

# APPLICATION FOR CARE AT CHIROPRACTIC FIRST OF ROCKFORD

## PATIENT DEMOGRAPHICS

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Person who carries insurance: \_\_\_\_\_ Birth date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and Ages: \_\_\_\_\_ **WOMEN:** Are you pregnant? \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

Have you ever been to a chiropractor before?  Yes  No If yes, when was your last adjustment? \_\_\_\_/\_\_\_\_/\_\_\_\_

## HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_  
Secondarily: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

**Primary** or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Third** complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Fourth** complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week **How did the injury happen?** \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes **If yes, when:** \_\_\_\_\_ **by whom?** \_\_\_\_\_

How long were you under care: \_\_\_\_\_ **What were the results?** \_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_  N/A

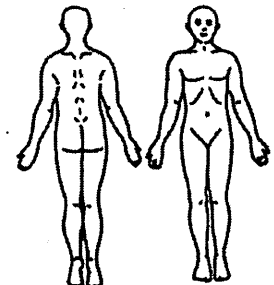
**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling**

What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_

Is your problem the result of ANY type of accident?  Yes  No



List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

List any supplements you take regularly: \_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes If yes how many times? \_\_\_\_\_  
When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes If yes, please state what type of treatment: \_\_\_\_\_  
and who provided it: \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results.  Favorable  Unfavorable →  
please explain. \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have and N for Never have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Cancer \_\_\_ Other serious conditions:

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →		
SURGERIES →		
CHILDHOOD DISEASES →		
ADULT DISEASES →		

**SOCIAL HISTORY**

- 1. Smoking:  cigars  pipe  cigarettes → How often?  Daily  Weekends  Occasionally  Never
- 2. Alcoholic Beverage: consumption occurs →  Daily  Weekends  Occasionally  Never
- 3. Recreational:  Daily  Weekends  Occasionally  Never

**FAMILY HISTORY:**

- 1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- 2. Any other hereditary conditions the doctor should be aware of.  No  Yes: \_\_\_\_\_

I hereby authorize payment to be made directly to Chiropractic First of Rockford for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Chiropractic First of Rockford for any and all services I receive at this office.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_\_  
Date Completed

Doctor's Signature

Date Form Reviewed

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: \_\_\_\_\_

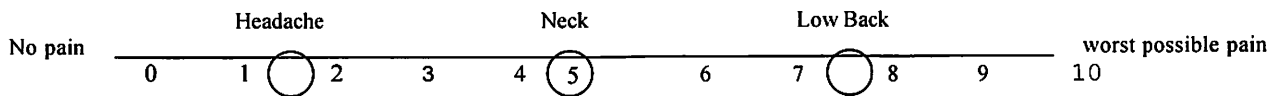
Date: \_\_\_\_\_

Please read carefully:

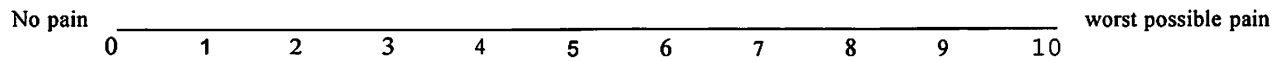
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

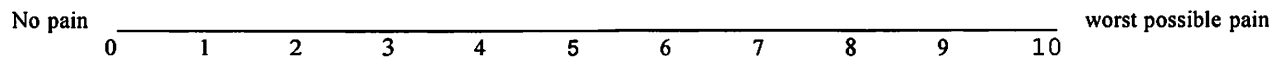
Example:



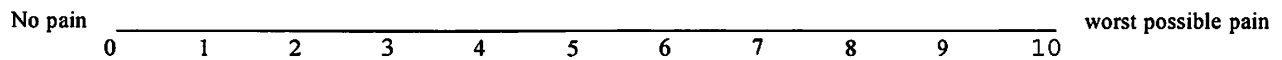
1. What is your pain RIGHT NOW?



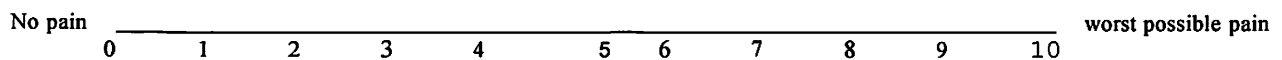
2. What is your TYPICAL or AVERAGE pain?



3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

\_\_\_\_\_ 3 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Activities of Daily Living/Symptoms

### Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

**Please mark P for in the Past, C for Currently have and N for Never**

- |  |                            |                     |                              |                          |
|--|----------------------------|---------------------|------------------------------|--------------------------|
| ___ Headache                           | ___ Pregnant (Now)         | ___ Dizziness       | ___ Prostate Problems        | ___ Ulcers               |
| ___ Neck Pain                          | ___ Frequent Colds/Flu     | ___ Loss of Balance | ___ Impotence/Sexual Dysfun. | ___ Heartburn            |
| ___ Jaw Pain, TMJ                      | ___ Convulsions/Epilepsy   | ___ Fainting        | ___ Digestive Problems       | ___ Heart Problem        |
| ___ Shoulder Pain                      | ___ Tremors                | ___ Double Vision   | ___ Colon Trouble            | ___ High Blood Pressure  |
| ___ Upper Back Pain                    | ___ Chest Pain             | ___ Blurred Vision  | ___ Diarrhea/Constipation    | ___ Low Blood Pressure   |
| ___ Mid Back Pain                      | ___ Pain w/Cough/Sneeze    | ___ Ringing in Ears | ___ Menopausal Problems      | ___ Asthma               |
| ___ Low Back Pain                      | ___ Foot or Knee Problems  | ___ Hearing Loss    | ___ Menstrual Problem        | ___ Difficulty Breathing |
| ___ Hip Pain                           | ___ Sinus/Drainage Problem | ___ Depression      | ___ PMS                      | ___ Lung Problems        |
| ___ Back Curvature                     | ___ Swollen/Painful Joints | ___ Irritable       | ___ Bed Wetting              | ___ Kidney Trouble       |
| ___ Scoliosis                          | ___ Skin Problems          | ___ Mood Changes    | ___ Learning Disability      | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers |                            | ___ ADD/ADHD        | ___ Eating Disorder          | ___ Liver Trouble        |
| ___ Numb/Tingling legs, feet, toes     |                            | ___ Allergies       | ___ Trouble Sleeping         |                          |

## **Chiropractic First of Rockford's NOTICE OF PRIVACY PRACTICE**

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

### **PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

### **YOUR RIGHTS:**

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### **COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call Chiropractic First at (779) 423-2044. If they are unavailable, you may make an appointment with our receptionist to see them within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

