The Ohio Neck & Back Pain Relief Centers

491 E Center St, Marion, OH 43302
(740) 386-6580 (p) ~ (740) 386-6586 (f)

Date: _____

Confidential Patient Information

Patients Name: _____ Social Security #_____

Address: _____ Home Phone: _____

City: _____ Cell Phone: _____

State _____Zip: _____ Cell Provider: _____

Birth Date: _____Marital Status: M S W D Email: _____

Occupation: _____ Employer: _____

Who or What referred you to our office: _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holder Employer: _____

Family Physician: _____ May we send your health information to this provider ? **Y / N**

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **The Ohio Neck & Back Pain Relief Centers (Marion Waldo Chiropractic, LLC)**, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Guardian_____Date:_____

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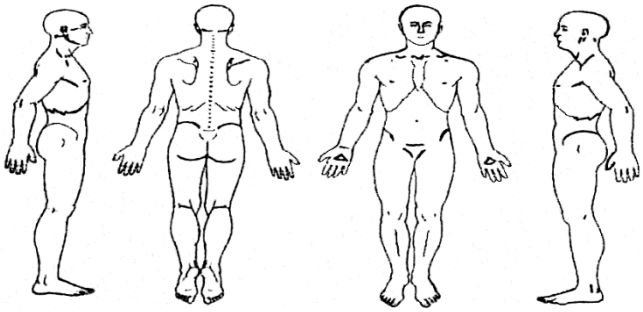
CASE HISTORY

Patient Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Please mark the figures where you experience pain.



2. Symptoms are worse in the (circle all that applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles / Tightness
4. Symptom (b) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles / Tightness
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No _____Yes. How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
16. List any other major injuries you have had, other than those mentioned above: _____

_____

17. Any other musculoskeletal problems? ____No ____Yes Any neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ **Date:** _____

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Patient Name:_____

Family History

	Father	Mother	Siblings	Grandparents	Children
Cancer	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐	☐
Alcohol Use	☐	☐	☐	☐	☐
Tobacco Use	☐	☐	☐	☐	☐
Drug Use	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Family Members still Alive	☐	☐	☐	☐	☐
Other Hereditary Disorders	☐	☐	☐	☐	☐

How many children do you have? _____

What are their current ages? _____

Personal Habits

Type	**Amount_____Per*_**
Exercise	_____
Dairy Products	_____
Soda/Pop	_____
Coffee/Tea	_____
Alcohol	_____
Tobacco(any type)	_____
Drugs(any type)	_____
Vitamins	_____

*please write Day, Week, or Month as applicable

Occupation

What is your trade?_____

Does your job require you to :
☐ Sit ☐ Stand ☐ Bend ☐ Walk ☐ Lift
How Much?_____

Women Only:
To the best of my knowledge I **am / am NOT** pregnant
and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.

HIPAA Statement

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 HIPPA NOTICE that is available to you at the front desk before signing this consent. Upon request, you will be given a copy. If there is anyone you do not want to receive your medical records, please inform our office.

Patient/Guardian signature_____**Date:**_____

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Patient Name: _____ **Date: _____**

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of provider in your health care regimen. I understand that if I am accepted as a patient by a physician at **The Ohio Neck & Back Pain Relief Centers**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.
Any missed appointment that is not canceled 24 hours prior to scheduled appointment will be charged $25.00

Consent to Evaluate and Treat a Minor:

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.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]
May we contact you via email? Yes [ ] No [ ]

Name of emergency contact_____Relation_____Phone_____

Address_____City_____State_____Zip_____

Acknowledgement

I have read and fully understand the above statements

Patient/Guardian Signature _____ Date: _____

Patient Name:_____Date:_____

FUNCTIONAL RATING INDEX

For Neck and/or Back Problems only: Please circle the number which most closely describes your condition right now.

Section 1 – Pain Intensity

0) No pain
1) Mild pain
2) Moderate pain
3) Severe pain
4) Worst possible pain

Section 2 – Sleeping

0) Perfect sleep
1) Mildly disturbed sleep
2) Moderately disturbed sleep
3) Greatly disturbed sleep
4) Totally disturbed sleep

Section 3 – Personal Care(Washing, Dressing, etc.)

0) No pain; No restrictions
1) Mild pain; No restrictions
2) Moderate pain; Need to go slowly
3) Moderate pain; Need some assistance
4) Severe pain; Need 100%

Section 4 – Traveling (Driving, etc.)

0) No pain on long trips
1) Mild pain on long trips
2) Moderate pain on long trips
3) Moderate pain on short trips
4) Severe pain on short trips

Section 5 – Work

0) Can do usual work plus unlimited extra work
1) Can do usual work but *no* extra work
2) Can do 50% of usual work
3) Can do 25% of usual work
4) Cannot work

Section 6 – Recreation

0) Can do all activities
1) Can do most activities
2) Can do some activities
3) Can do a few activities
4) Cannot do any activities

Section 7 – Frequency of pain

0) No pain
1) Occasional pain; 25% of the day
2) Intermittent pain; 50% of the day
3) Frequent pain; 75% of the day
4) Constant pain; 100% of the day

Section 8 – Lifting

0) No pain with heavy weight
1) Increased pain with heavy weight
2) Increased pain with moderate weight
3) Increased pain with light weight
4) Increased pain with any weight

Section 9 – Walking

0) No pain; any distance
1) Increased pain after 1.0 mile
2) Increased pain after .5 mile
3) Increased pain after .25 mile
4) Increased pain with all walking

Section 10 – Standing

0) No pain after several hours
1) Increased pain after several hours
2) Increased pain after 1 hour
3) Increased pain after ½ hour
4) Increased pain with any standing