MARTY
CHIROPRACTIC & WELLNESS

18476 Kenrick Ave, Suite 201 Lakeville, MN 55044 (ph) 612-440-5776 (fax) 952-236-6732 www.martychiropracticandwellness.com

# CHIROPRACTIC PATIENT INTAKE FORM

Patient Name:_____Date of Birth:_____/_____/_____
(Last, First, Middle Initial)

Address:_____

Phone: (C):_____(H):_____(W):_____

Email:_____

Primary Healthcare Provider and/or Clinic:_____

Who referred you to our clinic?_____

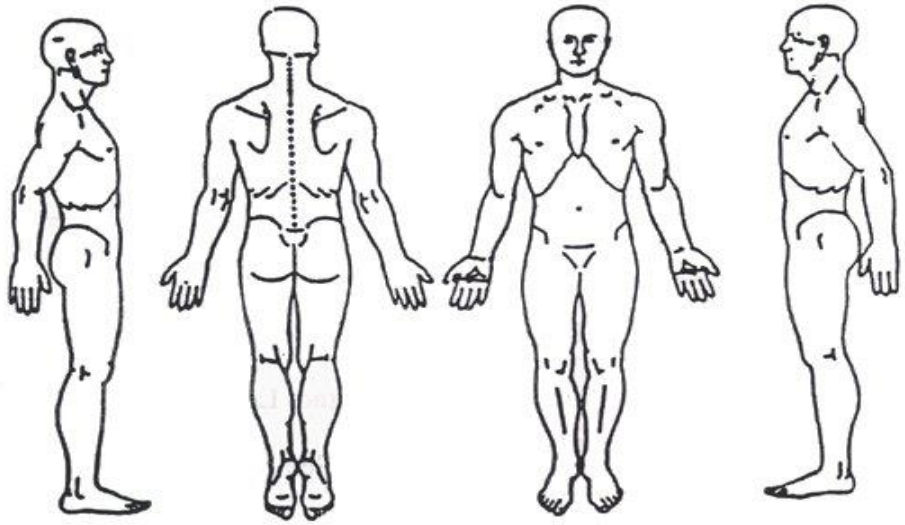
Your answers to the following questions will help us learn more about you and your health. Please take a few moments to complete the following questions. Ask your provider for help with any questions.

1. **What is your reason for seeking care at our clinic?**_____
2. **What are your goals for care?**

   ☐ Acute Symptom Relief ☐ Maintenance of a Chronic Condition ☐ Wellness Care
3. **When did your condition/symptoms begin?**_____
4. **How did your condition/symptom begin?**_____
5. **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)
6. **Indicate on the picture below where you have pain or other symptoms, as well as the nature of your symptoms:**



Use the symbols below:

Numbness
=========

Pins and Needles
000000000

Burning
XXXXXXXXX

Stabbing
//////////

Aching
+++++++++

Other
*********

**During the past 4 weeks:**

a. How much has pain interfered with your normal work (including work outside the home and housework)

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

b. How much of the time has your condition interfered with your social activities (like visiting with friends, relatives, etc.)

☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None

**7. How are your symptoms changing?**

☐ Getting Better ☐Not Changing ☐Getting Worse

**8. In general, would you say your overall health right now is:**

☐ Excellent ☐Very Good ☐Good ☐Fair ☐Poor

**9. Who have you seen for your symptoms?**

☐No one ☐Chiropractor ☐Medical Doctor ☐Physical Therapist ☐Other_____

a. What treatment did you receive and when?_____

b. What tests have you had for you symptoms and when were they performed?

☐X-rays date: _____ ☐CT Scan date: _____ ☐MRI date: _____ ☐Other date: _____

**10. Have you had similar symptoms in the past?** ☐Yes ☐No

a. If you have received treatment in the past for the same or similar symptoms, whom did you see?

☐This office ☐Chiropractor ☐Medical Doctor ☐Physical Therapist ☐Other_____

**For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past. If you presently have a condition listed below, place a check in the PRESENT column.**

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| | | Headaches | | | High Blood Pressure | | | Cancer |
| | | Migraines | | | Heart Attack | | | Tumor |
| | | | | | Chest Pains | | | |
| | | Neck Pain | | | Stroke | | | Smoking/Tobacco Product Use |
| | | Upper Back Pain | | | Angina | | | Drug/Alcohol Dependence |
| | | Mid Back Pain | | | | | | |
| | | Low Back Pain | | | Kidney Stones | | | Allergies |
| | | | | | Kidney Disorders | | | Depression/Anxiety |
| | | Shoulder Pain | | | Bladder Infection | | | Systemic Lupus |
| | | Elbow/Upper Arm Pain | | | Painful Urination | | | Endocrine Disorders |
| | | Wrist Pain | | | Loss of Bladder Control | | | Epilepsy |
| | | Hand Pain | | | | | | Dermatitis/Eczema/Rash |
| | | Hip/Upper Leg Pain | | | Abnormal Weight Gain/Loss | | | HIV/AIDS |
| | | Knee/Lower Leg Pain | | | Loss of Appetite | | | |
| | | Ankle/Foot Pain | | | Abdominal Pain | | | **Females Only** |
| | | Jaw Pain | | | Irregular Bowel Habits | | | Birth Control |
| | | | | | Ulcer | | | Hormonal Replacement |
| | | Joint Swelling/Stiffness | | | Hepatitis | | | Infertility |
| | | Arthritis | | | Liver/Gall Bladder Disorder | | | Uterine Disorders |
| | | Rheumatoid Arthritis | | | | | | |
| | | | | | Asthma | | | **Males Only** |
| | | General Fatigue | | | Apnea | | | Prostate Conditions |
| | | Muscular Incoordination | | | Respiratory Disorders | | | Erectile Dysfunction |
| | | Visual Disturbances | | | | | | |
| | | Dizziness | | | Diabetes | | | **Other Health Problems/Issues** |
| | | Change in Hearing | | | Excessive Thirst | | | |
| | | Chronic Sinusitis | | | Frequent Urination | | | |

**FAMILY HISTORY**
Please list any serious health conditions (cancer, diabetes, heart conditions, autoimmune disorders, etc.) within your immediate family (mother, father, grandparents, brothers, sisters, etc.):

**MEDICAL HISTORY**
Please list any surgeries and their date(s):

Please list any trauma(s) or injuries and their date(s):

**List current medications:**

| Medication: | Dose: | Purpose: | Prescribed By: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**List all nutritional/herbal supplements you are taking:**

| Supplement: | Dose: | Purpose: | Prescribed By: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

How many children do you have?_____

**Females only, please list:**
Number of pregnancies:_____ Number of births:_____

Are you currently pregnant? Yes / No If yes, how many weeks?_____

**PREVENTATIVE HEALTH HISTORY** (Please indicate health screenings within the last year)

| | | | |
|---|---|---|---|
| Blood Pressure | Yes / No | Fasting Blood glucose | Yes / No |
| Breast Exam | Yes / No | Cholesterol | Yes / No |
| Pap Smear | Yes / No | Dental | Yes / No |
| Prostate Exam | Yes / No | Vision | Yes / No |
| Colonoscopy | Yes / No | | |

1. **How often do you typically consume alcoholic drinks (wine, beer, etc.)?**
   Daily Some days Rare Not at all
2. **How often do you typically consume caffeinated drinks (coffee, soda, tea, etc.)?**
   Daily Some days Rare Not at all
3. **Do you use tobacco products (cigarettes, chewing tobacco, pipe, etc.)?**
   Yes / No In the past (year quit_____) No, never
4. **On average, how much physical activity, exercise, or sports activities do you take part in?**
   None Less than 1 time/week 1-2 time/week 2-3 times/week 4 or more times/week
5. **What is your occupation?**_____
   a. What is your current work status? ☐Full-Time ☐Part-Time ☐Self-employed ☐Unemployed ☐Off-work
6. **What is your height and weight?** Height (ft. and in.) _____ Weight (lbs.) _____

**QUADRUPLE VISUAL ANALOGUE SCALE**

Patient name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

| | Headache | | | | neck | | | | low back | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | (2) | 3 | 4 | (5) | 6 | 7 | (8) | 9 | 10 worst possible pain |

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1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 worst possible pain

OTHER COMMENTS:

_____

_____

_____



SCORE: _____

**NECK PAIN INDEX**

Patient name _____ Date _____

This form is to be completed by patients being seen for neck pain. This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which closely describes your problem right now.

**Pain Intensity**

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain is moderate and does not vary much
3 The pain is fairly severe at the moment
4 The pain is severe but comes and goes
5 The pain is severe and does not vary much

**Personal care (washing, dressing, etc.)**

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 manage most of my personal care
4 I need help every day in most aspects of self-care
5 I do not get dressed, 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 but I can manage light to medium weights if they are conveniently positioned
4 I can lift only very light weights
5 I cannot lift or carry anything at all

**Reading**

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

**Headache**

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

**Concentration**

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

**Work**

0 I can do as much work as I want to
1 I can only do my usual work, but no more
2 I can 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

**Driving**

0 I can drive my car without neck pain
1 I can drive my car as long as I want with slight pain in my neck
2 I can drive my car as long as I want with moderate pain in my neck
3 I cannot drive my car as long as I want because of moderate pain in my neck
4 I can hardly drive my car at all because of severe pain in my neck
5 I have no social life because of pain

**Sleeping**

0 My sleep is never disturbed by pain
1 My sleep is occasionally disturbed by pain
2 Because of pain I have less than 6 hours sleep
3 Because of pain I have less than 4 hours sleep
4 Because of pain I have less than 2 hours sleep
5 Pain prevents me from sleeping at all

**Recreation**

0 I am able to engage in all recreational activities with no pain in my neck at all
1 I am able to engage in all recreational activities with some pain in my neck
2 I am able to engage in most, but not all recreational activities because of pain in my neck
3 I am able to engage in a few of my usual recreational activities because of pain in my neck
4 Pain restricts me to short necessary journeys under 30 minutes
5 I cannot do any recreational activities at all

**SCORE (X2) _____**

**LOW BACK OSWESTRY 2.1A**

Patient name _____ Date _____

This form is to be completed for patients being seen for back pain. This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one number only in each section that most closely describes you today.

**Pain Intensity**

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain is moderate at the moment
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

**Personal care (washing, dressing, etc.)**

0 I can look after myself normally without causing extra pain
1 I can look after myself normally but it is very painful
2 It is painful to look after myself and I am slow and careful
3 I need some help but manage most of my personal care
4 I need help every day in most aspects of self-care
5 I do not get dressed, 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
3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
4 I can lift only very light weights
5 I cannot lift or carry anything at all

**Walking**

0 Pain does not prevent me walking any distance
1 Pain prevents me walking more than one mile
2 Pain prevents me walking more than a quarter of a mile
3 Pain prevents me walking more than 100 yards
4 I can only walk using a stick or crutches
5 I am in bed most of the time and have to crawl to the toilet

**Sitting**

0 I can sit in any chair as long as I like
1 I can sit in my favorite chair as long as I like
2 Pain prevents me from sitting for more than 1 hour
3 Pain prevents me from sitting for more than half an hour
4 Pain prevents me from sitting for more than 10 minutes
5 Pain prevents me from sitting at all

**Standing**

0 I can stand as long as I want without extra pain
1 I can stand as long as I want but it gives me extra pain
2 Pain prevents me from standing for more than 1 hour
3 Pain prevents me from standing for more than half an hour
4 Pain prevents me from standing for more than 10 minutes
5 Pain prevents me from standing at all

**Sleeping**

0 My sleep is never disturbed by pain
1 My sleep is occasionally disturbed by pain
2 Because of pain I have less than 6 hours sleep
3 Because of pain I have less than 4 hours sleep
4 Because of pain I have less than 2 hours sleep
5 Pain prevents me from sleeping at all

**Sex life (if applicable)**

0 My sex life is normal and causes no extra pain
1 My sex life is normal but causes some extra pain
2 My sex life is nearly normal but is very painful
3 My sex life is severely restricted by pain
4 My sex life is nearly absent because of pain
5 Pain prevents any sex life at all

**Social Life**

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

**Travelling**

0 I can travel anywhere without pain
1 I can travel anywhere but it gives extra pain
2 Pain is bad but I manage journeys over two hours
3 Pain restricts me to journeys of less than one hour
4 Pain restricts me to short necessary journeys under 30 minutes
5 Pain prevents me from travelling except to receive treatment



**SCORE (X2) _____**

**The Keele STarT Back Screening Tool**

Patient name _____ Date _____

Thinking about the **last 2 weeks** tick your response to the following questions:

| | | Disagree 0 | Agree 1 |
|---|---|---|---|
| 1 | My back pain has **spread down my leg(s)** at some time in the last 2 weeks | ☐ | ☐ |
| 2 | I have had pain in the **shoulder** or neck at some time in the last 2 weeks | ☐ | ☐ |
| 3 | I have only **walked short distances** because of my back pain | ☐ | ☐ |
| 4 | In the last 2 weeks, I have **dressed more slowly** than usual because of back pain | ☐ | ☐ |
| 5 | It's not really safe for a person with a condition like mine to be physically active | ☐ | ☐ |
| 6 | **Worrying thoughts** have been going through my mind a lot of the time | ☐ | ☐ |
| 7 | I feel that **my back pain is terrible** and **it's never going to get any better** | ☐ | ☐ |
| 8 | In general, I have **not enjoyed** all the things I used to enjoy | ☐ | ☐ |

9 Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

| Not at all | Slightly | Moderately | Very Much | Extremely |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| 0 | 0 | 0 | 1 | 1 |

**Total Score (all 9): _____ Sub Score (Q5-9): _____**


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# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

Marty Chiropractic and Wellness is committed to patient privacy and the confidentiality of the patient information/personal health information that is entrusted to us.

The ways in which we may use or disclose your health information are detailed in our Privacy Practices.

**Your Right to Limit Uses or Disclosures:**
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

**Your Right to Request that Your Patient Record be Amended:**
You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record, we will provide you with a Request to Amend Protected Health Information form.

**Your Right to Revoke Authorization:**
You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE THE RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUR YOUR CONSENT, HOWEVER, MARTY CHIROPRACTIC AND WELLNESS WILL NOT BE ABLE TO SUBMIT YOUR CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

By signing below, I give consent to the Marty Chiropractic and Wellness clinicians or staff to use or disclose my personal health information as stated in the Notice of Privacy Practices.

_____ _____ _____/_____/_____
(Signature of Patient) (Print Name) (Date)

_____ _____/_____/_____
(Signature of Authorized Representative) (Date

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# PATIENT FINANCIAL ACKNOWLEDGEMENT

**Please read thoroughly. Initial your acknowledgement, then sign and print your name and the date. Thank you.**

ASSIGNMENT OF BENEFITS

☐ I assign all benefits payable to me for my care with] Marty Chiropractic and Wellness. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

GUARANTEE OF PAYMENT

☐ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

CANCELLATION POLICY

☐ To maintain our excellence in customer service, we require a 24-hour cancellation notification for all appointments. Please notify the clinic within 24 hours to avoid a charge for the missed appointment.

_____ _____ ____/____/____

**SIGNATURE (PATIENT/GUARDIAN)** **PRINT NAME** **DATE**

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***OFFICE USE ONLY***

CIRCLE INSURANCE

UHC MEDICA PREF ONE LANDMARK/CCMI (HP, CIGNA, PT. CHOICE) MEDICARE MA SELECT CARE BCBS OTHER

CHIROPRACTIC

1. Deductible/Co-Insurance?_____
2. Is there a copay?_____
3. Limit on visits or services?_____

- o 992XX (Examination)
- o 97110 (Therapeutic Exercise)
- o 97112 (NMS Re-education)

- o Extra-spinal Manipulation
- o Laboratory
- o Orthotics_____ # per year
- o Orthotics not verified

- o Radiology non-spinal]
- o Radiology spinal

- o Strapping

- o 97010 (Hot/cold packs)
- o 97032 (EMS Attended)
- o 97035 (Ultrasound)
- o S8948 (Cold Laser)
- o 97012 (Mechanical Traction)
- o 97140 (Manual Therapy)

ACUPUNCTURE

1. Deductible/Co-Insurance?_____
2. Is there a copay?_____
3. Limit on visits or services?_____
4. Authorization/Precertification needed?_____

- o Acupuncture benefits not verified.

- o Acupuncture not a benefit on this plan.

**BASED ON THE INFORMATION PROVIDED ABOVE BY THE HEALTH INSURANCE PLAN, SERVICES CHECKED ARE NOT COVERED.**

MARTY
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# CHIROPRACTIC INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment for management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the known risks:**

**Temporary soreness or increased symptoms or pain.** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

**Dizziness, nausea, flushing.** These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

**Factures.** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. IT is important to disclose to your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

**Disc herniation or prolapse.** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

**Stroke.** A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary medical care visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

**Other risks.** Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

**Bruising.** Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science and I acknowledge that no guarantee can be given as to results or outcome of my care.

***PATIENT PLEASE REVIEW * PRINT & SIGN NAME***

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

Patient Name (print)_____ Date of Birth_____

_____ _____ _____ _____

(Patient/Guardian Signature) (Date) (Translator/Interpreter Signature) (Date)

*Clinician Only*

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

- ☐ Of legal age
- ☐ Oriented X3
- ☐ Appears unimpaired
- ☐ Fluent in English
- ☐ Consent given through guardian
- ☐ Assisted by a translator/interpreter

_____, DC _____

(DC Signature) (Date)