DELANEY FAMILY CHIROPRACTIC

Patient Name:	**Date:**

Address_____ City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email Address: _____

Sex: M F Marital Status: M S D W Date of Birth____/____/____ Age_____ Social Security #_____

Occupation_____ Employer_____

Primary Care Physician (Name, Address, Phone) _____

Age: _____ years Height: ____ feet ____ inches Weight: _____ lbs. Any recent changes in Weight? Yes / No

Referred by: _____ Is this visit due to an injury? Yes / No Auto Accident / Work Related

Have you ever received Chiropractic Care? ◯ Yes ◯ No If Yes, when? _____ Name of Chiropractor:_____

Symptoms (in order of severity):

1._____ Began (Mo/Yr):_____ Previous Episodes:_____

2._____ Began (Mo/Yr):_____ Previous Episodes:_____

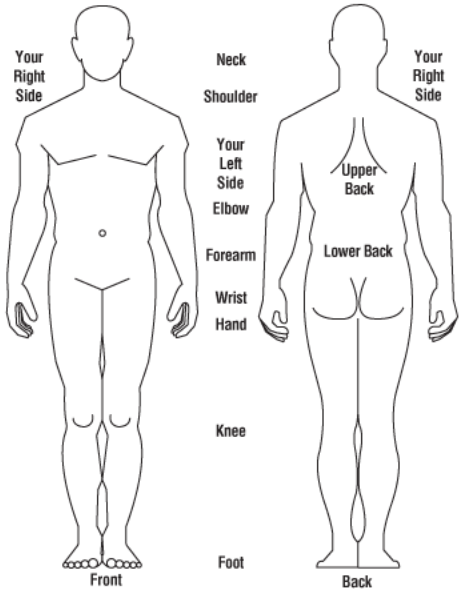
3._____ Began (Mo/Yr):_____ Previous Episodes:_____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

Primary Reason For Visit:

Please mark the drawing to the right with the corresponding letter indicating your symptom(s) using the following indicators:

P = Pain
S = Spasm
N = Numbness
T = Tingling



Symptom 1:

Circle the number that best describes the symptom most of the time:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Percent of waking hours you experience your symptoms _____%

What caused the problem?_____

How did the symptoms begin? Suddenly / Gradually (circle one)

Are symptoms worse at (circle all that apply)
Morning Afternoon Evening Night Unaffected by time of day

What makes the symptom worse? (circle all that apply):
Bending Turning head Sitting Standing Lying Down Walking Going up steps Rising from sitting position Lifting Any movement Nothing Other (please describe): _____

What makes the symptom better? (circle all that apply):
Sitting Standing Lying Down Rest Ice Heat Stretching Exercise Massage Pain medication (which ones_____) Nothing Other (please describe): _____

Symptom 2:

Circle the number that best describes the symptom most of the time:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Percent of waking hours you experience your symptoms _____%

DELANEY FAMILY CHIROPRACTIC

Patient Name:	**Date:**

What caused the problem?_____

How did the symptoms begin? Suddenly / Gradually (circle one)

Are symptoms worse at (circle all that apply)
Morning Afternoon Evening Night Unaffected by time of day

What makes the symptom worse? (circle all that apply):
Bending Turning head Sitting Standing Lying Down Walking Going up steps Rising from sitting position Lifting Any movement Nothing Other (please describe): _____

What makes the symptom better? (circle all that apply):
Sitting Standing Lying Down Rest Ice Heat Stretching Exercise Massage Pain medication (which ones_____) Nothing Other (please describe): _____

****Please attach additional pages for more than 2 symptoms

PAST MEDICAL HISTORY – PROBLEMS:

I **HAVE / HAVE NOT** ever had surgery. (circle one)

Please indicate if you currently have or have had in the past any issues related to the following.
Describe ALL **ISSUES, INJURIES, or SURGERIES.**

System	***Current***	***Past***	***Describe Issue***
Heart & Vascular	____	____	
Respiratory	____	____	
Musculoskeletal	____	____	
Rheumatologic	____	____	
Neuromuscular	____	____	
Ear, Nose, Throat	____	____	
Eyes	____	____	
Skin	____	____	
Allergies	____	____	
Gastrointestinal	____	____	
Gynecological (female)	____	____	
Gento-Urinary (male)	____	____	
Endocrine	____	____	
Constitutional	____	____	
Psychiatric	____	____	
Cancer	____	____	
Other	____	____	

DELANEY FAMILY CHIROPRACTIC

Patient Name:	**Date:**

FAMILY HISTORY:

Mother Living? ☐ Yes Current state of health: _____ ☐ No Age at death _____ Cause of death_____

Father Living? ☐ Yes Current state of health: _____ ☐ No Age at death _____ Cause of death_____

Sibling(s) Living? ☐ Yes Current state of health: _____ ☐ No Age at death _____ Cause of death_____

SOCIAL HISTORY:

Marital Status: ___ Single ___ Married/Partnered ___ Divorced ___ Separated ___ Widowed

Number of Children: _____

Highest Level of Education Completed:
___ Not Completed HS ___ HS graduate ___ BA / BS degree ___ MA degree ___ MD / DO / Ph.D

Do you eat a well-balanced diet? ___ never ___ rarely ___ occasionally ___ usually ___ regularly

Do you exercise? ___ never ___ rarely ___ occasionally ___ usually ___ regularly

Type of Exercises: _____

Do you drink alcohol? ___ daily ___ frequently (more than 3 days/week) ___ occasionally ___ former ___ never

Smoking Status:
___ I currently smoke _____/day ___ I do not smoke currently – I did smoke but I quit _____ ___ I never smoked

Have you ever had a substance abuse issue? ___ Yes ___ No If yes, which substance(s)?_____

Anything else you think should be noted about your social history:

This Box For Office Staff To Complete:

Blood Pressure: (normal range 120/80) right arm: _____ / _____ left arm: _____ / _____

Pulse Rate: _____ BPM (normal 72)

DELANEY FAMILY CHIROPRACTIC

Patient Name: **Date:**

OSWESTRY QUESTIONNAIRE:

Please select the best option(s) for each section below:

Section 1 – Pain Intensity
___ A. Pain comes and goes and is mild
___ B. Pain is mild and does not vary
___ C. Pain comes and goes and is moderate
___ D. Pain is moderate and does not vary much
___ E. Pain comes and goes and is severe
___ F. Pain is severe and does not vary much

Section2 – Personal Care
___ A. Does not change habits to avoid pain
___ B. Does not change habitis / some pain
___ C. Does not change habits / Increases pain
___ D. Changes habits / Increases pain
___ E. Unable to do some care without help
___ F. Unable to wash or dress without help

Section 3 – Lifting
___ A. Lifts heavy weights with no pain
___ B. Lifts heavy weights with pain
___ C. Cannot lift heavy weights off the floor
___ D. Can lift heavy weights from a table
___ E. Can lift light weights from a table
___ F. Can lift only very light weights

Section 4 – Walking
___ A. Pain does not prevent walking
___ B. Cannot walk more than one mile
___ C. Cannot walk more than ½ mile
___ D. Cannot walk more than ¼ mile
___ E. Can walk only with crutches/walker
___ F. Bedridden and must crawl to toilet

Section 5 – Sitting
___ A. Can sit in any chair as long as desired
___ B. Can sit only in favorite chair as long as desired
___ C. Can sit no more than 1 hour
___ D. Can sit no more than ½ hour
___ E. Can sit no more than 10 minutes
___ F. Cannot sit at all due to pain

Section 6 – Standing
___ A. Can stand for an unlimited time without pain
___ B. Some pain standing / doesn't increase with time
___ C. Cannot stand for more than 1 hour
___ D. Cannot stand for more than ½ hour
___ E. Cannot stand for more than 10 minutes
___ F. Cannot stand at all

Section 7 – Sleeping
___ A. No pain in bed
___ B. Gets pain in bed, but sleeps well
___ C. Normal sleep reduced by 1/4
___ D. Normal night's sleep reduced by 1/2
___ E. Normal night's sleep reduced by 3/4
___ F. Cannot sleep due to pain

Section 8 – Traveling
___ A. Travel without pain
___ B. Travel causes some pain, but not made worse
___ C. Causes extra pain / no change in form
___ D. Causes pain / Uses alternate travel
___ E. Pain restricts all forms of travel
___ F. Pain restricts travel except lying down

Section 9 – Social
___ A. Normal and causes no pain
___ B. Normal but causes extra pain
___ C. Limits energetic interests
___ D. Pain limits / doesn't go out as often
___ E. Pain restricted social lift to home
___ F. Pain restricts all social life

Section 10 – Changing Degree of Pain
___ A. Pain is rapidly improving
___ B. Pain fluctuates but is improving
___ C. Improvement is slow
___ D. Pain level is unchanged
___ E. Pain is gradually worsening
___ F. Pain is rapidly worsening

Any additional information or clarification you would like to add:

LOW BACK PAIN DISABILITY QUESTIONNAIRE
(ROLAND-MORRIS)

Name _____ Number _____ Date _____

SCORE: _____

When your back hurts, you may find it difficult to do some of the things you normally do.
Mark only the sentences that describe you today.

- ☐ **I stay at home most of the time because of my back.**
- ☐ **I change position frequently to try and get my back comfortable.**
- ☐ **I walk more slowly than usual because of my back.**
- ☐ **Because of my back, I am not doing any jobs that I usually do around the house.**
- ☐ **Because of my back, I use a handrail to get upstairs.**
- ☐ **Because of my back, I lie down to rest more often.**
- ☐ **Because of my back, I have to hold on to something to get out of an easy chair.**
- ☐ **Because of my back, I try to get other people to do things for me.**
- ☐ **I get dressed more slowly than usual because of my back.**
- ☐ **I stand up only for short periods of time because of my back.**
- ☐ **Because of my back, I try not to bend or kneel down.**
- ☐ **I find it difficult to get out of a chair because of my back.**
- ☐ **My back is painful almost all of the time.**
- ☐ **I find it difficult to turn over in bed because of my back.**
- ☐ **My appetite is not very good because of my back pain.**
- ☐ **I have trouble putting on my socks (or stockings) because of pain in my back.**
- ☐ **I sleep less well because of my back.**
- ☐ **Because of back pain, I get dressed with help from someone else.**
- ☐ **I sit down for most of the day because of my back.**
- ☐ **I avoid heavy jobs around the house because of my back.**
- ☐ **Because of back pain, I am more irritable and bad tempered with people than usual.**
- ☐ **Because of my back pain, I go upstairs more slowly than usual.**
- ☐ **I stay in bed most of the time because of my back.**

Reference: Roland, Morris. A Study of the Natural History of Back Pain Part 1: Development of a Reliable and Sensitive Measure of Disability in Low-Back Pain. Spine 1983; 8(2): 141-144

FORM 503

DELANEY
FAMILY CHIROPRACTIC

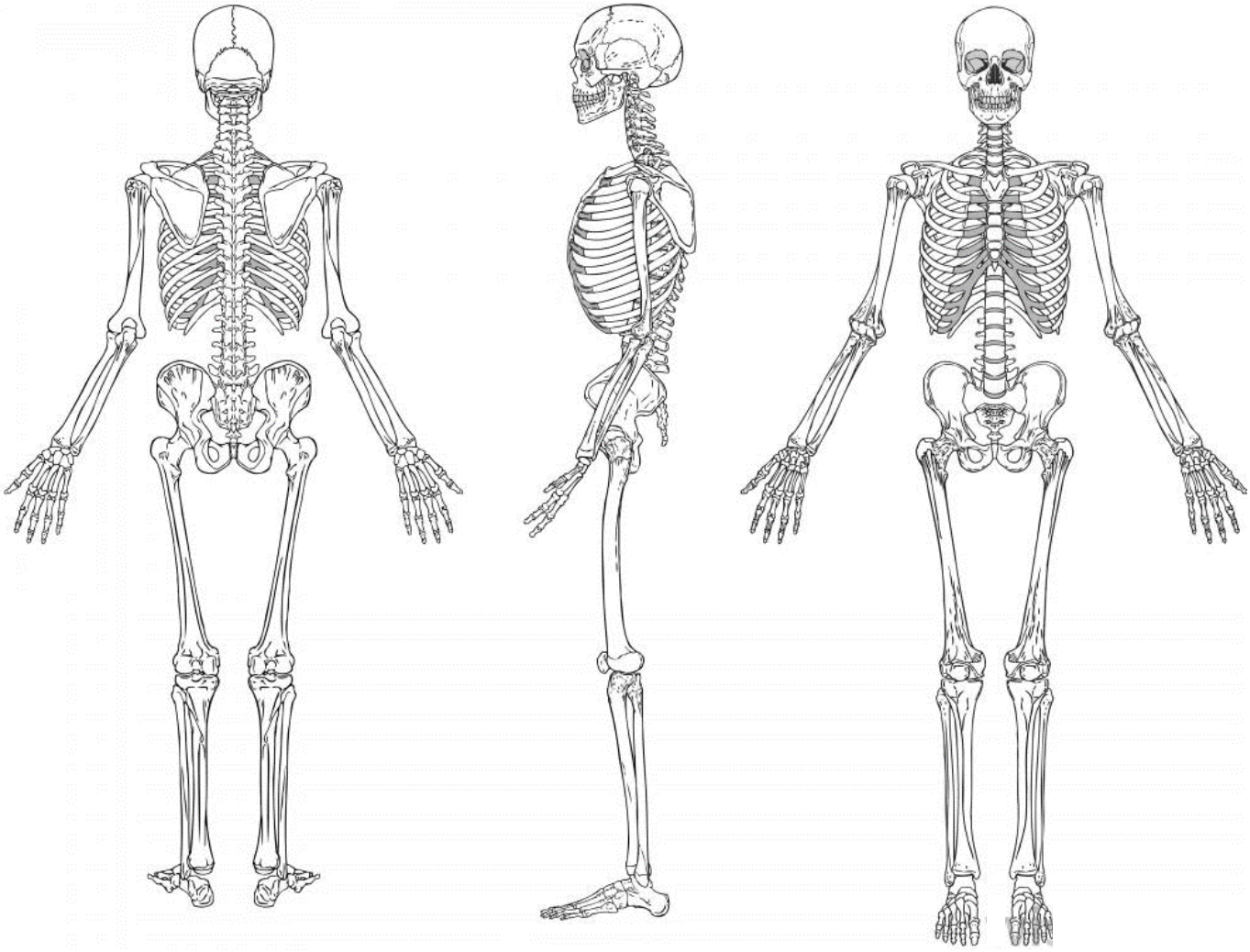
Patient Name:	**Date:**

For Office Use Only

DX Codes:

1)	3)	5)	7)	9)
2)	4)	6)	8)	10)

EVALUATION NOTES:



DELANEY
FAMILY CHIROPRACTIC

Patient Name:	**Date:**

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to DeLaney Family Chiropractic for services performed.

To meet the needs of our patients, DeLaney Family Chiropractic participates in various insurances programs. Each carrier has its own specific guidelines regarding the patient's financial responsibility. While we will work with you and your insurance carrier to provide you with quality and compassionate care within the guidelines of your plan, we expect our patients to understand and acknowledge their financial responsibilities.

Please carefully review the following items:

- Payment for all services rendered is your financial responsibility
- If during our registration you provide us with your complete health insurance information, we will submit our charges to your insurance carrier for payment. You are responsible for all charges if you do not provide complete current accurate insurance information.
- If our practice is one of your network providers, you are responsible for paying your co-payments, deductibles, and coinsurance along with charges for non-covered items or services at the time of your appointment or when services are rendered.
- If our practice is non-network (*out-of-network*) provider, you are responsible for all charges.
- If Medicare is your primary insurance carrier and you have a valid secondary insurance on file with us, we will submit the 20% coinsurance not paid by Medicare to your secondary carrier. If Medicare is your only insurance carrier, you are responsible for the 20% coinsurance not paid by Medicare.
- All auto and workers' compensation patients are asked to provide their private health insurance, including any necessary referrals, in addition to your complete auto/workers' compensation billing information. In the event your auto/workers' compensation claim is denied, we will submit any charges incurred to your private health insurance carrier. If you private health insurance information is not on file you will be billed directly for all charges.
- As authorization is not a guarantee of payment, if your health insurance carrier(s) denies payment for charges submitted to them, we will bill you directly for those charges.

All patients are requested to sign an acknowledgement of their financial responsibility. In the event the patient chooses not to sign the acknowledgment of responsibilities, DeLaney Family Chiropractic reserves the right to withhold treatment.

By signing below, you agree to the terms and conditions above.

Patient or Representative Signature _____ Date_____

I _____give permission for the following person(s) to have access to my PHI (personal health information). You may share results and discuss my treatment with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Your Signature Date

DELANEY FAMILY CHIROPRACTIC

Patient Name:	Date:

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient of Representative Date

_____

Printed Name