ORANGE PARK & ARGYLE CHIROPRACTIC CENTER

CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office. *Thank You*

Birth date ______________________ E-mail ______________________

PART A

Date ______________

Name ______________________________ Home Phone ______________

Address ____

Street Box or Number *City* *State* *Zip*

Purpose of this appointment ______________________________

Is this the same problem you were originally under care for? ( ) Yes ( ) No

If yes, are there additional symptoms? ______________________

Other doctors seen for this condition ______________________

What medications or drugs are you taking? ______________________

PART B

Occupation ______________________ Employer ______________________

Employer's address ______________________ Work Phone ______________

Spouse ______________________ Spouse's Employer ______________________

PART C

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I request this chiropractic clinic to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care, as determined by my treating doctor, any fees for professional services will be immediately due and payable.

____

Signature

Health Insurance Coverage? ( ) Yes ( ) No

Company ______________________________

1. What symptoms are you now experiencing? ______________________________

____

2. When did the most recent episode of pain begin? ______________________________

____

3. How did it occur? ______________________________

____

4. Where were you when the symptoms started? ______________________________

5. How frequent is the condition? ______________________________

6. When do you experience pain? ______________________________

7. What type of pain is it (sharp, ache, etc.)? ______________________________

8. Does anything provide relief? ______________________________

9. What makes it worse? ______________________________

10. Since the onset of symptoms are you getting better, worse, or the same? ____________

11. Who is your family medical doctor/clinic? ______________________________

____

12. Are you currently being treated for any other medical/health problems? ____________

13. List current medications. ______________________________

14. When did you last see your MD? List reason. ______________________________

____

15. List any injuries/broken bones/surgeries, etc. since last visit. ______________________________

____

16. Any other chiropractic treatment since last visit? List name/date. ____________

____

17. **For women only**: Pregnant? Yes / No / Not Sure (Circle one)

Date ____________________ Signed ______________________________

PLEASE USE THE FOLLOWING COLORS TO SHOW THE PRESENT AREAS OF COMPLAINTS AND THE TYPES OF PAIN:

BLUE	=	PAIN / ACHE / TENDERNESS
PINK	=	BURNING
GREEN	=	SPASMS / CRAMPING
YELLOW	=	PINS / NEEDLES / NUMBNESS / TINGLING
ORANGE	=	TIGHTNESS / STIFFNESS

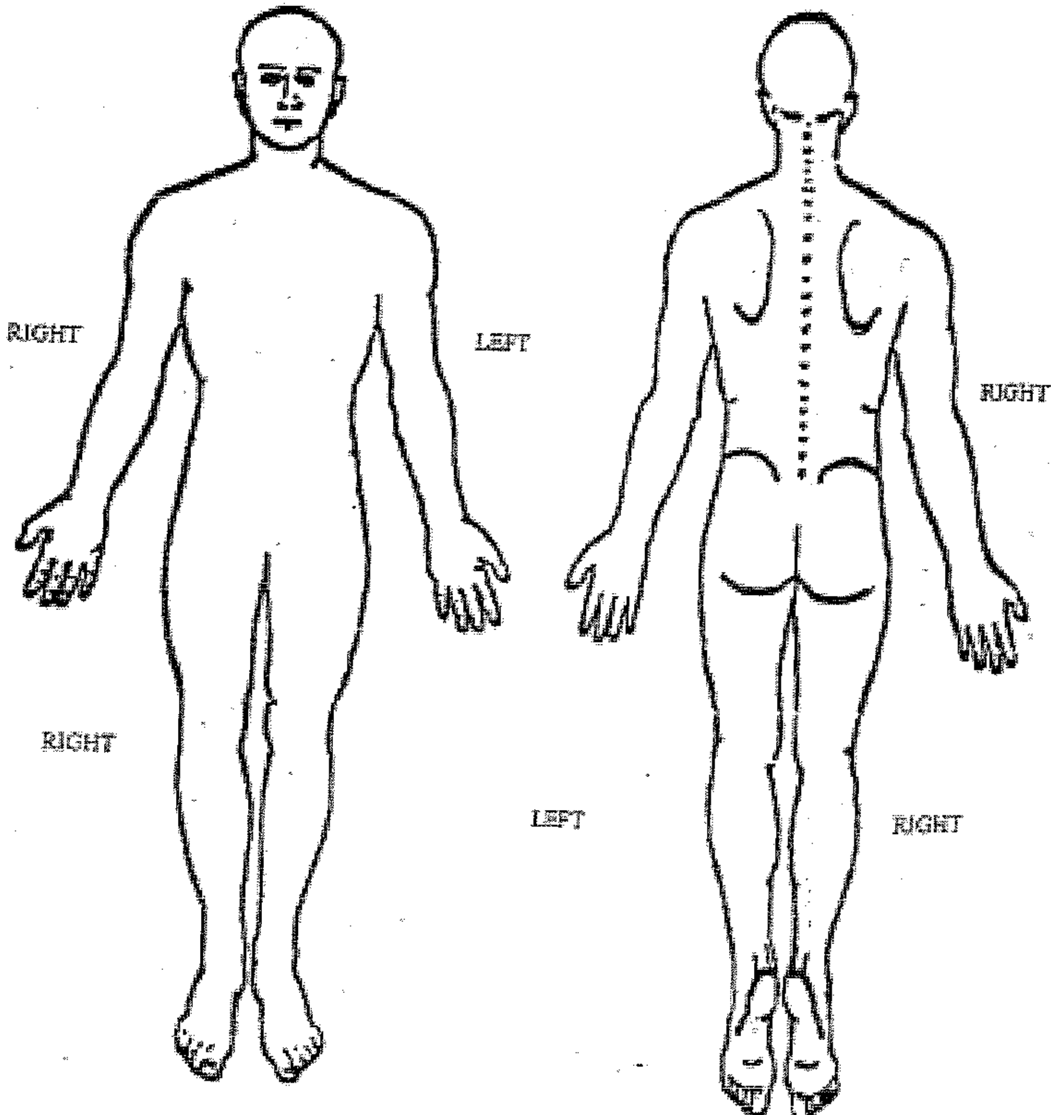
Comments: ______________________________

Patient's Signature: ______________________________ Date: ______________

Name Printed: ______________________________

Using a scale of 1 – 10, Rate the Intensity of each complaint area:

1 = Least Intensity
10 = Greatest Intensity



STRESS-RELAXATION PROFILE:

Circle all stressors: Coworker Boss Financial Home Personal Health Issues

Friend Parent Child Spouse Ex-Spouse Mental Health Issue Emotional

Circle all relaxation methods: Sleep TV Read Music Alcohol Smoking Drugs Eating Quietness

Walk Jog Run Swim Prayer Meditate Centering Solitude Deep Breathing

FAMILY HISTORY: Review the disease categories and use the appropriate letter (s):

GP (grandparent) F (father) M (mother) H (husband) W (wife) B (brother) S (sister) C (child)

Arthritis ____________________	Kidney/Liver ____________________
Asthma ____________________	Low Back Pain ____________________
Cancer ____________________	Mental Illness ____________________
Depression ____________________	Migraine ____________________
Diabetes ____________________	Multiple Sclerosis ____________________
Disc Degeneration ____________________	Polio ____________________
Emphysema/Lung ____________________	Scoliosis ____________________
Epilepsy ____________________	Sinus Infections ____________________
Headaches ____________________	Stomach ____________________
Heart Attack ____________________	Thyroid ____________________
High Blood Pressure ____________________	Tuberculosis ____________________

FOR WOMEN ONLY: Are you pregnant? N Y Any Chance? N Y

Use Birth Control? N Y Pills Condoms Shots Diaphragm Tubal Hysterectomy Vasectomy

Date last menstrual period began: _____/_____/_____ Do you have painful periods? N Y

Patient Signature ____ Date ____________________

PLEASE CIRCLE ALL CURRENT CONDITIONS

SKIN
Skin Disorder
Shingles
Bruises Easily
Boils
Hives or Allergies

RESPIRATORY
Difficulty Breathing

Chronic Cough
Coughing Phlegm/Blood
Asthma

NERVOUS SYSTEM
Hot/Cold Spots

Numbness/Tingling
Dizziness
Paralysis
Fainting
Convulsions
Irritability
Tremors
Insomnia
Depression
Confusion
Forgetfulness

GENERAL
Fever
Thyroid Disorder
Chills
Diabetes
Sweats
Rheumatic Fever
Chronic Fatigue
Cancer
Loss of Weight
Weight Trouble

GENIO-URINARY
Urine Disorder Frequent
Excessive/Scanty/Painful
Discolored/Blood/Pus
Kidney Infections/Stones
Cancer
Prostatitis
Bladder Trouble

FEMALE
Periods-Painful
Irregular/Cramps
Hot Flashes
Breast-Lumps/Congested
Menopause Symptoms

GASTRO-INTESTINAL
Chronic Nausea
Vomiting
Vomiting Blood
Difficulty Chewing
Swallowing
Excessive Thirst
Gastritis/Heartburn
Pain over Stomach
Ulcers/Stomach Disorders
Distention of Abdomen
Constipation
Diarrhea
Liver Trouble
Gallbladder Trouble

PRIMARY SYMPTOMS
Recurring Headaches
Facial/Jaw Pain
Restricted Movement
Head/Neck
Neck Pain
Neck Spasms
Poor Posture
Upper Back Pain

Sore Aching
"Shawl Muscles"
Pain Shoulder/Arm/Hand
Restricted Movement
Shoulder/Arm/Hand
Swollen Arm/Hand

Arthritis
Pain Beneath/Under
Shoulder Blade
Pain around Collar Bone
Mid Back Pain
Scoliosis
Low Back Pain
Neuritis
Buttock Pain
Hip Pain
Sciatica
Restricted Movement
Leg/Foot
Leg Cramps
Leg Pain/Lower/Upper
Sore Weak Muscles
Walking Problems

CARDIO VASCULAR
Heart Attack
High Blood Pressure
Low Blood Pressure
Rapid Beating Heart
Slow Beating Heart
Pain Over Heart
Hardening Arteries
Swelling of Ankles

Poor Circulation
Stroke
Varicose Veins

EYES/EARS/NOSE AND THROAT

Zig Zag Flashes
Chronic Earache
Hearing Loss
Ear Discharge
Nose Pain
Nose Bleeding
Sore Throat
Hoarseness

Sign ______________________________ Date: ____________

Witness ______________________________ Date: ____________

Neck Index

Form NI-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.

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.

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).

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.

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.

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.

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.

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.

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.

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 ______

Back Index

Form BI-100

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.

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.

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.

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.

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.

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.

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.

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.

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.

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

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION and AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.

PLEASE READ AND SIGN THE FOLLOWING:

1) I authorize this office to release or receive any information necessary for my medical file and to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to this physician of any insurance benefits otherwise payment to me.
4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not paid by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover that fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my doctor's bill directly. Further, I agree to pay Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A. the difference, if any, between the total amount of charges and the amount paid to me by the attorney and/or insurance carrier.

I further understand and agree that if I had to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

A photo static copy of these authorizations and agreement shall be as valid as the original.
I understand that if I am accepted as a patient at Orange Park Chiropractic Center, P.A. / Argyle Chiropractic Center, P.A., I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks associated with chiropractic will be explained upon my request.

Signature ______________________________
Date ____________________
Witness ______________________________

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

____ ____________________
Patient Name (please print) Date

____
Parent, Guardian or Patient's Legal Representative

____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. 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. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctors' objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________	______________________	__________
Print Name	Signature	Date

Consent to evaluate and adjust minor child:

I, ________________________, being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ______________________

______________________________	__________
Signature	Date

Date: ______________

ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER

DR. KEITH A. SCHERTELL
DR. TINA WARREN

MASSAGE NOTICE

I agree that a No-show fee of 15.00 will be assessed for any missed Neuro Muscular Therapy appointments without a 24 hours cancellation notice.

X______________________________