PATIENT CONFIDENTIALITY PERSONAL DATA

No._____ Date_____
Patient:_____ Date of Birth:_____
Home Address:_____ City:_____ State:_____ Zip:_____
Social Security No.:_____ Home Phone:_____ Mobile:_____
Work Phone:_____ Email:_____
Employer:_____ Address:_____
Name of Spouse:_____ SS No.:_____ No. of Children:_____
Spouse's Employer:_____ Address:_____
How did you learn of this clinic?_____
Nearest relative not living with you?_____ Phone:_____
Who is responsible for payment? ☐ Self ☐ Spouse ☐ Other_____

PATIENT'S INSURANCE
Name of Company:_____
Address:_____
ID & Group No.:_____
Phone No.:_____

SPOUSE'S INSURANCE
Name of Company:_____
Address:_____
ID & Group No.:_____
Phone No.:_____

Purpose of this appointment and list your complaints:_____
_____
Date of illness:_____ Time:_____ ☐ AM ☐ PM Location:_____
How did accident occur? ☐ Auto ☐ On the job ☐ Other,_____
Please describe the circumstances and what makes the condition(s) better or worse:_____
_____
_____
_____
Other Doctor seen for this condition:_____
Have you been treated by a Doctor for any health condition in the last year? ☐ Yes ☐ No
If yes, please describe:_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement 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 collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. 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.

Signature Physician:_____ **Signature Patient:**_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATON

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature:_____
Parent's or Guardian's Signature:_____

HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Date: _____

Patient: _____ No.: _____

MUSCULO SKELETAL SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

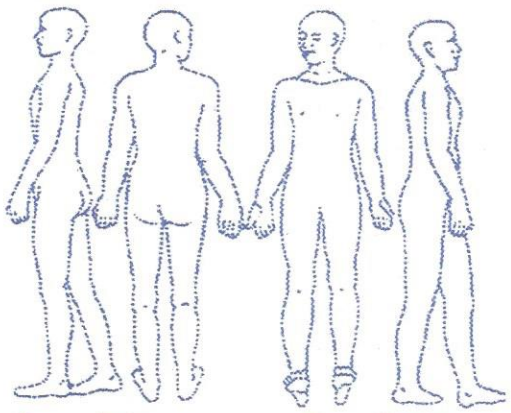
FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ YES ☐ NO

SYMPTOM LOCALIZATION



P ___ Pain
N ___ Numb
S ___ Spasm

T ___ Tender
H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ _____

CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw Pain

Patient's Signature _____

●●●●●●●●●●●●●●●●●●●●●●DO NOT WRITE BELOW THIS LINE●●●●●●●●●●●●●●●●●●●●●●

_____

_____

_____

_____

Patient Accepted? ☐ Yes ☐ No Doctor's Signature _____

ANDERSON HILLS CHIROPRACTIC

YOUR:
Auto Insurance Co.: _____
Policy #: _____
Claim #: _____
Phone #: _____
Address: _____
Agent Name: _____

OTHER PARTY:
Auto Insurance Co.: _____
Policy #: _____
Claim #: _____
Phone #: _____
Address: _____
Agent Name: _____

This is a comprehensive case history of your car accident. Fill this out completely. For each question, please select the response(s) that most accurately describes what occurred to you during the accident. In some questions more than one response may be necessary to explain what happened.

1. Date of Accident: _____
2. Time of Accident: _____
3. Location of Accident: _____

Please explain in detail how your accident happened: _____
_____
_____

Have you retained an attorney?: Yes ____ No ____ Not Yet ____
If so, his/her name, address, and phone #: _____
_____

Number of people in your vehicle: _____ Were police notified?: Yes ____ No ____
Did your head strike windshield or other object?: Yes ____ No ____
Were you knocked unconscious? Yes ____ No ____ If so, for how long? _____
Were you struck from: Behind ____ Front ____ Left ____ Right ____
Were you the: Driver ____ Passenger ____ If passenger: Front Seat ____ Back Seat ____
Were you using a seat belt?: Yes ____ No ____
Did you feel pain immediately after the accident? _____
Were you taken anywhere after the accident? _____
Was treatment given?: _____
Was any doctor consulted after the accident?: _____
Was treatment given?: _____
How often and how long did you see the doctor?: _____
Have you ever had any complaints in the involved area before?: Yes ____ No ____
If so, what were the complaints?: _____
Before the injury were you capable of working on an equal basis with others your age?:
Yes ____ No ____
Are your work activities restricted as a result of this accident?: Yes ____ No ____
Since the accident, are your symptoms: Improving ____ Worse ____ Same ____

Name _____ Date: _____

Anderson Hills Chiropractic
Health Care Privacy Notice

This facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practice in health care. Our facility may change and/or modify the terms of this notice at any time without additional notice to you except to publically post in our facility and/or make available to patients any updated notices. Photocopy of this notice is available to you upon request. The term "facility" refers to this office or clinic. The term "provider" refers to doctors and/or licensed professionals of this facility.

Our facility and staff are committed to maintaining your privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future, and past physical and mental health or condition and the care and treatment you receive from our practice. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this notice and direct any questions, misunderstanding, or concern to the Compliance Officer of this facility. Our facility may use and disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctor and staff of this facility for the purpose of your care treatment; paying; health care bills; and to support the operations of this practice. Your doctor and staff will take all reasonable measures to maintain the confidentiality of your PHI. The privacy rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to your or another person. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. You may request to have an amendment placed in your record if you disagree with anything in your records. This does not mean that anything will be removed or changed and the provider has the right to respond with rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's authorization notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the office of Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our facility from taking any retaliatory actions against anyone who files a complaint.

Informed Consent

I understand that this facility, its doctors and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any diagnostic test, procedure, or examination, a guarantee of improvement of complete recovery cannot be made and it's even possible that no change will occur. I further understand in the practice of medicine, chiropractic, psychological counselling, massage therapy, and physical therapy, there are some risks, including but not limited to fractures, disk injuries, strokes, dislocations, sprains/strains, drug interactions/reactions, and/or other injuries or side effects which cannot be predetermined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications and I wish to rely on the doctor/provider to exercise judgment during the course if the procedure(s) which the doctor/provider feels at this time is in my best interest. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment, your provider will discuss specific consequences with you.

Therefore, I give my full consent to the doctor/provider to render treatment on me or minor, whom I am legally responsible for, at this facility.

Patient Consent & Signature

By my signature below, I acknowledge that I have read or have had read to me the Health Care Privacy Notice and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective as an original.

Print patients name	Date	Signature (if minor, parent/guardian must sign)

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Duties Performed Under Duress/ Loss of Enjoyment

Patient_____ Today's Date_____ Date of Injury_____

☑ Initial ☐ Update

Please check all that apply to your WORK *because of the accident.*

__ I go to work but work in pain
__ I limit my work activities
__ Bending/stooping/kneeling at work hurts
__ Sitting at work hurts
__ Using the Computer at work hurts
__ Pushing/pulling at work hurts
__ I have lost status in my company
__ I have lost job security
__ I didn't get a promotion
__ I don't enjoy work as much as before
__ I doze off/daydream at work

__ I take unpaid time off work to go to Dr.
__ I feel tired at work
__ I work in pain because I have bills to pay
__ I can't take time off, I would lose my job
__ I keep working so I don't lose work status
__ My business would fail if I took time off
__ I believe in working even when I'm in pain
__ I feel obligated to work in pain
__ Business would lose money if I took time off
__ Work is not as good as it was before accident
__ Boss reprimanded me for poor performance

__ I got a different job within the same company
__ I got a different job in another company
__ I make less money than before the accident
__ Cannot do same work/job as before accident
__ I can't concentrate as well at work
__ I take paid time off to go to Dr.
__ I make mistakes at work I didn't used to
__ I hide my poor work performance from boss
__ _____
__ _____
__ _____

Please check all that apply to your HOME/DOMESTIC duties *because of the accident.*

__ My house is not as clean now
__ My yard is not as neat now
__ My garden is not as productive now
__ I do yard work, but do it in pain
__ I cannot do my normal yard work
__ I do house work, but do it in pain
__ I cannot do my normal house work
__ Doing laundry hurts me
__ I cannot do laundry now
__ Washing dishes hurts me
__ I cannot wash dishes now

__ Vacuuming hurts me
__ I cannot vacuum now
__ Cooking hurts me
__ I cannot cook now
__ Washing the car hurts me
__ I cannot wash my car
__ Cannot take off because I care for children
__ I have ___children ages_____
__ I had to hire a paid housekeeper
__ I asked someone for unpaid housekeeping
__ I had to hire a paid gardener

__ I asked someone for unpaid yard work help
__ Mowing the lawn hurts me
__ I cannot mow the lawn
__ Taking out the trash hurts me
__ I cannot take out the trash
__ I do not enjoy my gardening/yard work
__ I do not enjoy my housework like I used to
__ Gardening hurts me
__ I cannot do my gardening since the accident
__ Others living with me do my share of the work
__ _____

Please check all that apply to your EXERCISE & SPORTS Activity *because of the accident.*

__ My exercise was affected by this crash
__ I go to the gym & work out in pain
__ I no longer go to the gym to work out
__ I run but in pain
__ I no longer run

__ I take walks & have pain while walking
__ I no longer take walks
__ I used to make income at sports
__ I have lost sports income since crash
__ I am an amateur athlete

__ I have gained __ pounds since the accident
__ I had to quit my _____team after the accident
__ I don't enjoy the sport of _____anymore
__ I don't enjoy the sport of _____anymore
__ I didn't enjoy the sport of _____for __weeks

Patient_____ Today's Date_____ Date of Injury_____

Please check all that apply to your HOBBY Activities *because of the accident.*

__ My hobbies were affected by accident
__ Hobby _____
__ I can't do hobby anymore
__ I do hobby but in pain
__ I have lost money from not doing
__ I didn't do hobby for _____weeks

Please check all that apply to your TRAVEL Activities *because of the accident.*

__ Business travel was affected by crash
__ Pleasure travel was affected by crash
__ I hurt driving in my own car
__ I am in too much pain to drive
__ I hurt when a passenger in a car
__ I have anxiety when I'm in a car
__ I hurt when I'm on an airplane
__ I am in too much pain to travel by plane
__ Travel Plan _____
__ I did not on travel plan
__ I went, but did not enjoy as much
__ I went and the accident had no effect on

Please check all the DAILY LIVING Activities that cause you pain *because of the accident.*

__ Dressing
__ Putting on pants
__ Putting on/ tying shoes
__ Putting on shirt
__ Washing/drying/combing my hair
__ Taking a shower
__ Lying in bed
__ Sitting in my favorite chair
__ Sleeping
__ Going out with my friends
__ Sitting in a restaurant/movie theater/church
__ Shopping
__ Driving to/from work
__ Playing with/ caring for my children
__ Bending at the waist
__ Eating
__ Squatting down
__ Kneeling
__ Brushing my teeth
__ Opening a jar
__ Lifting a pan when cooking
__ Closing the trunk on my car
__ Opening the garage door
__ Using my home computer
__ Going up or down stairs
__ Sexual activity
__ Turning my head to left or right
__ Holding my head up all day
__ Watching TV
__ Talking on the phone
__ Reading/Writing
__ Opening doors
__ Drying with a towel after bath
__ Life has become a chore
__ It is depressing to live like this

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident.*

__ School was affected by the accident
__ I am a student at _____
__ I am in the _____year/grade
__ I was __full time __part time
__ I am now __full time __part time
__ I had to take fewer classes b/c crash
__ I missed ___ days of school
__ I had to drop out of school b/c of crash
__ My grades are lower since the crash
__ I have pain carrying my school books
__ I hurt sitting in class more than ___ minutes
__ My neck hurts when I look down to read
__ I don't learn as quickly as before the crash
__ I have difficulty concentrating in class
__ It takes much longer to study/do my homework
__ _____
__ _____

Signature_____ Today's Date_____

Records Release

PATIENTS NAME: _____ D.O.B_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby authorize and request _____ to release information pertaining to my health records and treatment including consultation on conditions, x-rays, and MRI's concerning the undersigned:

TO: ANDERSON HILLS CHIROPRACTIC
7758 BEECHMONT AVE
CINCINNATI, OH 45255

PATIENT'S SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

PAUL G. BAUER, DC, CICE, MBA, BSN
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