergency contact name: _____

Relationship to emergency contact: _____

Emergency contact phone number: _____

Circle one: Minor Single Married Divorced Widowed

Ethnicity: African-American Caucasian Hispanic Indian Asian Other_____

Preferred Language: _____

# HEALTH HISTORY

1. What is your MAJOR COMPLAINT today_____
2. WHEN did THIS happen? _____
3. HOW did this happen? _____
4. Is the pain getting better, worse or staying the same? _____
5. Is the pain stopping you from doing any of your normal daily activities? Yes No If yes, please describe:_____
6. Are you pregnant or trying to get pregnant? Yes No
7. Describe your pain. Dull achy stiff sharp shooting burning tingling throbbing pressure spasms Other: _____
8. Is the pain CONSTANT, FREQUENT, or does it COME and GO?
9. Does the pain radiate? Yes/No If yes, WHERE? Arm R/L Hand R/L Leg R/L Foot R/L Buttock R/L
10. When is the pain worse: Morning, Afternoon, Evening, Disturbs Sleep, As day progresses, No change
11. What makes the pain WORSE? Walking, Standing, Sitting, Bending, Lifting, Trying to Stand Up, Driving, Work, Sports, Sleeping, Coughing, Sneezing, Laughing, Other: _____
12. When is the pain better: Morning, Afternoon, Evening, Disturbs Sleep, As day progresses, No change
13. What makes the pain BETTER? Ice, Heat, Stretches, Sitting, Lying Down, Standing, Walking, Medication: _____Other:_____
14. Do you have any weakness in your arms, hands, or legs? Yes No _____
15. Do you have any recent changes in your bowel or bladder? Yes No _____
16. Are you RIGHT handed or LEFT?
17. Height: _____ ft. _____ in. Weight: _____ lbs.
18. Please list your MEDICATIONS and what you are taking them for:

    _____
19. Please list any ALLERGIES to MEDICATIONS/Environment/Food:

    _____
20. List any major SURGERIES, past ILLNESSES, TRAUMAS or FRACTURES.
    _____DATE: _____ _____DATE: _____
21. Have you had any recent X-RAYS, MRI'S, CT SCAN, ETC:_____
22. Please indicate illness on family history; Cancer, Diabetes, Stroke, Heart Condition, Other:

Mother_____Father_____

Sister_____Brother_____

MaternalGrandmother_____ Maternal Grandfather_____

Paternal Grandmother_____ Paternal Grandfather_____

23. Occupation: _____
24. Marital Status: Single Married Divorced Widowed
25. Smoking History: Never Smoked Former Smoker Currently Smokes Everyday Some days
26. Alcohol Use: None Casual Moderate Heavy Drinks Beer Drinks Wine
27. Caffeine Use: None <3 drinks/day 3-6 drinks/day >6 drinks/day
28. Exercise: None Daily Weekly Walks Runs Swims Weight Lifting
29. Do you have any OTHER SYMPTOMS you would like to discuss at this time? _____

Patient Name: _____

Patient Signature: _____ Date: _____

# E&M PAIN DRAWING

Please circle on the pain scale from 0 to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition, 0 being no pain.

Type of Headache pain: Achy, Dull, Sharp, Throbbing, Pressure
Circle Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Type of Neck Pain: Stiff, Achy, Burning, Numb/Tingling, Sharp, Throbbing, Pressure, Spasms
Circle Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Type of Shoulder/Arm Pain: Stiff, Achy, Burning, Numb/Tingling, Sharp, Throbbing, Pressure, Spasms
Circle Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Type of Mid Back Pain: Stiff, Achy, Burning, Numb/Tingling , Sharp, Throbbing, Pressure, Spasms
Circle Pain Level: 0 1 2 3 4 5 6 7 8 9 10

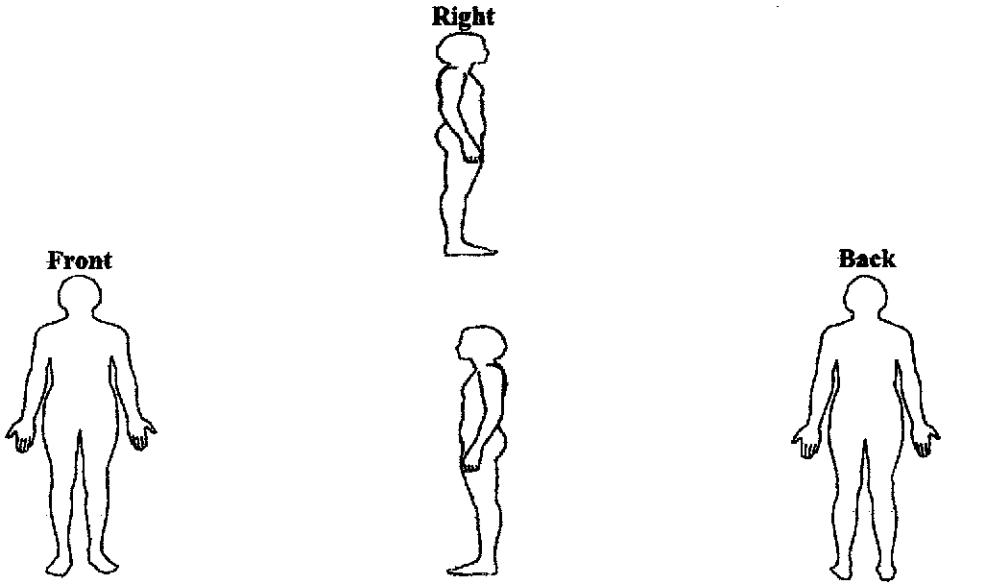
Type of Low Back Pain: Stiff, Achy, Burning, Numb/Tingling, Sharp, Throbbing, Pressure, Spasms
Circle Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Type of Hip/Leg Pain: Stiff, Achy, Burning, Numb/Tingling, Sharp, Throbbing, Pressure, Spasms
Circle Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Type of Foot/Ankle Pain: Stiff, Achy, Burning, Numb/Tingling, Sharp, Throbbing, Pressure, Spasms
Circle Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Mark areas of pain on figures below.

**Pain Chart**



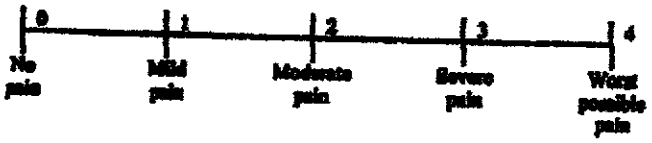

**Patient Name:**_____

**Patient Signature:**_____ **Date:** _____

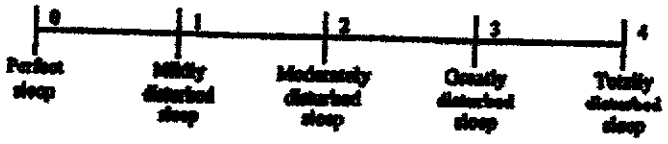
# Functional Rating Index

**In order to properly assess your condition, we must understand how much your neck and/or back problems has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.**

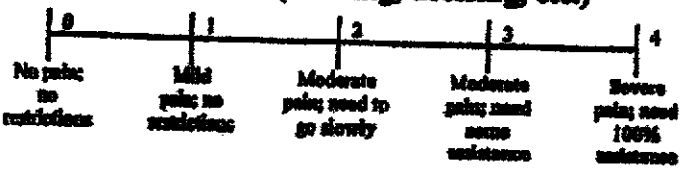
### 1. Pain Intensity



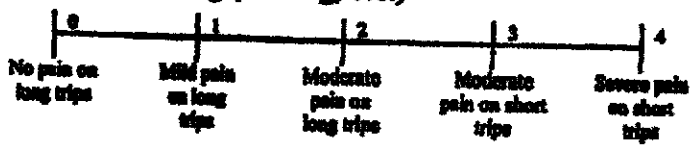

### 2. Sleeping




### 3. Personal Care (washing, dressing, etc.)




### 4. Travelling (driving, etc.)




### 5. Work

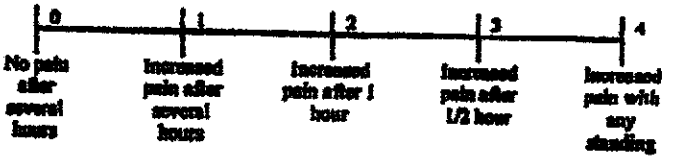

### 6. Recreation


### 7. Frequency of Pain


### 8. Lifting


### 9. Walking


### 10. Standing




_____

**Patient's Signature**

_____

**Date**

**For Office Use Only:**

**Practitioner ID#:** _____

**Total Score** _____ / 40

**Clinical Diagnosis Codes:**

**Patient ID#:** _____

# Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic/therapeutic procedures, including various modes of physical therapy, manual therapy, massage therapy, acupuncture, and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible), by Dr. Lindsey and/or Associate Doctors who now or in the future treat me while employed or serving as back-up Dr. Lindsey and/or Associate Doctors as well as any Therapists and/or clinic personnel trained to assist in my care.

I have had an opportunity to discuss with the Doctor, Associates, and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the Doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular, and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of treatment in this clinic. I understand that the Chiropractor will use their hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which they feel at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information given by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, the practice originated and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among other health professionals who may contribute to my care, a source of information for applying my diagnosis and treatment information to my bill, and a means by which a third-party payer can verify that services billed were actually provided.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, expect to the extent that the practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to chiropractic adjustments and chiropractic/therapeutic procedures. I have also had an opportunity to ask questions about its content, and by signing below I agree to, but not limited to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name (Patient): _____ Date: _____

Signature: _____

Witness to Patient's Signature: _____

# The following are internal policies set in place by the administration of Lindsey ChiroPlus. Your signature is required at the bottom of the form in order to be seen by any of the practice's providers.

**Insurance Filing**

As a courtesy we will bill your insurance company for charges incurred at our clinic. Please remember your health insurance is a contract between you and your insurance company. Our office will attempt to settle any outstanding bill with your insurance company. If your insurance company deems a service to not be covered by your insurance plan you will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance carrier within 90 days will become your responsibility as a non-covered service. We will furnish information required by the insurance company to receive payment. Benefits should be paid directly to the practice from your insurance company. If your insurance company pays you directly, payment will be expected within 10 days after your receipt of such payment. You are responsible for payment of any deductibles, co-pays, coinsurance or other similar charges.

**Bad Debt & Bankruptcy Account Status**

I realize that if my account is in bad debt or bankruptcy status I will be required to pay my past balance in full before treatment and any future appointments need to be paid in full at time of service.

**Non-Sufficient Funds**

A $29.00 charge will be added for any non-sufficient funds notice from your bank. If your account is sent to collections and we have to litigate in court, your visit(s) with our office may become a matter of public record.

**Non-Insured Patients**

New Patient Office Visit: $157.00 Established Patient Office Visit: $57.00-$114.00

Final charges will be determined after the physician sees the patient and a complete assessment is made. Additional fee information is available upon the patient's request. We offer Care Credit as a financing option as well as a discount program.

**Financial Responsibility (Copayments, Coinsurance & Non-Covered Services)**

Payments for services are due at the time services are rendered, unless our staff has approved other arrangements in advance. It is my responsibility as a Guarantor or covered persons under my insurance plan to know and understand my benefit coverage. This is only a "Quote of Benefits" and is NOT a guarantee of payment. After claims are submitted to my insurance company, the remaining balance is my responsibility. I agree to be responsible for payment of all services rendered on my behalf or on my dependent's behalf.

**Authorization**

I certify that I have answered all questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including diagnosis and the records of any treatment or examination rendered to myself or my child. I authorize this information to be released to third party payers and/or health practitioners, if needed. I request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me.

**Cancellation Policy**

A 24 hour notice of cancellation is required for all chiropractic and therapy appointments. If a 24-hour notice is not received for my scheduled appointment, I will be charged the price of what my appointment was made for. The cancellation fee is billed only to me and not to my insurance company. I agree to provide a 24-hour notice of cancellation for all chiropractic and therapy appointment. I understand that if I do not provide notice, I will be financially responsible for the cancellation fee.

Signature of Patient or Parent: _____

Printed Patient Name: _____ Date: _____