

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

Date _____

Name _____ Male Female Social Security # _____

Birthdate _____ Age _____ Single Married Widowed Separated Divorced Children? _____

Address _____ City/State/Zip _____

Home phone _____ Work phone _____

Patient's occupation _____ Employer _____

Employer address/city/state/zip _____

EMAIL ADDRESS _____

SPOUSE PARENT LEGAL GUARDIAN (check one)

Name _____ Male Female Social Security # _____

Birthdate _____ Age _____ Single Married Widowed Separated Divorced Children? _____

Address _____ City/State/Zip _____

Home phone _____ Work phone _____

Patient's occupation _____ Employer _____

Employer address/city/state/zip _____

How were you referred to our office? _____

INSURANCE

Who is responsible for this account? _____ Relation to Patient _____

Patient's Insurance _____ Spouse's Insurance _____

Name of Ins. _____ Name of Ins. _____

Address _____ Address _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Phone # _____ Phone # _____

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 Sullivan Family Chiropractic 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 Sullivan Family Chiropractic will be credited to my account upon receipt. I also give Sullivan Family Chiropractic 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.

Patient's Signature _____ Date _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release Dr. Sullivan and whomever he/she may designate as his assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any other services that he deems necessary in my case. I further authorize Dr. Sullivan to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to Sullivan Family Chiropractic or to the patient or to a family member or employer of the patient for all or part of the services rendered to me, including and not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds or employers.

Patient's Signature _____ Date _____

IF A MINOR-Signature of Parent/Guardian _____ Date _____

HEALTH QUESTIONNAIRE

Patient's Name _____

DATE _____

CURRENT CONDITION

Describe your symptoms/location of problems? _____
 Your goals for treatment/what do you want to be able to do that you currently cannot: _____
 Date symptoms first appeared? _____ Is this related to an automobile or work-related accident? _____
 What caused your pain to begin? _____
 What treatment, tests, xrays, and/or medications have you already received for your condition? _____

Other doctors seen for this condition: _____
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
 Type of pain (mark all that apply): sharp dull throbbing numbness aching burning shooting tingling cramps stiffness swelling other
 How often are your symptoms present: constant frequent occasional intermittent (comes and goes)
 Since it began, is your problem: improving no change getting worse
 What makes the problem better? _____
 What makes the problem worse? _____
 Can you perform your daily home activities? yes yes, limited by myself yes, only with help not at all
 Can you perform your daily work activities? yes yes, limited by myself yes, only with help not at all
 Describe your daily job requirements: _____
 Your stress level: none mild moderate severe

PAST HEALTH HISTORY

Have you been treated by a doctor or health care professional in the last year? ____ If yes, for what conditions: _____
 Have you ever been under chiropractic care before? _____ Where: _____
 Same condition? _____ Other _____

If you have *ever* had a listed symptom in the *past*, please check the symptom in the *past column*. If you are presently experiencing a particular symptom, check that symptom in the *present column*. KNOWLEDGE OF THESE CONDITIONS MAY INFLUENCE THE TYPE OF TREATMENT OR THERAPY YOU ARE TO RECEIVE.

Past Present Condition	Past Present Condition	Past Present Condition
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Heartburn/Indigestion	<input type="checkbox"/> General fatigue
<input type="checkbox"/> Shoulder pain R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash	<input type="checkbox"/> Irregular menstrual cycle
<input type="checkbox"/> Pain in upper arm or elbow R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Numbness	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Hand pain R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Breast soreness <input type="checkbox"/> lumps <input type="checkbox"/>
<input type="checkbox"/> Wrist pain R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> PMS
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Heart Attack (date) _____	<input type="checkbox"/> Loss of bladder control
<input type="checkbox"/> Pain in upper leg or hip R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Stroke (date) _____	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Pain in lower leg or knee R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Cancer, explain below	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Pain in ankle or foot R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Tumor, explain below	<input type="checkbox"/> Excessive bowel action
<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Constipation
<input type="checkbox"/> Swelling, stiffness of joint(s)	<input type="checkbox"/> Prostate problems	Avg.# of bowel movements per day _____
<input type="checkbox"/> Pain that wakes you at night	<input type="checkbox"/> Blood disorder	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Fainting	<input type="checkbox"/> Emphysema (chronic lung disorders)	<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Headache	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/> Ulcer	
<input type="checkbox"/> Tinnitus (ringing or noises in ear)	<input type="checkbox"/> Liver/gallbladder problem	
<input type="checkbox"/> Rapid Heart Beat	<input type="checkbox"/> Kidney stones	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Bladder Infection	
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Kidney Disorders	
<input type="checkbox"/> Abnormal weight loss	<input type="checkbox"/> Colitis/Irritable Colon	
<input type="checkbox"/> Abnormal weight gain	<input type="checkbox"/> Excessive thirst	
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Chronic sinusitis (sinus infections)	

If a family member has had any of the following, please mark the appropriate box:
 Cancer Epilepsy Rheumatoid
 Diabetes Heart problems Lung problems
 Stroke Mental problems Back problems
 Other _____
 Relationship to patient _____

Please check all that apply to you:
 currently pregnant # of births _____ Tobacco Alcohol Drug or alcohol dependence

CURRENT MEDICATIONS/HOSPITALIZATIONS/SURGERIES: _____

PRIMARY CARE PHYSICIAN:
 NAME/LOCATION _____

I AUTHORIZE DR. SULLIVAN TO SEND A MEDICAL UPDATE OF MY CURRENT CONDITION TO MY PRIMARY CARE PHYSICIAN Signature _____

HEALTH CARE AUTHORIZATION FORM

This form authorizes us to file your insurance, have your signature on file for insurance purposes, comply with Health Insurance Portability and Accountability Act (HIPAA) regulations, and provide you with better overall service. THE PATIENT IDENTIFIED BELOW AUTHORIZES SULLIVAN FAMILY CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

- ✓ I give Sullivan Family Chiropractic permission to treat me in an area where other patients are also being treated. I give permission to use my name aloud in the office during my visit (Including but not limited to, general conversation with me, calling me from the waiting area, taking me to treatment room). I am aware that other persons may overhear some of my protected health information during the course of care. Please hold any private information or questions until you are in a private room with the staff or doctor. (It is our office policy to not discuss health information and private issues in front of other patients, all precautions will be made to adhere to this policy)

- ✓ I authorize the use of my name in print for general purpose; such as posting my name on an internal Referral Board if and when I refer people to their office for evaluation and treatment, patient of the month listing, etc. I further authorize the use of my signature to be on a universal (consecutively viewed by each patient signing in) sign in sheet for each visit.

- ✓ I authorize Sullivan Family Chiropractic to use my address, phone numbers and clinical records to contact me with appointment reminders, to leave a message, to reschedule an appointment, missed appointment notification, birthday cards, newsletters, holiday cards, or other health related information. If I am contacted by phone, I give permission to leave a message with a member of my household, on my answering machine or voice mail.

- ✓ I authorize use of this form on all of my insurance submissions [SIGNATURE ON FILE] I authorize release of information to all my insurance companies. I authorize Sullivan Family Chiropractic to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to Sullivan Family Chiropractic from my insurance companies.

- ✓ I understand that I am ultimately responsible for my bill and payment is due when services are rendered, unless other arrangements have been made.

- ✓ I permit a copy of this authorization to be used in place of the original.

- ✓ I understand that this office is complying with federal HIPAA guidelines by advising me that they are doing everything in their power to protect my private health information. At any time, I am able to ask this office of the safety and protected nature of my health information, or any other related issues or concerns.

- ✓ By signing this form I am giving Sullivan Family Chiropractic permission to use and disclose my protected health information in accordance with the directives listed above.

Name (Please print) _____ Date of Birth _____

Signature _____ Date _____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/guardian Signature _____ Date _____

Witness Signature _____ Date _____

GENERAL PAIN DISABILITY INDEX

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words we would like to know how much your pain is preventing you from doing what you would normally do. Respond to each category indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories or daily living listed, **PLEASE NUMBER EACH ITEM WITH A SCORE OF 0-10 WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** A score of 0 means no functioning at all and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

0	1	2	3	4	5	6	7	8	9	10
NO LIMITATION COMPLETELY ABLE TO FUNCTION					TOTAL LIMITATION UNABLE TO FUNCTION					

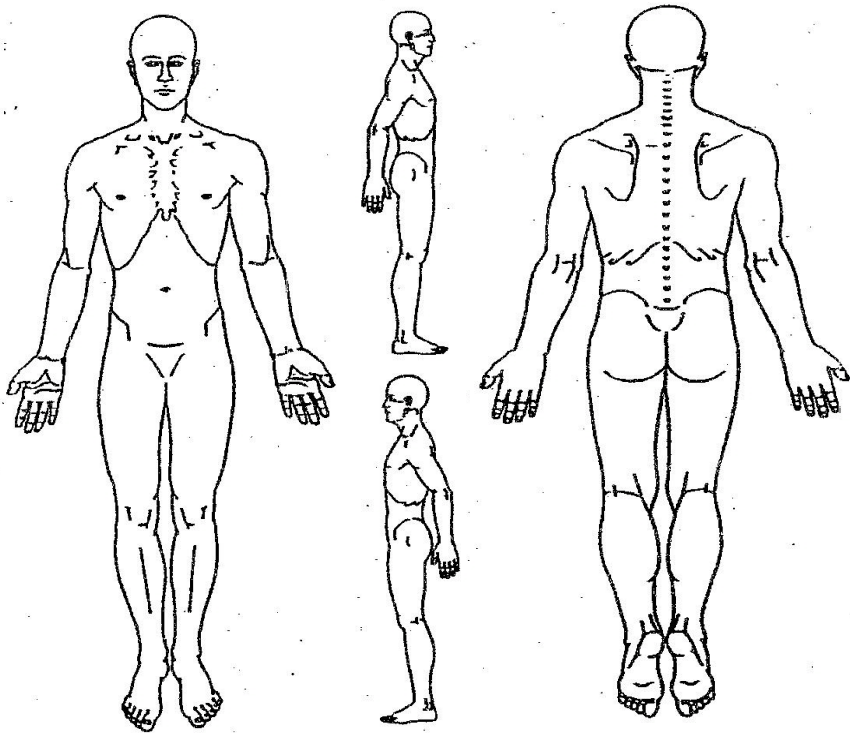
- _____ **1. Family/Home Responsibilities**-Chores and duties performed around the house (ex. Yard work, carpool, etc.)
- _____ **2. Recreation**-Hobbies, sports, and other similar leisure time activities.
- _____ **3. Social Activity**-Participation with friends and family. Parties, theater, concerts, dining out and other social functions.
- _____ **4. Occupation**-Directly related to your job. Full, part, or non-paid positions; including homemaker.
- _____ **5. Self Care**-Personal maintenance and independent daily living (ex. Taking a shower, driving, getting dressed, etc.)
- _____ **6. Life-Support Activity**-Eating, sleeping, and breathing.

_____ Total _____ Signature _____ Date

VISUAL ANALOG PAIN SEVERITY SCALE (VAS SCALE)

INSTRUCTIONS: Please mark on the line below how you currently feel.

NO PAIN-----WORST PAIN EVER



PLEASE MARK ON THE BODIES TO THE LEFT, THE LOCATION AND TYPE OF PAIN YOU ARE EXPERIENCING

NUMBNESS	=====
BURNING	XXXXXX
SHARP/STABBING	////////
PINS AND NEEDLES	oooooo
ACHING	aaaaaa