Stiles Chiropractic Offices

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: _____ Soc Sec No.: _____ Home Phone: _____

Address: _____ City: _____ Zip Code: _____

Age: _____ Birth Date: _____ Marital: ☐M ☐S ☐W ☐D How many children: _____

E-Mail Address: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Address: _____ Office Phone: _____

Insured's name if patient is a dependent: _____ Soc. Sec. No.: _____

Name of insurance Company: _____ Address: _____

Name of Wife or Husband: _____ Occupation:_____ Birth Date: _____

Employer: _____ Address: _____

Patients nearest relative: _____ Address: _____ Phone: _____

Referred by: _____

Is condition due to injury or sickness arising out of patient's employment? ☐YES ☐NO

Date symptoms appeared or accident happened: _____

Patient ever had same or similar condition? ☐YES ☐NO If yes, when and describe: _____

_____

Have you lost any days from work: _____ Date of last examination: _____ Female: Are you pregnant? _____

What operations have you had? _____

Serious illnesses: _____

Have you ever been under Chiropractic Care? ☐YES ☐NO Doctor's Name: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the doctor to treat my condition as (she deems appropriate through the use of adjustment throughout my spine. It is understood and agreed the amount paid the doctor for x-rays is for examination only and the x-ray negatives will remain the property of the office, being on file where they may be seen at any time while a patient of this office. The patient also agreed that (s)he is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I understand that appropriate credit bureau reports may be obtained.

Patient Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

Information Taken by: _____ Date: _____

CHIROPRACTIC
It is important to recognize the difference between Chiropractic and medicine. Either can be important to your health, but for entirely different reasons. Chiropractors seek to restore health through natural means and without the use of surgery. Although a medical diagnosis may be of great importance to a patient, such diagnosis does not necessarily assist the Chiropractor in her efforts. The Chiropractor's purpose is to restore heath through the natural flow of energy in the nervous system. This gives the body maximum opportunity to heal itself. Success of the Chiropractic procedures often depends upon underlying causes and conditions. It is important to understand what to expect from Chiropractic and medical services in order that you, the patient, can determine whether either or both may be of benefit to you.

ANALYSIS
A Chiropractor conducts a chiropractic analysis for the express purpose of determining whether there is evidence of spinal subluxations. When such subluxations are found, Chiropractic adjustments are given to restore proper spinal alignment it is the chiropractic premises that proper spinal alignment allows free nerve flow throughout the body, and gives the body its best chance to restore health. Due to the complexities of nature, no chiropractor can promise you specific results. This depends upon the recuperative powers of the body.

DIAGNOSIS
Although Chiropractors are experts in Chiropractic analysis, they are not specialists in the field of diagnosis. Internists are medical specialists who are highly qualified to diagnose. Every chiropractic patient should be mindful of his/her own symptoms, and should secure medical opinion if he has any concern as to the nature of his/her illness or injury. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you should take the initiative if in doubt.

CHIROPRACTIC ADJUSTMENTS
The patient, in coming to the Chiropractor, gives the Chiropractor permission and authority to adjust the patient in accordance with the Chiropractic analysis, The Chiropractic adjustment is usually beneficial, and seldom causes any problem. In rare cases, underlying Physical defects, deformities, or pathology may render the patient susceptible to injury. The Chiropractor, of course, will not give a Chiropractic adjustment if she is aware that such conditions exist. Again, it is the responsibility of the patient to make it known, to learn through medical procedures whether he is suffering from latent pathological defect, illness, or deformities which would otherwise not come to the attention of the Chiropractor. The patient should not look to the doctor of Chiropractic for in-depth diagnostic procedures. The Doctor of Chiropractic provides a specialized health service, and does not and should not become involved in the patient's medical regimen. A patient should never ask or accept advice from a Chiropractor concerning the taking of prescriptive medicines, The Doctor of Chiropractic is not licensed in medical practices.

RESULTS
The purpose of Chiropractic service is to promote natural health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of Chiropractic procedures. Sometimes the response is phenomenal. In some cases, there is a gradual, but quite satisfactory response. Occasionally, the results are mediocre or dismal. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond Chiropractically, may come under control or be cured under medical science. The fact is the sciences of Chiropractic and medicine may never be so exact as to provide definite answers to many problems. Both have made great strides in alleviating pain and controlling disease.

QUESTIONS
The patient should discuss any questions or problems with the Doctor before signing this statement of policy.

ACKNOWLEDGEMENT
I have read the foregoing and understand it.

Signature: _____ Date: _____

Due to the very important information presented in your extended consultation, it is extremely important that your spouse attends your report of findings consultation. We at Stiles Chiropractic Offices believe that your health affects your whole life, and your family's participation is important.

Visual Analog Scale & Activities of Daily Living

Name: _____ Date: _____

Please mark the areas in which you feel the described sensations. List the sensation for affected areas in the major complaints section.

Dull / Aching /Soreness

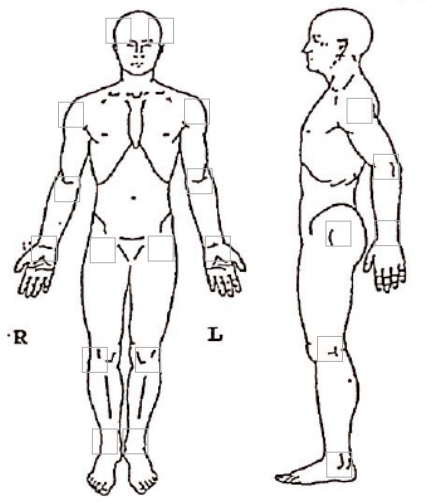
Stabbing / Cutting

Burning

Numbness

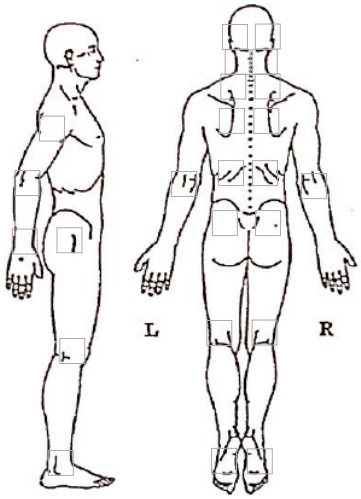
Tingling (Pins & Needles)

Cramping



Major Complaints

1. _____
2. _____
3. _____
4. _____



On a scale from 1-10 how bad is your pain:

_____

Please check all the activities that cause you pain:

- ☐ Bathing
- ☐ Drying hair
- ☐ Putting on shoes
- ☐ Washing hair/face
- ☐ Dressing/Undressing
- ☐ Using the restroom
- ☐ Walking
- ☐ Running
- ☐ Standing
- ☐ Kneeling
- ☐ Reaching
- ☐ Squatting down to pick up objects
- ☐ Carrying objects/bags
- ☐ Pulling objects
- ☐ Recreational activities/exercising/sports
- ☐ Climbing up/down stairs
- ☐ Lifting children
- ☐ Sex
- ☐ Housework
- ☐ Washing dishes
- ☐ Getting in/out of car
- ☐ Driving/Riding in a vehicle
- ☐ Reclining in chair
- ☐ Turning while laying in bed
- ☐ Laying in bed stomach/back
- ☐ Typing at the computer
- ☐ Grasping objects
- ☐ Other: _____

Patient Signature: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Name: _____ Number: _____ Date: _____

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 which score is for which complaint.

EXAMPLE:

HEADACHE NECK LOW BACK

□ 0 □ 1 ☑2 □ 3 ☑4 □ 5 □ 6 □ 7 □ 8 ☑9 □ 10

……

1. What is your pain RIGHT NOW?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

2. What is your TYPICAL or AVERAGE pain?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

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

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

` What percentage of your awake hours is your pain at its best? _____ %

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

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What percentage of your awake hours is your pain at its worst? _____%

by law to keep it in our records. Original films can only be released on referral to another physician.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- Required for your treatment, to obtain payment for services, to run our practice, and/or made to you.
- Necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- For national security, intelligence purposes, or law enforcement officers.
- That were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a 12 month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave .S.W., Room 509F, HHH Bldg, Washington, D.C. 20201.

This notice is effective as of January 1, 2003. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Staff Person

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.