Salisbury Chiropractic, PC

Patient Data **Date** ____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone (_____)** _____-_____

Cell Phone (_____) _____-_____ **Email** _____

Date of Birth ___/___/_____ **Age:**_____ **Sex:** □ Male □ Female **Height:**_____ **Weight:**_____

SSN _____-____-_____ **Marital Status:** □ Single □ Married Divorced Widow

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ Other_____

Employer Data

Name _____

Your Occupation _____ **Your Job Description** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Spouse Data ____

First Name _____ **Middle Initial** _____ **Last Name** _____**DOB:**_____

Home Phone (_____) _____-_____**Work Phone (_____)** _____-_____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____-_____ **Cell Phone (_____)** _____-_____

Doctor's Signature _____

Patient Name_____**Date**_____

How did you hear about our office? _____

Surgeries: (Circle all that apply to you)

□ Appendectomy	□ Cardiovascular procedure	□Cervical spine	□ Hysterectomy
□ Joint Replacement	□ Prostate	□ Lumbar spine	□ Gall Bladder
□ Brain	□ Shoulder	□ Thoracic spine	□ Knee
□ Carpal Tunnel	□ Gastro-intestinal	□ Uro-genital	□ Hernia
□ Other _____	Medical Device Implants eg: Pacemaker, etc.	NONE Apply	

Allergies: (Circle all that apply to you)

□ Eggs	□ Fish and Shellfish	□ Milk or Lactose	□ Peanuts
□ Soy	□ Sulfites	□ Wheat/Glutens	□ Other _____
□ Medication Allergies:_____		NONE	

Social History: (Circle all that apply to you)

Caffeine use:	□ occasional	□ often	□never
Drink Alcohol: □	occasional	□ often	□never
Cigarettes:	YES	NO	
Exercise:	□ occasional	□ often	□ never

Family History: (Circle all that apply)

Rheumatoid Arthritis: □	Mother	Father	□ Sibling	Grandparents
Asthma	Mother	Father	□ Sibling	Grandparents
Cancer:	Mother	Father	□ Sibling	Grandparents
Diabetes: □	Mother	Father	□ Sibling	Grandparents
Heart Disease	Mother	Father	□ Sibling	Grandparents
Hypertension	Mother	Father	□ Sibling	Grandparents
Stroke	Mother	Father	□ Sibling	Grandparents
Multiple Sclerosis	Mother	Father	□ Sibling	Grandparents

Occupational Activities: (Circle one that best describes your job description)

□ Administration	□ Business Owner	□ Clerical/Secretary	□ Computer User
□ Heavy Equipment operator	□ Daycare/Childcare	□ Construction	□ Health Care
□ Food Service Industry	□ Medium Manual Labor	□ Manufacturing	□ Home Services
□ Heavy Manual Labor	□ Light Manual Labor	□ Executive/Legal	□ Housekeeper
□ Other _____			

Doctor's Signature _____

Patient Name_____ **Date**_____

Review of Systems – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression				Tinnitus			
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness/Tingling								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Sweating				Joints Replaced			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Cancer				Broken Bones			
Weight Loss/Gain				Type				Arthritis			
Low Energy Level								Type			
Difficulty Sleeping											

Please list all current medications being taken (including over-the-counter)

_____

_____

Doctor's Signature _____

PAIN SCALE

Use this on following page

Remember, whenever a doctor asks you to rate your pain from 1 - 10, ask for a pain scale so you can be sure you're speaking the same language.

0 - Pain free

1 - Very minor annoyance - occasional minor twinges.

2 - Minor annoyance - occasional strong twinges.

3 - Annoying enough to be distracting.

4 - Can be ignored if you are really involved in your work, but still distracting.

5 - Can't be ignored for more than 30 minutes.

6 - Can't be ignored for any length of time, but you can still go to work and participate in social activities.

7 - Makes it difficult to concentrate, interferes with sleep. You can still function with effort.

8 - Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.

9 - Unable to speak. Crying out or moaning uncontrollably - near delirium.

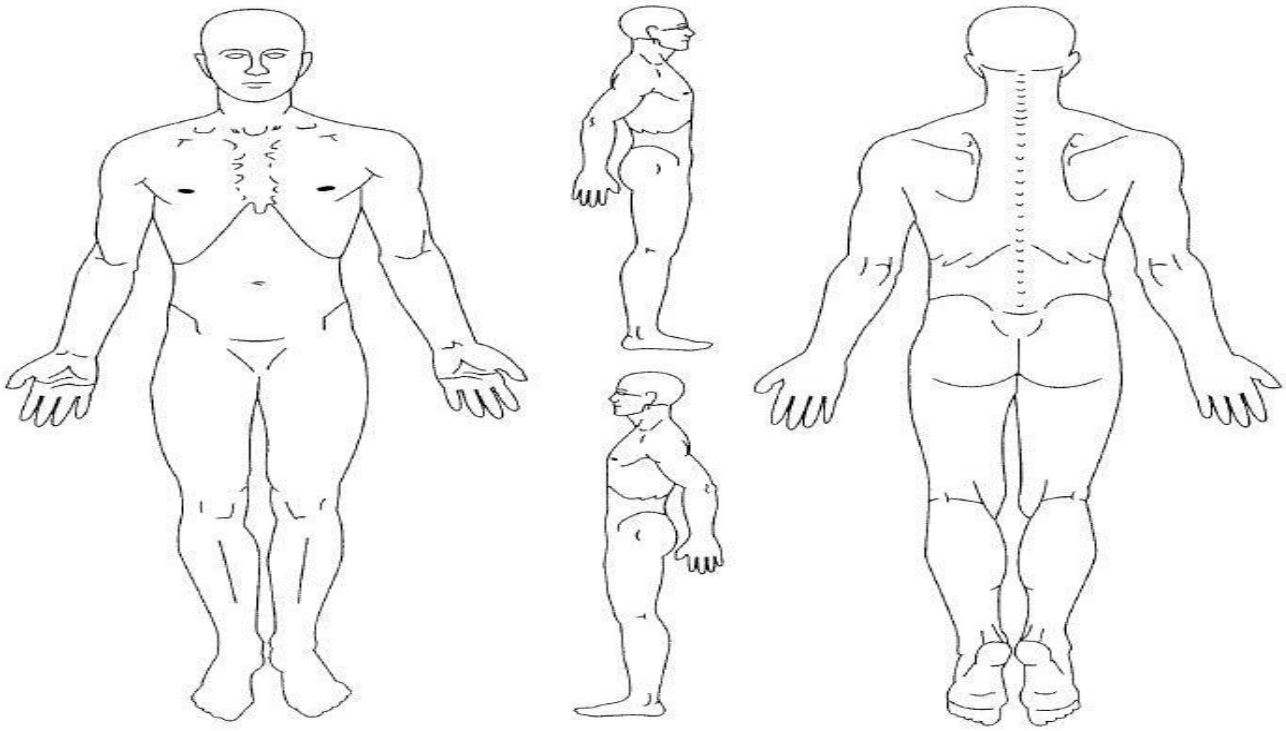
10 - Unconscious. Pain makes you pass out. HOSPITALIZED.

*****USE PAIN SCALE PROVIDED HERE****

Patient Name_____ Date_____

Are you pregnant? Yes_____ No _____N/A_____

Indicate area(s) of pain with "X" and rate your pain levels on a 0-10 pain scale with 10 being worse pain imaginable.



Describe your pain areas _____

_____

_____

When did your symptoms begin? Month_____ Day_____Year _____

Are your symptoms a result of: □ Motor Vehicle Collision □Work related Accident □ Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day)	□ Frequently (51-75% of the day)	□ Occasionally (26-50% of the day)	□ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

□ Sharp	□ Dull ache	□ Numb	□ Shooting
□ Burning	□ Tingling	□ Stabbing	□ Stiff

How are your symptoms changing?

□ Getting better	□ Not changing	□ Getting worse

Doctor's Signature _____

Updated 01/09/18

Patient Name_____Date_____

Payment/Insurance Information:

Who is responsible for your bill? □ Self □ Health Insurance □ Spouse □ Worker's Comp
□ Auto Insur. □ Medicare □ Medicaid □ Other _____

Provide the following information if you are NOT the primary policy holder:

Policy Holder's Name: _____

Policy Holder's Date of Birth _____ / _____ / _____

Worker's Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? □Yes □No Date: ____/____/____ Time: _____am / pm

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____

Date_____

SIGNATURE OF PHYSICIAN: _____Date: _____

Salisbury Chiropractic, PC
Financial Policies

The goal of Salisbury Chiropractic, PC is to do all that is possible to help receive the highest degree of chiropractic care available. There is a financial aspect to your healthcare as well, and we have prepared these policies to keep you aware of your current insurance benefits and payment policies.

1. The insurance you have is an agreement between you and the insurance company. Waiting for insurance is a courtesy and may be withdrawn at any time.

2. We will gladly file your insurance for you at no charge to you. The insurance is filed every week.

3. Proof of your deductible being met is required; otherwise, full payment for services rendered is expected until the deductible is met. If there is an over-payment we will gladly refund it to you.

4. You will be responsible to pay your co-pays and also any co-insurance portion that your insurance company does not pay.

5. Our insurance department will contact either your insurance carrier or your employer to obtain the proper information concerning deductibles, co-pays and co-insurance, limitations, exemptions, etc.

6. Each insurance policy is different and that is how we are choosing to treat it.
This office DOES NOT promise that an insurance company will pay. Nor does the office promise that an insurance company will or should pay the fees billed.

7. Once a claim is filed and we receive payment, we will check each detail to make sure that it is paid correctly and we will contact the carrier for an explanation as to how the claim was paid if necessary. Sometimes we may ask for your help if that information cannot be shared with us by your insurance company. This office will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. THIS IS A PATIENT OBLIGATION

8. Please be advised that if your insurance company chooses not to pay for a certain procedure, it will be your responsibility to do so. We will bill you and expect prompt payment from you.

9. Balances over 60 days past due will be charged a $2.00 monthly service fee for billing. There will also be a fee for having to send a certified letter to you as well as an 18% fee if your account goes into collection.

10. If your check is returned for any reason we will charge any fees we incur from the bank.

11. If you are being treated for injuries in an auto accident or work related accident, please keep in mind that you are ultimately responsible for making sure that your bills are paid in full.

We're here to help you in any way we can. Please feel free to talk to us about any particular situation that may arise with any of our procedures, policies, or insurance.

I have read and understand this office's financial policies.

_____ _____

Signature Date

INFORMED CONSENT FORM
Salisbury Chiropractic, PC

PATIENT NAME: _____

DATE:_____

To the patient: Please read this entire document prior to signing it. It is very important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

**spinal manipulative therapy	**palpation	**vital signs
**range of motion testing	**orthopedic testing	** basic neurological
** muscle strength testing	**postural analysis testing	
**ultrasound	**hot/cold therapy	**Electrical Stim
**radiographic studies	** mechanical traction	

___ Other (please explain)

_____

_____

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. David D. Godwin and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ ____**David D. Godwin, D.C.**_____

Patient’s Name **Doctor’s Name**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian
(If a minor)

Updated 10/20/15

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

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

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).

Reading

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

Concentration

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

Work

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

Personal Care

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

Lifting

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

Driving

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

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.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score