

Phone Number: _____

Patient Information

Date: _____	SSN: _____	Birthday: _____
First Name: _____	Middle Name: _____	Last Name: _____
Sex: <input type="radio"/> M <input type="radio"/> F	Height: _____	Weight: _____
Marital Status: <input type="radio"/> Yes <input type="radio"/> No	Spouse Name: _____	# of Children: _____
Home #: _____	Cell #: _____	Work #: _____
Address: _____		
City: _____	State: _____	Zip: _____
Emergency Contact: _____	Emergency Relation: _____	Emergency Phone: _____
Email: _____		

Referral Information

Referring Physician: _____	Referred Patient: _____	Referred by: _____
Advertisement: <input type="radio"/> Yes <input type="radio"/> No	Advertisement: _____	
Referred Directory: <input type="radio"/> Yes <input type="radio"/> No	Referred Directory: _____	

Employer Information

Employed: <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Homemaker <input type="radio"/> Unemployed	Employer Name: _____	
Employer Address: _____		
Employer City: _____	Employer State: _____	Employer Zip: _____
Occupation: _____	Work Supervisor: _____	Supervisor #: _____
Work Duties: _____		

Insurance Information

Payment: <input type="radio"/> Personal <input type="radio"/> 3rd Party <input type="radio"/> Self	Resp. for Payment: _____	Responsible Phone: _____
Payment Name: _____	Primary Phone #: _____	Primary ID/Policy: _____
Payment Address: _____		
Payment City: _____	Payment State: _____	Payment Zip: _____
Primary Group #: _____	Primary Name: _____	Primary DOB: _____
Secondary Name: _____	Secondary Phone #: _____	Secondary ID/Policy: _____
Secondary Address: _____		
Secondary City: _____	Secondary State: _____	Secondary Zip: _____
Secondary Group #: _____	Secondary Name: _____	Secondary DOB: _____
Claim #: _____	Claim Contact: _____	Claim Phone #: _____
Attorney Name: _____	Attorney Phone #: _____	

Complaint Information

Injury Occurred:	<input type="radio"/> Automobile	<input type="radio"/> Work	<input type="radio"/> Third-Party	<input type="radio"/> Other	Injury Date:	_____
Injury Origin:	_____					
Desc Discomfort:	_____					
Frequency:	<input type="radio"/> Always	<input type="radio"/> Hourly	<input type="radio"/> Daily	<input type="radio"/> Occasionally		
Interfere w/ Activities:	<input type="radio"/> Yes	<input type="radio"/> No	Affected Sleep:	<input type="radio"/> Yes	<input type="radio"/> No	
Missed Work:	<input type="radio"/> Yes	<input type="radio"/> No	Unable to Work from:	_____	Unable to Work til:	_____
Affected Appetite:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Reduced Work:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Does it Worsen:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Weather Affects it:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Aggravates Condition:	_____					
Improves Condition:	_____					
Received Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
X-rays Taken:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____		
Same Condition Before:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Practitioner:	_____

History

Last Physical Exam:	_____	Primary Phys:	_____	Phys Phone #:	_____		
Phys City:	_____	Phys State:	_____	Phys Zip:	_____		
Health Conditions:	_____						
Previous Chiro Care:	<input type="radio"/> Yes	<input type="radio"/> No	Date:	_____	Explain:	_____	
Chance Pregnant:	<input type="radio"/> Yes	<input type="radio"/> No	Planning:	<input type="radio"/> Yes	<input type="radio"/> No		
Medications:	_____						
Supplements:	_____						
Broken Bones:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Sprains/Strains:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Hospitalized:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Surgery:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Auto Accident:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Struck Unconscious:	<input type="radio"/> Yes	<input type="radio"/> No	Treatment:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____
Eating Disorder:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Stroke:	<input type="radio"/> Yes	<input type="radio"/> No	Explain:	_____			
Family Health Hist:	_____						

Patient Social

Alcohol:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Caffeine:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Diet Food Products:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Drugs:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
OTC Stimulants:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Exercise:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Homemade Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Processed Food:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Soft Drinks:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never	Tobacco:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never
Water:	<input type="radio"/> Daily	<input type="radio"/> Weekly	<input type="radio"/> Occasion	<input type="radio"/> Never					

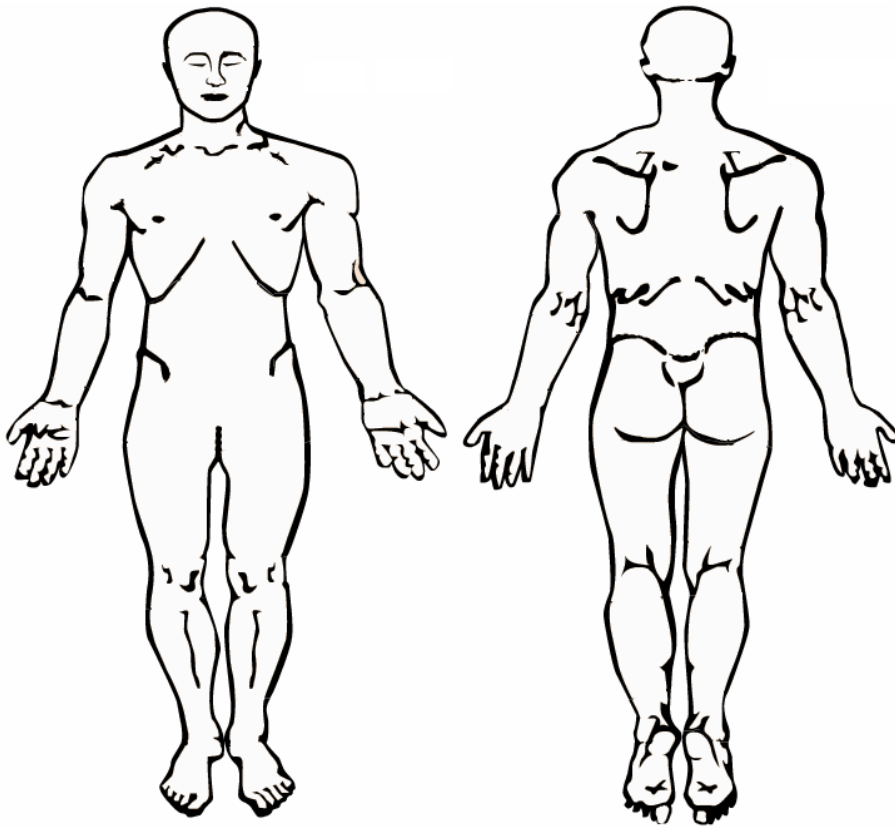
Health Checklist

<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cramps
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestion Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Eye Pain or Difficulties
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Headache
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Irregular Menstrual Cycle	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Polio	<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Spinal Curvatures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Other: _____		

Patient Signature: _____

Date: _____

Patient Symptoms



A – Achy/Dull

B – Burning

S – Sharp/Stabbing

T – Throbbing

N – Numb/Tingling

P – Pins/Needles

C – Cramping

O - Other

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

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 mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes. Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 -- Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hours sleep. Even when I take tablets I have less than 4 hours sleep. Even when I take tablets I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

Section 8 – Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

Section 9 – Traveling

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

Section 10 – Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at the present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Comments _____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Section 1 - Pain Intensity

- I can tolerate the pain without having to use painkillers.
- The pain is bad but I can manage without taking painkillers.
- Painkillers give complete relief from pain.
- Painkillers give moderate relief from pain. Painkillers give very little relief from pain.
- Painkillers have no effect on the pain and I do not use them.

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

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

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

Section 4 – Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than one-half mile. Pain prevents me from walking more than one-quarter mile I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score x 2) / (Sections x 10) = _____ %ADL

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 mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

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

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

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

Section 4 – Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck. I can read as much as I want with moderate pain.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5-Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have slight headaches which come frequently.
- I have moderate headaches which come infrequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7—Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8 – Driving

- I drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9 – Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is moderately disturbed (1-2 hrs. sleepless). My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-4 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score x 2) / (Sections x 10) = L %ADL

HIPAA Acknowledgement and Consent

I, undersigned, acknowledged that I have had access to a copy of the NOTICE OF PRIVACY PRACTICES. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient signature _____ Date _____

AUTHORIZATION TO BILL INSURANCE: I understand my insurance will be billed for services rendered at Harpenau Family Chiropractic, PLLC.
AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charged and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

MEDICARE ASSIGNMENT (if applicable): I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment below.

ACKNOWLEDGEMENT AND UNDERSTANDING: I hereby acknowledge; That is there is no insurance company obligated to pay for services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor, or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then the payment of services rendered by Harpenau Family Chiropractic, PLLC will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

SPECIAL CONSIDERATION: I understand that should I have a financial hardship and am unable to completely satisfy my deductible/copyay/or coinsurance I will notify Harpenau Family Chiropractic, PLLC and a separate written contract will be created and signed.

Patient signature _____ Date _____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Harpenau Family Chiropractic, PLLC. I understand, and am informed that, while extremely rare, there are some risks to treatment included, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of procedure, based on the facts then known is in my best interest. I have read or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment for any future conditions for which I seek treatment.

Patient Signature _____ Date _____

Parent/Legal guardian name (please print) _____

Guardian Signature _____ Date _____

Harpenau Family Chiropractic

29930 W 12 Mile Suite 3
Farmington Hills, MI 48334

Notice of Privacy Practices – Acknowledgment and Consent

Use and Disclosure of your Protected Health Information

Your protected health information will be used by Harpenau Family Chiropractic, PLLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the front desk.

Requesting a Restriction on the Use or Disclosure of your Information

You may request a restriction on the use or disclosure of your protected health information. This office may or may not agree to restrict the use or disclosure of your protected health information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which you revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information

Patient or legally authorized individual signature _____ Date _____

Print patient's full name _____ Time _____

Witness signature _____ Date _____

Harpenau Family Chiropractic

X-Ray Consent Form

Patient Consent to X-Ray

I hereby authorize the performance of diagnostic x-rays. Dr. Harpenau has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: _____

Consent to X-Ray a Minor

I am a parent or legal guardian of _____, who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. Dr. Harpenau has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Signed: _____ Date: _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff of Harpenau Family Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed: _____ Date: _____

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