WELCOME

to CHIROPRACTIC WELLNESS CONNECTION

where your family's health comes naturally

*Date:*_____

Name:		*Preferred to be called:*
Address:		*City, St, ZIP*
Home Phone:	*Other Phone:*	□*Male* □*Female*
Date of Birth:	*Age:*	*SS#:*
EMPLOYER:		*Work Phone:*
Work Address:		*City, St, ZIP*
Marital Status: □*Single* □*Married* □*Divorced* □*Widowed* □_____		*Spouse Name:*
Emergency Contact:		*Contact #:*

Your Email Address: (we will not give out to others): _____

Who may we thank for referring you to our office? _____

CURRENT CONDITION:

Describe your current conditions:_____

_____

How did your conditions develop?_____

Date of Onset:_____ Have you had these symptoms before?_____

Is this condition… □Getting Worse □Staying Same □Constant □Comes and Goes

Is it interfering with □work □sleep □daily routine □hobbies/other:_____

Percent of time pain is present: □No pain □1% □25% □50% □75% □100%

Rate your pain: (0=no pain, 10= excruciating pain) _____/10

What makes your pain better?_____ worse?_____

Other treatment for this condition:_____

MD's Name:_____ Previous Chiropractor:_____

Current Medication (prescription, over the counter, vitamins): _____

_____

HEALTH HISTORY

Please Circle the correct letter if you, your mother, your father or other member in your family has had any of the following: **S=self M=mother F=father O=other family member**

S M F O Heart Attack	S M F O Stroke	S M F O Rheumatoid
S M F O Heart Defect	S M F O Cancer	S M F O Scoliosis (spinal curvature)
S M F O Parkinson's	S M F O Lupus	S M F O Multiple Sclerosis
S M F O Diabetes	S M F O HIV/AIDS	S M F O Seizures/ Epilepsy
S M F O High blood pressure	S M F O Low blood press.	S M F O Alzheimer's
S M F O Venereal Disease	S M F O Fainting	S M F O Psychiatric Problems

Other serious medical conditions that you've had: _____

_____

Allergies: _____

Surgeries: _____

Accidents: _____

LIFESTYLE: DO YOU....
Smoke Y N If so, how much?_____ How long?_____
Drink alcohol Y N If so, how much?_____ How long?_____
Exercise Y N If so, how much/ how often?_____

WOMEN: ARE YOU...
Pregnant? Y N If Yes, how long?_____
Taking any birth control Y N If Yes, what kind?_____
Have you been pregnant? Y N If Yes, when and how many live births:_____

PAYMENT INFORMATION:

□ I currently have BCBS or Medicare. I give full authorization to Chiropractic Wellness Connection and its employees to do and release all that is necessary to have the insurance payments covered. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I do know that I am ultimately responsible for any balance on my account.

*CWC will need a copy of your insurance card and all of the insured's information in order to bill today.

□ I have other insurance and would like a receipt that I can send to my insurance company myself for possible reimbursement. I know that I am responsible for any balance on my account.

□ I have a workman's compensation, automobile accident or other personal injury account and claim that has been opened and is current. I am seeking treatment for injuries directly related from this accident. I know that I am responsible for any balance on my account.

□ I do not have insurance benefits and will be paying as a cash patient. I am fully responsible for my account.

Responsible Party (if other than patient or if patient is a minor)_____

I hereby authorize the staff to perform any necessary services needed for proper diagnosis and treatment procedures. I further acknowledge this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes.

Signature: _____ Date: _____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and circle only ONE choice** which applies to you. We recognize you may consider that two of the statements in any one section relate to you, but **please just circle which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

0. I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
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

Section 2 – Personal Care (washing, dressing, ect)

0. I can look after myself normally without causing 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 manage most of my personal care
4. I need help everyday in most aspects of self care
5. I do not get dressed. I wash with difficulty, and stay in bed

Section 3 – Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives extra pain
2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, for example on a table
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4. I can lift very light weights
5. I cannot lift or carry anything at all

Section 4 – Reading

0. I can read as much as I want to with no pain in my neck
1. I can read as much as I want to with slight pain in my neck
2. I can read as much as I want with moderate pain in my neck
3. I can't read as much as I want because of moderate pain in my neck
4. I can hardly read at all because of severe pain in my neck
5. I cannot read at all

Section 5 – Headaches

0. I have no headaches at all
1. I have slight headaches which come infrequently
2. I have slight headaches which come frequently
3. I have moderate headaches which come frequently
4. I have severe headaches which come frequently
5. I have headaches almost all the time

Section 6 – Concentration

0. I can concentrate fully when I want to with no difficulty
1. I can concentrate fully when I want to with slight difficulty
2. I have a fair degree of difficulty in concentrating when I want to
3. I have a lot of difficulty concentrating when I want to
4. I have a great deal of difficulty in concentrating when I want to
5. I cannot concentrate at all

Section 7 – Work

0. I can do as much work as I want to
1. I can do my usual work, but no more
2. I can do most of my usual work, but no more
3. I cannot do my usual work
4. I can hardly do any work
5. I cannot do any work at all

Section 8 – Driving

0. I can drive my car without any neck pain
1. I can drive my car as long as I want with slight pain in my neck
2. I can drive my car as long as I like with moderate pain in my neck
3. I cannot drive my car as long as I want because of moderate pain in my neck
4. I can hardly drive at all because of pain in my neck
5. I cannot drive my car at all

Section 9 – 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)

Section 10 – Recreation

0. I am able to engage in all my recreation activities with no neck pain at all
1. I am able to engage in all my recreation activities, with some pain in my neck
2. I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck
3. I am able to engage in a few of my usual recreation activities because of pain in my neck
4. I can hardly do any recreation activities because of pain in my neck
5. I cannot do any recreation activities at all

Patient Signature:_____ **Date:**_____

Revised OSWESTRY Chronic Low Back Pain Disability Questionnaire

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and circle only ONE choice which applies to you. We recognize you may consider that two of the statements in any one section relate to you, but please just circle which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

0. I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
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

Section 2 – Personal Care (washing, dressing, ect)

0. I can look after myself normally without causing 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 manage most of my personal care
4. I need help everyday in most aspects of self care
5. I do not get dressed. I wash with difficulty, and stay in bed

Section 3 – Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives extra pain
2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, for example on a table
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4. I can lift very light weights
5. I cannot lift or carry anything at all

Section 4 – Walking

0. Pain does not prevent me from walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ¼ of a mile
3. Pain prevents me from walking 100 yards
4. I can only walk using a cane or crutches
5. I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting

0. I can sit in a chair as long as I like
1. I can sit in my favorite chair as long as I like
2. Pain prevents me from sitting for more than 1 hour
3. Pain prevents me from sitting for more than 30 minutes
4. Pain prevents me from sitting for more than 10 minutes
5. Pain prevents me from sitting at all

Section 6 – Standing

0. I can stand as long as I want without extra pain
1. I can stand as long as I want but it gives me extra pain
2. Pain prevents me from standing more than 1 hour
3. Pain prevents me from standing more that 30 minutes
4. Pain prevents me from standing more than 10 minutes
5. Pain prevents me from standing at all

Section 7 – Sleeping

0. My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain, I have less than 6 hours of sleep
3. Because of pain, I have less than 4 hours of sleep
4. Because of pain, I have less than 2 hours of sleep
5. Pain prevents me from sleeping at all

Section 8 – Social Life

0. My social life is normal and causes me no pain
1. My social life is normal, but increases the degree of my pain
2. Pain has no significant effect on my social life apart from limiting my more energetic interest, e.g. dancing, ect.
3. Pain has restricted my social life and I do not go out as often
4. Pain has restricted my social life to my home
5. I have no social life because of pain

Section 9 – Traveling

0. I can travel anywhere without pain
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but I manage journeys of over 2 hours
3. Pain is bad but I manage journeys less than 1 hour
4. Pain restricts me to short necessary journeys under 30 minutes
5. Pain prevents me from traveling except to the doctor or hospital

Section 10 – 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 at present
3. My pain is neither getting better or worse
4. My pain is gradually getting worse
5. My pain is rapidly getting worse

Patient Signature:_____ **Date:**_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

CHIROPRACTIC TREATMENT or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation performed by hand or instrument. Like most healthcare procedures, the chiropractic adjustment carries with it some risk and results are not guaranteed. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. The following are the known risks with chiropractic treatment:

Temporary soreness, muscle spasm, or increased symptoms or pain: it is not uncommon for patients to experience temporary soreness, muscle spasm or increased symptoms or pain after the first few treatments

Dizziness, nausea, flushing: These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures: When patients have underlying conditions and/or treatments that weakens bones, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease, condition or medical treatment. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse: Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic treatment, there is also an association between this type of stroke and primary care medical visits. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Patients who experience this condition often, but not always, present to their chiropractor or medical doctor with neck pain and headache.

Other possible risks: Other possible risks include but are not limited to bruising, disruption of internal medical devices, dislocations, and/or sprains and strains. If any of these conditions or symptoms occur, notify your chiropractor immediately.

It is important to know that it is not possible to consider every possible complication to care.

ACUPUNCTURE treatment is form of therapy in which fine needles are inserted into specific points on the body. Acupuncture is generally very safe and serious side effects are very rare. Acupuncture may be contraindicated on certain patients so notify chiropractor before treatment if you have any of the following: are pregnant, have a pacemaker or other electrical implant, bleeding disorder, blood borne pathogens, or are taking anticoagulants or any other medications. It is important to not move during the insertion, retention or removal of the needles.

Pt Initals:___

The following are known risks with **acupuncture care:**

Drowsiness occurs after treatment in a small number of patients, and, if effected, you are advised not to drive.

Minor bleeding, bruising, and/or pain may occur during or after acupuncture treatment.

Temporary worsening of symptoms, numbness and tingling, and/or muscle contractions may occur.

Dizziness or fainting can occur in certain patients particularly in the first treatment.

Infection is another possible risk, although the chiropractor uses sterile, single use, disposable needles.

It is important to know that it is not possible to consider every possible complication to care.

It is also important that you understand there are treatment options available for your condition other than chiropractic and acupuncture procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and healthcare as you see fit.

I have read, or had read to me, the above consent. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this document. I acknowledge that no guarantee can be given as to the results or outcome of my care. I have made my decision voluntarily and freely. I hereby give my consent to the performance of diagnostic tests, procedures and chiropractic treatment, acupuncture treatment and physical modalities recommended by my chiropractor and/or management of my conditions.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____ Date:_____

Brookside Radiology Consultants, Inc. P.O. Box 349 Buzzards Bay, MA 02532 Ph: 508-743-5691 Fax: 774-302-4713

Patient's Name: _____ Age: _____ Sex: M / F

Referring Doctor: _____ Date of Films: _____ Date of Injury: _____

Chief Complaint/Clinical Concern: _____

Diagnosis Code(s) _____ Previous Diagnosis, Surgery, Trauma, Cancer _____

BILLING OPTIONS: (X) **Time of Service (TOS) Discount** Payment Must Be Enclosed For Discount (Credit Card or Check)

( ) INSURANCE Billing – Assumes Referring Doctor Billed "-TC" Only ( ) Bill Doctor (If Referring Doctor Bills Globally)

Card Type: _____ Card #: _____ Expiration Date: _____ V- Code: _____

Submit Copy of Insurance Card / Documentation OR Complete the Following

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Date of Birth: ____/____/____ SS #: _____

Insured's Name: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Relationship to Patient ( ) Self ( ) Spouse ( ) Child ( ) Other _____

Primary Insurance Company: _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____

Policy #: _____ Claim /ID#: _____ Group/Plan #: _____

Secondary Insurance Company: _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____

Policy #: _____ Claim/ID #: _____ Group/Plan#: _____

( ) Accident Related to Employment? Insured's Employer: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____

( ) Personal Injury? ( ) Automobile Accident? Attorney: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____

Patient X-Ray Assignment Agreement and Consent

I understand that this office will have my X-Rays interpreted by John R. Henry DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology. I am aware that I will be responsible for this service and accordingly I hereby authorize **Brookside Radiology Consultants, Inc. (BRC, Inc.)** assignment of benefits for services rendered directly from my insurance carrier or attorney. Therefore, I authorize **BRC, Inc.** to obtain information necessary to secure payment of benefits and **authorize the use of this signature** on associated benefit submissions. I also authorize the release of any medical information necessary to process the claim. Any amounts owed but not allowed will be my responsibility. Furthermore, I acknowledge that I have reviewed, with my doctor, and understand and agree to the Notice of Privacy Practices of **BRC, Inc.**

This Service is Not Covered by Medicare

Patient's/Guardian's Signature: _____ **Date:** _____

√	CPT	DESCRIPTION	FEE
	72040-26	Cervical 2-3v	$20.00
	72050-26	Cervical 4v	$24.00
	72052-26	Cervical 6-7v	$26.00
	72070-26	Thoracic 2v	$20.00
	72100-26	Lumbar 2v	$20.00
	72110-26	Lumbar 4-5v	$24.00
	72170-26	Pelvis	$20.00

√	CPT	DESCRIPTION	FEE
	73030-26	Shoulder 2v	$20.00
	73080-26	Elbow 2-4v	$20.00
	73100-26	Wrist 2-4v	$20.00
	73120.26	Hand 2-3v	$20.00
	73510-26	Hip Uni 2v	$20.00
	73560-26	Knee 2v	$20.00
	73630-26	Foot 3v	$20.00

√	CPT	DESCRIPTION	FEE
	73600-26	Ankle 2v	$20.00
	71010-26	Chest 1v	$20.00
	71020-26	Chest 2v	$20.00
	71101-26	Ribs 2-3v	$20.00
	72010-26	Full Spine	$50.00
	72148-26	MRI Over Read	$70.00

Jennifer Daniel-Price, D.C.
Abby Sherwood, D.C.

Chiropractic Wellness Connection
410 E. Elm St. Canton, IL 61520
309-647-7490 ph

Communication Regarding Confidential Information

In order for Chiropractic Wellness Connection to keep communication regarding your health information confidential, please complete this form:

May we contact you at home? Yes _____ No _____ Phone number: _____

May we contact you at work? Yes _____ No _____ Phone number: _____

May we contact you on your cell phone? Yes _____ No _____ Phone Number: _____

I prefer to be contacted: At Home _____ At work _____ On my Cell _____

May we contact you by e-mail? Yes _____ No _____ E-mail: _____

May we contact you with appointment reminders? Yes _____ No _____
If yes, how would you like your reminder? Text to Cell phone _____ E-mail _____
If text to cell phone, who is your cell phone provider? (Verizon, Sprint, etc) _____

May we leave a message with another party? Yes _____ No _____
If yes, please list authorized party to receive protected health information on your behalf:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Please list any other special requests regarding your health information: _____
_____

I, the undersigned, herby acknowledge that by signing this Consent:

1. I am aware that the Practice's Privacy Notice is available to me upon request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carryout health care operations. The Privacy Notice is also available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.
3. The Practice's "Notice of Privacy Practices" is provided at 410 E. Elm St., Canton, IL 61520. I may also request a copy from this office at any time directly from the office or via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

Patient's Name (please print): _____

Signature: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____