ORANGE PARK & ARGYLE CHIROPRACTIC CENTERS

NEW PATIENT QUESTIONNAIRE

Date: _____

Email Address: _____

Last Name: _____ First: _____ Middle: _____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Best Contact #: _____

Sex: M F DOB: ___/___/___ Marital Status: S M D W

Employed By: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

HEARD ABOUT OUR OFFICE BY: _____

Is patient here as the result of an accident? Y N **Date of Accident:** ___/___/___

Accident type: AUTO WORK HOME RECREATION SPORTS

Primary Insurance Company: _____

Insured: SELF SPOUSE PARENT/GUARDIAN

Insured's DOB: ___/___/___ Insured's SS#: _____

Insured Employer: _____

Who is your Primary Care Physician? _____

WHAT IS YOUR CURRENT AREA(S) OF COMPLAINT? _____

What surgeries have you had (type and when): _____

_____

List any previous accidents and falls: (Auto, Work, Sports, Home, Other): _____

_____

List any broken bones you may have had: _____

Do you have any drug allergies?

_____

Do you smoke: Y N How Much? _____ Are You Trying To Quit: Y N

If Trying To Quit, What Method Used_____ Alcohol: Y N How Often_____

ASSIGNMENT OF BENEFITS

I, _____, hereby irrevocably assign to Argyle Chiropractic Center, P.A. / Orange Park Chiropractic Center, P.A. any and all benefits and rights I have under any policy of insurance, indemnity agreement, or any other collateral source as defined by the Florida Statutes for any service and/or charges provided by Argyle Chiropractic Center, P.A. / Orange Park Chiropractic Center, P.A.

In witness whereof, the undersigned have hereunto set their hands, this _____ day of _____ of 20____.

_____ X_____

Patient Name Patient Signature

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

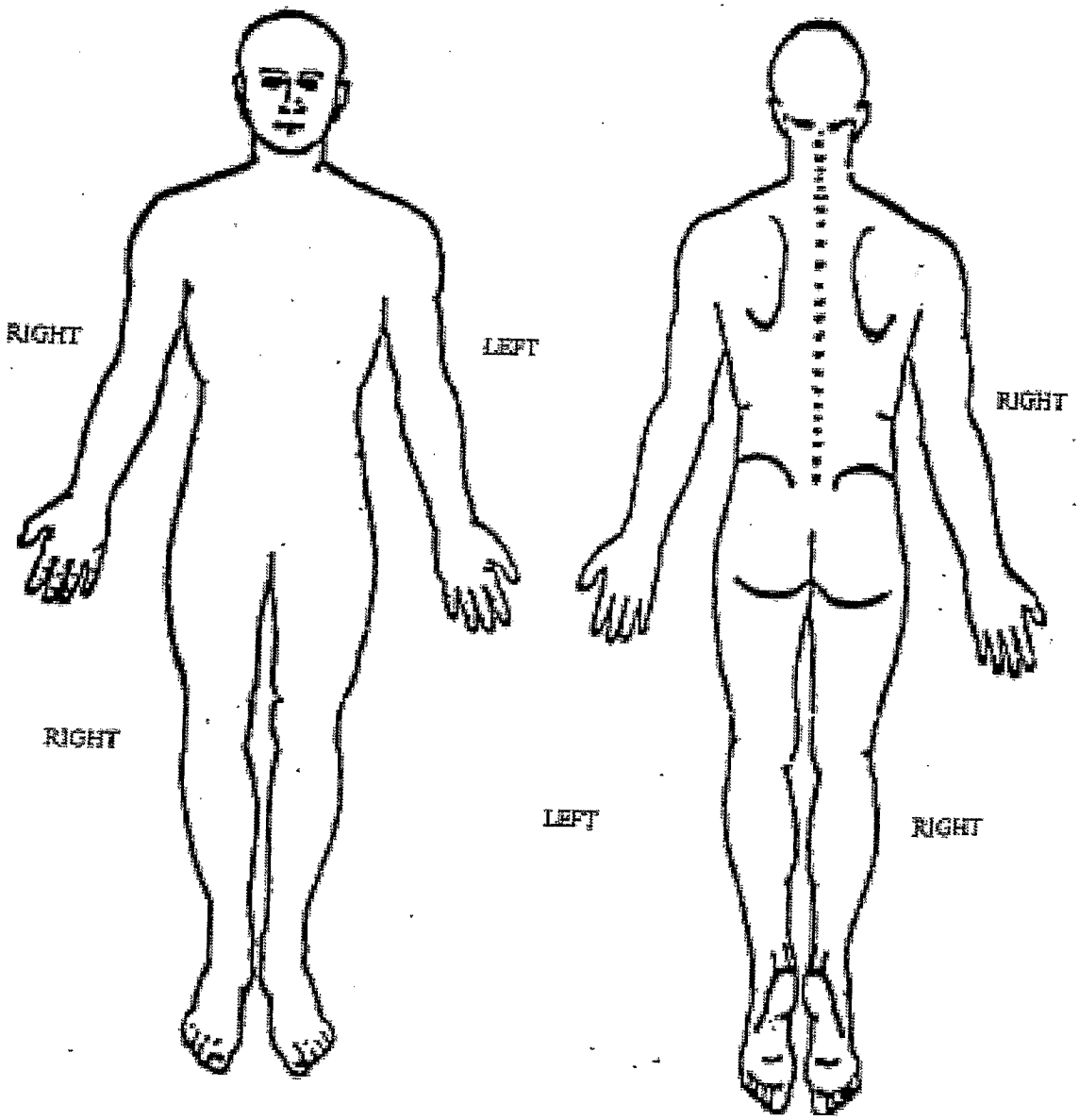
Comments: _____

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



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
HIV
Hepatitis C

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: _____

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 _____

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.

ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER

DR. KEITH A. SCHERTELL

NEUROMUSCULAR THERAPY 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_____ Date:_____

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 _____

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

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 _____

ORANGE PARK CHIROPRACTIC CENTER
ARGYLE CHIROPRACTIC CENTER

DR. KEITH SCHERTELL

Policy: NO Show for Scheduled Appointments: Dismissal from practice after 3 No Shows for a scheduled appointment, or when patients fail to show for medically necessary follow up.

Procedure:

1. Call to cancel a scheduled appointment prior to the appointment.

   Patients are expected to keep their scheduled appointment, if a patient needs to cancel their appointment, please call as soon as possible prior to the scheduled time. Cancellations can be taken by calling the office at any time, this includes after business hours. We will call to reschedule during business hours.

2. Appointments for follow up are crucial to good medical care, scheduled appointments must be kept.

3. If a patient NO SHOWS does not cancel their appointment or attempt to reschedule a follow up appointment we deem medically necessary, the patient may be dismissed from the practice.

4. Dismissal from the practice will be given in writing with 30 days for the patient to find a new physician and transfer their medical care and chart. Patients will be able to receive emergent medical care during that time period.

5. Dismissed patients may not be seen by the practice again.

Signature _____ Date _____

Orange Park Chiropractic Center
784 Blanding Boulevard, Suite 106, Orange Park, Florida 32065
Phone (904) 272-4555 Fax 276-2521

Argyle Chiropractic Center
6251 Argyle Forest Boulevard Unit 101, Jacksonville, Florida 32244
Phone (904) 778-0968 Fax (904) 573-1821

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 affect 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.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy, diagnostic x-rays and spinal decompression, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while implied by, working, or associated with, or serving as back-up for the chiropractor named below, including those working at the clinic or office listed below or any other office or clinic associated with the following clinic: Orange Park Chiropractic Center/ Argyle Chiropractic Center.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is my best interest. Alternative treatments may include: medication, surgery, or Physical Therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, your condition could get worse, remain the same, or improve.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition. Any new condition other than what I am being treated for will be explained to me and a new consent will be signed.

Patient's Signature Date

To be completed by patient's Representative, if patient is a minor or is physically or mentally incapacitated.

Name of Patient

Doctor's Signature Date

Signature of Patient's Representative

Relationship to Patient

What I'm Taking	Reason for Use	Form *(pill, patch, liquid, injection, etc.)*	Dosage	How Much & When	Use *(regularly or occasionally)*	Start/Stop Dates *(1/05/05 – 3/05/05) (1/01/94 – ongoing)*	Notes or Special Directions
*Be sure to include ALL prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.							
①							
②							
③							
④							
⑤							
⑥							
⑦							
⑧							
⑨							
⑩							