Walker Chiropractic **INITIAL HEALTH STATUS**

PATIENT INFORMATION

Patient Name: _____ Age: _____ Gender: M F

Date of Birth: _____/_____/_____ Social Security Number: _____ - _____ - _____ Marital Status: M S D W

Spouse's Name: _____How many children: _____

Patient Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Referred by: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone Number: _____

Primary Care Physician Name: _____ PCP Phone: _____

Date of last physical exam: _____ Do you give permission to send your PCP a report? Yes No

What is your race? (Please circle one) White Black or African American Asian American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Declined to Answer

What is your ethnicity? (Please circle one) Hispanic or Latino Not Hispanic or Latino Declined to Answer

What is your preferred language? (Please circle one) English Spanish French German Italian Russian Portuguese Chinese Japanese Korean Vietnamese Declined to Answer

What is your preferred method of communication for private health data? (Please circle one)

Home Phone Work Phone Mobile Phone e-Mail Postal Mail In Person

I give Walker Wellness & Chiropractic permission to communicate with me via the contact information above: Yes No

INSURANCE – Please provide your card to our staff

Policy Holder's Name: _____ Relationship to patient: □ Self □ Spouse □ Child □ Other

Insurance Company: _____ ID # _____

Policy Holder's Date of Birth: _____/_____/_____ Secondary Insurance? Yes No (please present card)

HISTORY OF COMPLAINT – Describe your Current Problem and How it Began

□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □ Other: _____

Is this? □ Work Related □ Auto Related □ N/A

Date Problem Began: _____

How Problem Began: _____

Current Complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No pain Unbearable Pain

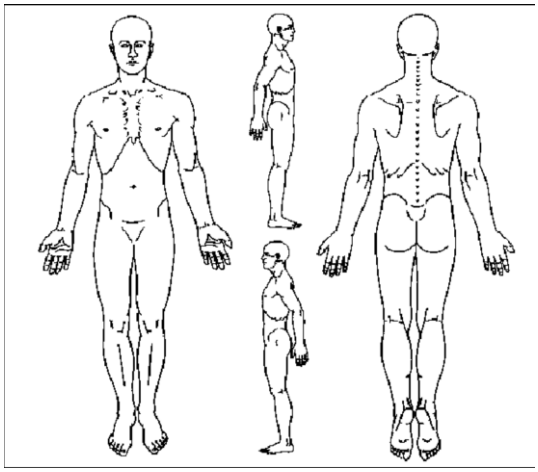
How often are your symptoms present?

(Occasional) □ 0 - 25% □ 26 – 50% □ 51 - 75% □ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, household chores)?

0 1 2 3 4 5 6 7 8 9 10

No interference Unable to carry on any activities



Mark an X on the picture where you have pain or other symptoms

In general would you say your overall health right now is:

□ Excellent □ Very Good □Good □ Fair □ Poor

Have you had spinal x-rays, MRI, CT Scan for your areas of complaint? Yes No Date: _____

Area(s) taken: _____

What aggravates your health problem? (circle all that apply) Coughing Sneezing Walking Reaching Lifting Bending Sitting Lying down Standing Neck movement Bowel movement

What relieves your health problem? (circle all that apply) Nothing Resting Heat Sitting Standing Ice

Have you had recent treatment for this condition? Yes No **Who did you see?** _____

Treatment received: _____

Have you had chiropractic care before? Yes No **Preference of technique:** hands instrument no preference

Please check all of the following that apply to you:

□ Alcohol/Drug Dependence
□ Recent Fever
□ Diabetes
□ High Blood Pressure
□ Stroke (date) _____
□ Corticosteroid use (Cortisone, Prednisone, etc.)
□ Taking Birth Control Pills
□ Dizziness/Fainting
□ Numbness in Groin/Buttocks
□ Cancer/Tumor (explain) _____
_____
□ Osteoporosis
□ Other Health Problems (explain) _____
_____

□ Prostate Problems
□ Menstrual Problems
□ Urinary Problems
□ Currently Pregnant, # Weeks _____
□ Abnormal Weight □ Gain □Loss
□ Marked Morning Pain/Stiffness
□ Pain Unrelieved by Position or Rest
□ Pain at Night
□ Visual Disturbances
□ Surgeries _____
_____
□ Epilepsy/Seizures

Are you currently taking any medications? (Please circle one) **Yes** **No** If yes, please list with date started:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Are you allergic to any medications? (Please circle one) **Yes** **No** If yes, please list:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

What is your smoking status? (Please circle one)

Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker

Heavy tobacco smoker Light tobacco smoker

Family History: □ Cancer □ Diabetes □ High Blood Pressure
□ Heart Problems/Stroke □ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health benefit through the provider, I understand that I am liable for all services rendered and I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that payment of services is due at the time of service unless other financial arrangements have been made. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature: _____ Date: _____

Doctor Signature: _____

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

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

Reading

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

Concentration

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

Work

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

Personal Care

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

Lifting

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

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

X-RAY CONSENT FORM

The purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis, or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office.

I understand that all xrays taken in this office are to remain property of Walker Wellness & Chiropractic clinic. If I desire to borrow my xrays, I will be permitted to sign them out for a period of no more than two weeks. All borrowed x-rays must be returned to this office.

I fully understand the above and consent to chiropractic spinal x-rays.

Patient's signature Date

_____ _____

INSURANCE POLICY

It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under chiropractic care.

1. The privilege of insurance assignment is conditional on receiving all the necessary insurance information to process claims.
2. All deductible payments must be made prior to the submission of your insurance claim.
3. Because of the privacy and HIPAA regulations you, the patient (subscriber), must qualify insurance policies and chiropractic benefits.
4. All co-payments are due at the time of service. If co-insurance payments are indicated on an Explanation of Benefits (EOB), the co-insurance is due at the time of notification. A co-payment is the amount an insurer may require to be paid per visit out-of-pocket by the subscriber. A co-insurance is a percentage amount of the office fee to be paid by the subscriber to the provider.
5. A $100.00 deductible, co-payment or co-insurance balance must not be exceeded by any patient.
6. The office will file claims for your primary insurer. We will provide EOBs and receipts for a patient to submit to a secondary insurer.
7. The insurance policy is a contract between the patient (subscriber) and the insurer. If our office (the provider) has difficulty with your insurer we will require your assistance to obtain details and information. If information is not forthcoming then the privilege of accepting assignment will be terminated.
8. There is no promise of payment by an insurance company made by this office. Any services not paid by the insurance carrier are due from you, the subscriber. As reimbursement rates and coverage policies tend to vary from month to month, we cannot be responsible for changes in your coverage.
9. It is the goal of this office to provide the finest quality of chiropractic care possible. However, insurance policies accommodate only symptom care and corrective care. They do not cover maintenance care. Care beyond correction of posture or symptom care is frequently considered maintenance by insurers. Care that is monthly is also frequently considered maintenance care by insurers.

"I request that payment of authorized insurance benefits be made on my behalf to Walker wellness & Chiropractic. I authorize any holder of medical information about me to release it to the insurance company and its agents any information needed to determine these benefits payable for service."

Print Name:_____

Signature:_____

Date: _____

Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA
and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of metal impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(print name)

All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(signature) (date)

CREDIT GUARANTEE
INSURANCE ASSIGNMENT & PERSONAL BALANCES

INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 30 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

FILING PROCEDURE

Claims for initial services are submitted within 48 hours after your first visit. On Day 30, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you.

PERSONAL BALANCES

Estimated personal portions are paid at the time of service. Any personal balance not paid at the time of service will also be automatically charged to your designated card below.

UNINSURED PATIENTS

Patients who are uninsured or whose insurance does not cover chiropractic care because of high deductibles or other limitations are personally responsible for payment. Payments may be paid at the time of service or at the beginning of the week. As a service to you and to keep your account current, any balance not paid at the time of service will be automatically charged to your designated card below. (Our office will notify you prior to processing any charges.) This procedure will enable you to keep your account current.

CREDIT CARD: ___ AMEX ___ VISA ___ MC ___ DISCOVER

CARDHOLDER NAME _____

CARD # _____ EXP. DATE _____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 60 days after submission of my claim, or should I terminate care before being dismissed by your physician, I will be charged the amount due.

_____ _____

SIGNATURE DATE