Patient Information **Date:** _____

Title: (Check one) ◯ **Mr.** ◯ **Mrs.** ◯ **Ms.** ◯ **Miss** ◯ **Dr.** ◯ **Other**_____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____)_____-_____ **Cell Phone** (_____)_____-_____

Date of Birth _____/_____/_____ **Sex:** ◯ **Male** ◯ **Female**

Marital Status: ◯ **Single** ◯ **Married** ◯ **Other**

SS#: _____

Email Address: _____

Spouse Information

First Name _____ **Middle Initial** ____ **Last Name** _____

Date of Birth _____/_____/_____

Home Phone (_____)_____-_____ **Cell Phone** (_____)_____-_____

Children's names & ages: _____

Employer Information

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Medical Doctor

Name _____ **Phone** _____

How did you hear about our office?

_____

Health History & Information

Have you had any surgeries?

_____

_____

Do you have any known allergies?

_____

_____

Do you have a family history of any medical conditions:

_____

_____

Please list all current medications you are taking:

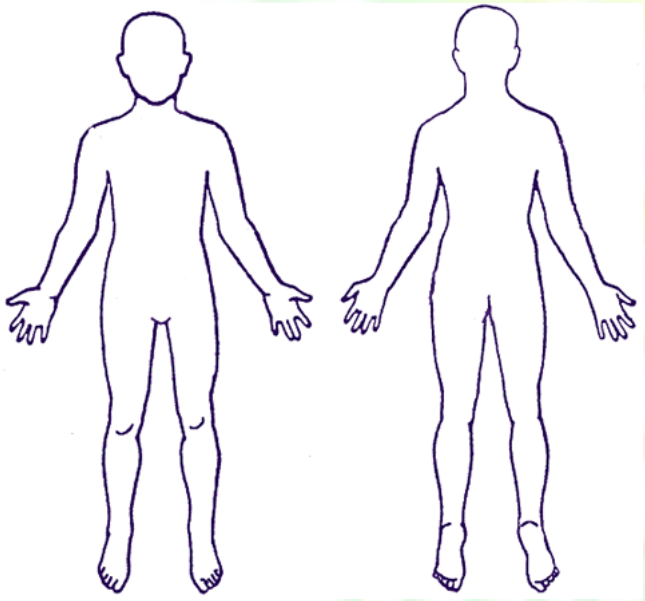
_____

_____

Using the key below, indicate on the body where you are experiencing the following symptoms

A=Ache; B=Burning; ST=Stabbing; SP=Spasm; N=Numbness; P=Pins & Needles; T=Throbbing

Front **Back**



When did your symptoms begin?

_____

Are your symptoms a result of:

◯**Motor Vehicle Accident**

◯**Work Related Accident**

◯ **Other** _____

How did your symptoms begin?

_____

_____

Mark an X on the line for the intensity of your pain, 0 being No Pain and 10 being Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

|____|____|____|____|____|____|____|____|____|____|____|

Describe your symptoms in order of severity, with the worst symptom being #1 listed first:

_____

_____

Please mark the items below for the sign(s) or symptom(s) you presently have or have experienced in the past:

GENERAL SYMPTOM
- — Convulsions
- — Dizziness
- — Fainting
- — Headache
- — Nervousness
- — Numbness
- — Wheezing

MUSCLE & JOINTS
- — Low back problems
- — Pain between shoulders
- — Neck problems
- — Arm problems
- — Leg problems
- — Swollen joints
- — Painful joints
- — Stiff joints
- — Sore muscles
- — Weak muscles
- — Problems walking
- — Sprains/strains
- — Broken bones

CARDIOVASCULAR
- — High blood pressure
- — Heart attack
- — Pain over the heart
- — Poor circulation
- — Heart trouble
- — Rapid heart
- — Slow heart
- — Strokes
- — Swelling ankles
- — Varicose veins

EAR/NOSE/THROAT
- — Earache
- — Ear noises
- — Enlarged thyroid
- — Frequent colds
- — Hay fever
- — Nasal blockage
- — Nose bleeds
- — Pain behind the eyes
- — Poor vision
- — Sinusitis
- — Sore throats
- — Tonsilitis

GASTROINTESTINAL
- — Belching/gas
- — Colon problems
- — Constipation
- — Diarrhea
- — Excessive hunger
- — Excessive thirst
- — Gall bladder issues
- — Hemorrhoids
- — Liver/gallbladder
- — Nausea
- — Abdominal pain
- — Ulcer
- — Poor appetite
- — Poor digestion
- — Vomiting
- — Vomiting blood
- — Black stool
- — Bloody stool
- — Weight loss/gain

RESPIRATORY
- — Asthma
- — Chronic cough
- — Difficulty breathing
- — Spitting blood
- — Spitting phlegm

GASTRO-URINARY
- — Blood in urine
- — Frequent urination
- — Kidney infection
- — Painful urination
- — Prostate problems
- — Loss of bladder control

SKIN OR ALLERGIES
- — Boils
- — Bruising easily
- — Dryness
- — Eczema/rash/dermatitis
- — Hives
- — Itching
- — SensItive skin

FOR WOMEN ONLY
- — Birth control
- — Hormone replacement
- — Cramps/backaches
- — Excessive flow
- — Hot flashes
- — Irregular cycle
- — Miscarriage
- — Painful periods
- — Vaginal discharge
- — Breast pain

Are you pregnant?

◯ **Yes** ◯ **No**

MISCELLANEOUS
- — AIDS/HIV
- — Alcoholism
- — Anemia
- — Arthritis
- — Asthma
- — Bleeding disorders
- — Cancer
- — Diabetes
- — Epilepsy
- — Hepatitis
- — Hernia
- — Herniated disc
- — High cholesterol
- — Gout
- — Heart disease
- — Kidney disease
- — Liver disease
- — Migraine headaches
- — Multiple sclerosis
- — Osteoporosis
- — Pacemaker
- — Parkinson's disease
- — Pinched nerve
- — Prosthesis
- — Psychiatric care
- — Rheumatoid arthritis
- — Other _____

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent/Guardian (circle one)

Informed Consent to Care

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy
___ palpation
___ vital signs
___ range of motion testing
___ orthopedic testing
___ basic neurological testing
___ muscle strength testing
___ postural analysis testing
___ radiographic studies
___ Other _____
_____
_____
_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Charles Fino and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient’s Name

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)

Dated: _____

_____
Doctor’s Name

_____
Signature

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

Patient: _____

Date: _____

I hereby authorize and request that payment of benefits by my primary insurance company _____, and my secondary insurance (if any) _____ be made directly to Fino Family Chiropractic & Wellness S.C. for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. In addition, I authorize Fino Family Chiropractic & Wellness S.C. to disclose any and all written information from the above named insurance company and/or its designated representatives, at the determination of services rendered at Fino Family Chiropractic & Wellness. Such disclosure shall be for reimbursement purposes for those services received. I hereby release Fino Family Chiropractic & Wellness S.C., its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives. By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist Fino Family Chiropractic & Wellness S.C. or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at anytime except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. Fino Family Chiropractic & Wellness S.C. is acting in filing for insurance benefits assigned to you, and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. A firm contracted by Fino Family Chiropractic & Wellness S.C. for billing and collection purposes may do billing.
7. Fino Family Chiropractic & Wellness S.C. is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. Fino Family Chiropractic & Wellness S.C. shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

_____ _____

Patient Signature Date

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care relationship, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Fino Family Chiropractic & Wellness S.C. to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Fino Family Chiropractic & Wellness S.C and its' employees to submit requested PHI to the health insurance company (ies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company (ies) require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Fino Family Chiropractic & Wellness S.C. has the right to refuse to give care.
8. From time to time we may send you birthday cards, or letters, use your name on a birthday list, or use your name on a referral board in our office. By your signature below you have given us permission to do so. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient/Guardian Signature Date

Agreement to Terms of Payment

I, _____(print name), acknowledge and accept full and complete responsibility for payment of all services rendered by Fino Family Chiropractic & Wellness, and/or its staff. I acknowledge that I have received written explanation of the fee schedule and payment policy and I agree to both. I understand that health insurance policies are an arrangement between my insurance company and myself, that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I understand that agreements regarding fee schedules are between myself and Fino Family Chiropractic & Wellness S.C. and are not related to potential insurance coverage. I understand that Fino Family Chiropractic & Wellness S.C. may assist me in completing forms to aid in collecting insurance benefits for services that are billable, but ultimately it is my responsibility to complete and file such forms. I agree to the release by Fino Family Chiropractic & Wellness S.C. and/or its duly authorized agents of any information that is requested by my insurance company.

_____ _____

Patient/Guardian Signature Date

PATIENT NAME:_____ Date:_____

Please Read: This questionnaire is designed to enable us to understand how much your **NECK PAIN** has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself 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 extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can 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 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

SIGNATURE:_____ **DATE:**_____

DISABILITY INDEX SCORE: **%**_____

PATIENT NAME: _____ **DATE**: _____

Please read: This questionnaire is designed to enable us to understand how much your **LOW BACK** pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 - Personal Care

A. I do not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain I am unable to do some washing and dressing without help.
F. Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights at the most.

SECTION 4 - Walking

A. I have no pain on walking.
B. I have some pain on walking but it does not increase with distance.
C. I cannot walk more than one mile without increasing pain.
D. I cannot walk more than 1/2 mile without increasing pain.
E. I cannot walk more than 1/4 mile without increasing pain.
F. I cannot walk at all without increasing pain

SECTION 5 - Sitting

A. I can sit in any chair as long as I like.
B. I can sit only in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than 10 minutes.
F. I avoid sitting because it increases pain straight away.

Signature: _____ Date:_____

SCORE%: _____

SECTION 6 - Standing

A. I can stand as long as I want without pain.
B. I have some pain on standing but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than 1/2 hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

A. I get no pain in bed.
B. I get pain in bed but it does not prevent me from sleeping well.
C. Because of pain my normal night's sleep is reduced by less than 1/4.
D. Because of pain my normal night's sleep is reduced by less than 1/2.
E. Because of pain, my normal night's sleep is reduced by less than 3/4.
F. Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life, and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 - Travel

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling, which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

A. My pain is rapidly getting better.
B. My pain fluctuates but overall is definitely getting better.
C. My pain seems to be getting better but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.