Dunns Corners Chiropractic Center

Robert C. Campbell, D.C., D.A.C.N.B. Michael Macijeski, D.C.

Name_____Home Phone_____Cell_____

Address_____City_____State_____Zip Code_____

Email Address_____

Age_____ DOB_____ Marital Status ☐ M ☐ S ☐ W ☐ D Number of Children_____

Employer_____ Occupation_____

Work Address_____ Work Phone_____

Name of Wife/ Husband / Significant Other_____Occupation_____

Employer_____ Work Phone_____

Patient's Nearest Relative_____ Address_____

Phone Number_____Office Phone_____

Referred By_____ ☐ Newspaper ☐ Yellow Pages ☐ Self ☐ Coupon

Preferred method of appointment reminder ____text____email Cell phone carrier_____

Date of last physical examination_____

Have you ever suffered from:

	Yes	No		Yes	No		Yes	No
1. Dizziness	☐	☐	6. Arthritis	☐	☐	11. Nervousness	☐	☐
2. Backaches	☐	☐	7. Headaches	☐	☐	12. Sinus Trouble	☐	☐
3. Heart Trouble	☐	☐	8. Asthma	☐	☐	13. Anemia	☐	☐
4. Diabetes	☐	☐	9. Neuritis	☐	☐	14. Cancer	☐	☐
5. Tuberculosis	☐	☐	10. Digestive Dis	☐	☐			

Reason for this appointment_____

Other doctors seen for this condition_____

Have you been treated by a physician in the last year? ☐ Yes ☐ No
Describe_____

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT! ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD**

Are you insured? ☐ No ☐ Yes, Ins Company_____Policy #_____

Name of
Insured_____DOB_____SS#_____

I understand and agree that health and accident insurance policies are an agreement between an insurance co. and myself. Furthermore, I understand that Dunn's Corners Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized be paid directly to Dunn's Corners Chiropractic Center and be credited to my account on receipt. However, I clearly understand and agree that any services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees from professional services rendered to me will be immediately due and payable.

PATIENT'S SIGNATURE_____ DATE _____

GUARDIAN OR SPOUSE'S SIGNATURE_____DATE_____

The Oswestry Disability Index for Back Pain

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section, and mark in each section the one box that 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 that most closely describes your present day situation.

Section 1. Pain Intensity

_____A. My pain is mild to moderate. I do not need pain killers
_____B. The pain is bad, but I manage without taking painkillers
_____C. Pain killers give me complete relief from pain
_____D. Pain killers give me moderate relief from pain
_____E. Pain killers give me very little relief form pain.
_____F. Pain killers have no effect on the pain.

Section 2 Personal Care

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

Section 3. Lifting

_____A. I can lift heavy weights without causing extra pain.
_____B. I can lift heavy weights but it gives me extra pain.
_____C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
_____D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
_____E. I can lift very light weights.
_____F. I cannot lift or carry anything at all.

Section 4. Walking

_____A. I can walk as far as I wish.
_____B. Pain prevents me from walking more than 1 mile.
_____C. Pain prevents me from walking more than ½ mile.
_____D. Pain prevents me from walking more than 1/4 mile.
_____E. I can walk only if I use a cane or crutches.
_____F. I am in bed or in a chair for most of the day.

Section 5. Sitting

_____A. I can sit in any chair for as long as I like.
_____B. I can sit in my favorite chair only, but for as long as I like
_____C. Pain prevents me from sitting for more than 1 hour.
_____D. Pain prevents me from sitting for than ½ hour.
_____E. Pain prevents me from sitting for more than 10 minutes.
_____F. Pain prevents me from sitting at all.

Section 6. Standing

_____ A. I can stand as long as I want without extra pain.
_____ B. I can stand as long as I want but it gives me extra pain.
_____ C. Pain prevents me from standing for more than 1 hour.
_____ D. Pain prevents me from standing for more than ½ hour.
_____ E. Pain prevents me from standing for more than 10 minutes.
_____ F. Pain prevents me from standing at all.

Section 7. Sleeping

_____ A. Pain does not prevent me from sleeping well.
_____ B. I sleep well but only when taking medicine.
_____ C. Even when I take medication, I sleep less than 6 hours.
_____ D. Even when I take medication, I sleep less than 4 hours.
_____ E. Even when I take medication, I sleep less than 2 hours.
_____ F. Pain prevents me from sleeping at all.

Section 8. Social Life

_____ A. My social life is normal and causes me no extra pain.
_____ B. My social life is normal, but increases the degree of pain.
_____ C. Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
_____ D. Pain has restricted my social life and I do not go out as often.
_____E. Pain has restricted my social life to my home.
_____F. I have no social life because of pain.

Section 9. Sexual Activity

_____A. My sexual activity is normal and causes no extra pain.
_____B. My sexual activity is normal, but causes some extra pain.
_____C. My sexual activity is nearly normal, but it is very painful.
_____D. My sexual activity is severely restricted by pain.
_____E. My sexual activity is nearly absent because of pain.
_____F. Pain prevents any sexual activity at all.

Secrion 10. Traveling

_____A. I can travel anywhere without extra pain.
_____B. I can travel anywhere, but it gives me extra pain.
_____C. Pain is bad, but I manage journeys over 2 hours.
_____D. Pain restricts me to journeys of less than 1 hour.
_____E. Pain restricts me to necessary journeys under ½ hour.
_____F. Pain prevents traveling except to the doctor/hospital.

Patient Name:_____

Date:_____ Score_____ _____

Signature

NECK DISABILITY INDEX

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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 causes extra pain.
- ☐ 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 self-care.
- ☐ I do not get dressed, I 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.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – Reading

- ☐ I can read as much as I want with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

SECTION 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

Date:_____

File #:_____

_____

Name

SECTION 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can not do any work at all.

SECTION 8 – Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

SECTION 9 – Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Dunns Corners Chiropractic Center

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Privacy Policy

1. All patient information is confidential.
2. Every attempt will be made to respect confidentiality when communicating with patients.
3. Patients will be informed of this policy upon entering the practice, and then yearly thereafter.
4. It is our policy to release patient information to other providers only with written Patient consent.
5. Only patients themselves may call for test results unless they have authorized us to give information to family members.
6. Employees will review this policy upon hiring, and then yearly thereafter.

Dear Patient,
Our sign in sheet is in open site, allowing the possibility for others entering the office to see your name. If you do not want to sign in, please let the receptionist know so we can make other arrangements.

At times the office may need to contact you regarding exam results, insurance claims, or appointment confirmation. If we call you and you are not available.

May we leave a message on an answering machine at home? Yes____ No____

May we leave a message on an answering machine at work? Yes____ No____

May we leave a message with a family member? Yes____ No____

May we leave a message with a co-worker? Yes____ No____

If yes, name of person_____

Please indicate the best telephone number for us to reach you:_____

Patient Signature:_____

Please Print Name:_____Date:_____

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as in necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-Mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date:_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in the policy. I understand that this consent shall remain in force from this time forward.

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BLANKET AUTHORIZATION/RELEASE FORM

___ **Insurance Assignment –** I authorize payment of medical benefits from _____ insurance company to be paid directly to: Robert C. Campbell, D.C., D.A.C.N.B., and his associate, for services rendered to me. If my current policy prohibits the direct payment to the doctor, then I also instruct and direct you to make out the check to me and mail it to our office. I also acknowledge that all services rendered to me are ultimately my financial responsibility. I agree to pay any balance that remains after my insurance company has made payment, and any unpaid balance that remains 60 days after services are rendered.

____ **Cash Policy** – I do not have insurance benefits available and agree to pay for all services rendered to me, at the time they incur, unless otherwise agreed to in the form of a financial payment contract.

____ **Records Release** – I hereby authorize the release of my x-rays and medical records from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form, to Dunn's Corners Chiropractic Center. SPECIFIC REQUEST FOR RECORDS FROM_____

____ **Authorize to Release Information** – I authorize your office to release any information you deem appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me in this chiropractic office. I hereby release you from any consequences thereof.

____ **Pregnancy Release** – To the best of my knowledge I am not pregnant. I understand that x-ray radiation may pose risks to an unborn child. I consent to having x-rays taken, and I release Dr. Robert Campbell, and his associate, and the office from any responsibility that could in any way associate damage to an unborn child with the x-ray examination. If you have any concerns, please consult the doctor.

____ **Termination of Care Waiver** – I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my attending chiropractor, I cannot expect maximum chiropractic results and the doctor has full and complete right to terminate my case and discharge me from care.

____ **Consent to Treat a Minor** – I hereby give my consent for Dr. Robert Campbell and/or his associate to examine and render treatment to my son/daughter_____who is a minor.

I have read the above blanket authorization/release form and agree to the _____ items checked off.

_____ _____
Patient Name (print) Patient/Guardian Signature

Date: _____ Witness:_____

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Patient's Signature Date

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

□ There is possibility that I may be pregnant at this time

□ Yes. I am definitely pregnant

□ No. I am definitely not pregnant at this time

□ I request that x-ray films not be taken because_____

_____

Date of last menstrual period: _____

_____

Patient's Signature Date