PATIENT INFORMATION

Date: _____ How did you hear about us? _____

First Name: _____ MI: _____ Last Name: _____

Problem Area: (circle) Neck Low Back Other: _____

SSN#: _____ DOB: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

E-Mail: _____

Emergency Contact: _____ Phone: _____

Do you have any x-rays or MRIs for this problem area? _____

If you don't have the films, where did you get them done?_____

Did a physician refer you to us for today's visit? ____ If so, Physician name: ____

Referring Physician Address/City: _____ Phone: _____

INSURANCE INFORMATION

Type: (circle) Auto Worker's Compensation Major Medical Medicare

Primary Insurance: _____Effective Date:_____

Policy Number: _____ Group Number: _____ Accident Date: _____

Policy Holder Name: (name on card) _____ Relationship to Patient: _____

SSN #: _____ DOB: _____ Sex: _____

Policy Holder Employer: _____

Secondary Insurance: _____ Effective Date:_____

Policy Number: _____Group Number: _____ Effective Date:_____

Policy Holder Name: (name on card) _____ Relationship to Patient: _____

SSN #: _____ DOB: _____ Sex: _____

Policy Holder Employer: _____

Acceptance as Patient

I understand and agree that the doctors of Alabama PainCare/SpineCare have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a medical history and the conduction of a physical examination are not considered treatment, but are part of the process of the information gathering concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

_____ _____

Signature of patient (or parent, if patient is a minor) Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to Privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments

I have received, read and understand your *notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

SpineCare

QUESTIONNAIRE

Name _____ Age _____ Occupation _____ Date _____

1. When (roughly what date) did your present pain start?
_____
Do you have buttocks, thigh or leg pain? ☐ Yes ☐ No
Which side? ☐ Right ☐ Left Please describe____
_____
Do you have arm, forearm pain or headaches? ☐ Yes ☐ No
Which Side? ☐ Right ☐ Left Please describe____
_____
Are you still working?
☐ Yes ☐ No Last day on the job?_____
When do you expect to be back at work?_____

2. How did the pain start? (check all that appy)

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Twisting
- ☐ Fall
- ☐ Turning
- ☐ Other_____
- ☐ Sleeping
- ☐ Injured at work
- ☐ Injured in auto accident
- ☐ Hit from behind
- ☐ Injured during sports
- ☐ No apparent cause

3. What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (afterward)
- ☐ Sitting
- ☐ Turning
- ☐ Lying
- ☐ Morning or evening
- ☐ Looking downward
- ☐ Looking upward
- ☐ Coughing
- ☐ Sneezing
- ☐ Rising (from sitting)
- ☐ When still / on the move

4. What activities make the pain better?

- ☐ Lying Down
- ☐ Sitting
- ☐ Walking
- ☐ Standing
- ☐ Manipulation
- ☐ Exercise
- ☐ Nothing
- ☐ Bending forward
- ☐ Bending backward
- ☐ Morning or evening
- ☐ When still / on the move
- ☐ Aspirin / anti-inflammatory
- ☐ Physical therapy
- ☐ Other_____

5. How long have you had this pain?
_____years _____months _____weeks
How many previous episodes? 0 1-5 6-10 11+
(circle one)
How long have you had similiar pain?
_____years _____months _____weeks

6. Have you had any ot these diagnostic studies?

	Yes	No	Date
Diagnostic x-rays	☐	☐	_____
CT (computer tomography scan)	☐	☐	_____
Myelogram (x-ray with dye injection)	☐	☐	_____
Electromyogram (EMG)	☐	☐	_____
Discography	☐	☐	_____
MRI (magnetic resonance imaging)	☐	☐	_____
Arthrogram or sonogram	☐	☐	_____
Injections	☐	☐	_____

7. Have you been hospitalized for your pain?
☐ No ☐ Yes
Number of times_____ Dates_____

8. Have you had surgery for this problem?
☐ No ☐ Yes
Number of times_____ Dates_____

9. How much caffeine do you consume? > 2 cups coffee, 3 cups of tea, or 2 soda beverages per day. (circle one)

10. What medications are you currently taking?_____
_____
_____

11. Rate your general health? Good / Fair/ Poor
(circle one)

12. Have you had any recent accidents? _____
_____

13. Do you have allergies?
☐ Yes ☐ No Please list_____
_____
What reactions have you had? _____
_____
Do you get motion sickness? ☐ Yes ☐ No

14. Do you smoke? ☐ Yes ☐ No How much?_____

15. Do you drink alcoholic beverages?
☐ Yes ☐ No How much?_____
_____

16. Have you received treatment from anyone?
☐ Yes ☐ No From whom?_____
What type of treatment? (check all that apply)

- ☐ Massage
- ☐ Manipulation
- ☐ Braces / Suppports
- ☐ Medication
- ☐ Psychological support
- ☐ Physical therapy
- ☐ Acupuncture
- ☐ Injections
- ☐ Exercises
- ☐ Other_____

_____
Did your treatment help the pain? ☐ Yes ☐ No
How long did the treatment help? _____

Last appointment _____/_____/_____

17. Who is your family physician? _____
_____

18. Do you have any additional information that would be helpful in understanding your problem?

_____
_____
_____
_____

QUESTIONNAIRE (cont.)

19. Previous operations or hospitalizations:

Date	Hospital	Reason

20. Do you have or have you had recently? (Please circle any and all that apply)

Head/Ears/Eye Problems

Glaucoma	□ Yes	□ No
Cataracts	□ Yes	□ No
Glasses/Contacts	□ Yes	□ No
Loss of Hearing	□ Yes	□ No
Painful chewing	□ Yes	□ No
Ringing in the ears	□ Yes	□ No

Respiratory Problems

Asthma	□ Yes	□ No
Shortness of breath	□ Yes	□ No
Pain with breathing	□ Yes	□ No
Coughing Up Blood	□ Yes	□ No
Lung Problems	□ Yes	□ No

Genital Problems

Infections	□ Yes	□ No
Herpes	□ Yes	□ No
AIDS	□ Yes	□ No
AIDS related disease	□ Yes	□ No

Metabolic Problems

Diabetes	□ Yes	□ No
Low Blood Sugar	□ Yes	□ No
Appetite Changes	□ Yes	□ No

Do you have a family history of:

Diabetes	□ Yes	□ No
Cancer	□ Yes	□ No
Heart Disease	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Strokes	□ Yes	□ No

Nose/Throat/Neck Problems

Hoarseness	□ Yes	□ No
Changes in Voice	□ Yes	□ No
Nose Bleeds	□ Yes	□ No
Thyroid Problems	□ Yes	□ No
Difficulty Swallowing	□ Yes	□ No
Painful Swallowing	□ Yes	□ No

Gastrointestinal Problems

Stomach Problems	□ Yes	□ No
Gallbladder Problems	□ Yes	□ No
Pancreatitis	□ Yes	□ No
Constipation/Diarrhea	□ Yes	□ No
Blood in Stool	□ Yes	□ No
Liver or Kidney Trouble	□ Yes	□ No

Neurological Problems

Headaches	□ Yes	□ No
Fainting/Blackouts	□ Yes	□ No
Seizures/Epilepsy	□ Yes	□ No
Strokes	□ Yes	□ No
Paralysis	□ Yes	□ No

Bleeding Disorders

Anemia	□ Yes	□ No
Bleeding Problems	□ Yes	□ No

Cardiovascular Problems

Chest Pains	□ Yes	□ No
Irregular Heartbeats	□ Yes	□ No
Low Blood Pressure	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Swollen extremities	□ Yes	□ No

Urinary Problems

Bloody Urine	□ Yes	□ No
Frequent Urine	□ Yes	□ No
Night time Urine	□ Yes	□ No
Trouble starting	□ Yes	□ No
Trouble stopping	□ Yes	□ No
Pain with urination	□ Yes	□ No

Skin Problems

Infections	□ Yes	□ No
Psoriasis	□ Yes	□ No
Skin Cancer	□ Yes	□ No
Swollen Ankles	□ Yes	□ No

General Problems

Fever or chills (night)	□ Yes	□ No
Swollen Ankles	□ Yes	□ No
Anxiety	□ Yes	□ No
Toothache	□ Yes	□ No
Frequent rashes	□ Yes	□ No
Hot or Cold spells	□ Yes	□ No
Leg or Foot Problems	□ Yes	□ No
Depression	□ Yes	□ No
Numbness in leg or thigh	□ Yes	□ No
Gout	□ Yes	□ No

Patient's Signature / Parents (if minor)

Date

Physician's Signature

Date

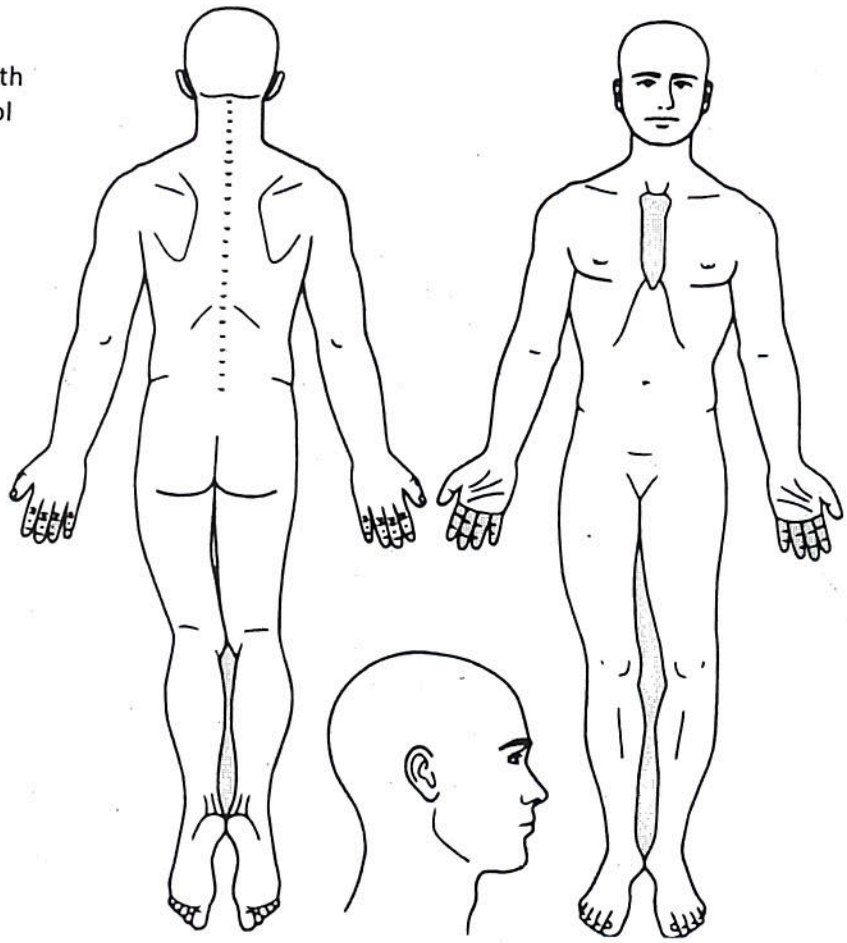
SpineCare

PAIN DIAGRAM

NAME _____ DATE _____

Ache	Numbness	Pins & Needles	Burning	Stabbing
Δ Δ Δ Δ	O O O O	• • • •	X X X X	////
Δ Δ Δ Δ	O O O O	• • • •	X X X X	////
Δ Δ Δ Δ	O O O O	• • • •	X X X X	////

Please mark areas with corresponding symbol



Visual Analog Scale (VAS)

Instructions: Please mark a vertical line through the line below indicating your pain today.

No Pain **Worst Possible Pain**

SpineCare
CHIROPRACTIC MEDICINE

Financial Statement

Thank you for choosing SpineCare. We are committed to your successful care. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Our financial policy is designed to give you a number of payment options to choose from to fit your unique financial needs.

We make every effort to verify your coverage and benefits prior to your doctor visit. This information is provided as a courtesy. It remains your full responsibility to know and understand your policy and benefits.

We require the payment of either the co-payment amount or the co-insurance percentage and any outstanding deductible at the time of service. If your primary and/or secondary insurance company reduces or denies any billed claim(s), you will be responsible for paying the remaining balance. If the insurance company has not paid a claim with 60 days of submission, we require patient payment for the balance via an approved payment method. You will ultimately be responsible for these charges.

SpineCare accepts cash, check, and these credit cards: Visa, MasterCard, Care Credit, Amex, and Discover.

Additional charges include a returned check fee of $25, and a missed visit fee, which will be assessed for $30-$50 when an appointment is missed without the required 24-hour notification. This fee will be waived in the event of an unforeseen emergency.

Thank you for trusting us with your health care. If you have any questions about our financial policy, or would like to discuss payment plan options, please inquire with the receptionist.

By signing below, I am acknowledging that I have read, understand, and agree to the provisions of this financial policy.

Signed: _____

Printed Name: _____

Date: _____