



FOX CHIROPRACTIC CENTER
(630) 232-6321

Patient Name: Birthdate: Sex: M/F Today's date
Address: City: State Zip
Telephone: Social Security #: Referred by:
Occupation: Employer: Work Phone:
Work Address: City: State: Zip:
Email Address: Cell # (Optional):
Insurance Co.: Subscriber Name: ID#:
Insured Employer: City: State: Insured DOB:
Spouse Name: Person to contact in case of emergency:
Phone:

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

[Blank lines for describing the problem]

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

DATE PROBLEM BEGAN:

Have you seen anyone else for this condition? If yes, describe:

[Blank lines for describing other treatments]

Have you had spinal X-Rays, MRI, CT Scan?

How often are your symptoms present:

0-25% 26-50% 51-75% 76-100%

Can you perform your daily activities? If No, describe:

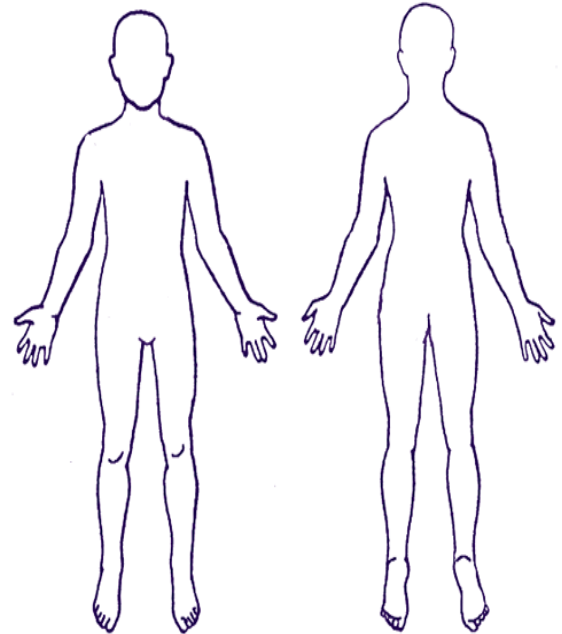
[Blank lines for describing daily activities]

On the line below, scale your level of pain:

(no pain) NOW (worst pain)

HEALTH HISTORY: Please check all that apply to you:

- AIDS/HIV, Depression, Neck pain, Alcoholism, Diabetes, Osteoporosis, Allergies, Dizziness/Fainting, Pregnancy, # of births, Anemia, Epilepsy/Seizures, Prostate problems, Anorexia/bulimia, Fracture, Stroke, Aortic aneurysm, Frequent urination, Thyroid problem, Arthritis, Gout, Tobacco use: yrs, Asthma, Heart disease, Tumor/growth, Back Pain, High blood pressure, Ulcer, Birth Control Pills, Hysterectomy, Vaginal infection, Cancer, Migraine headaches, Weight gain



Type of pain:

- burning, sharp, dull, stiff, numbness, shooting, tingling, aching

Family History:

Regular Medical Doctor:

Other Medical History:

Surgeries/Hospitalizations:

Medications:

Supplements:

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: Date:

# LOW BACK DISABILITY QUESTIONNAIRE

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your 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 MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

<p><b>SECTION 1 – PAIN INTENSITY</b></p> <p>A. The pain comes and goes and is very mild.          B. The pain is mild and doesn't vary much.          C. The pain comes and goes and is moderate.          D. The pain is moderate and doesn't vary much.          E. The pain comes and goes and is severe.          F. The pain is severe and doesn't vary much.</p>	<p><b>SECTION 6-STANDING</b></p> <p>A. I can stand as long as I want without pain.          B. I have some pain while standing, but it doesn't increase with time.          C. I can't stand for longer than 1 hour without increasing pain.          D. I can't stand for longer than ½ hour without increasing pain.          E. I can't stand for longer than 10 minutes without increasing pain.          F. I avoid standing, because it increases the pain straight away.</p>
<p><b>SECTION 2-PERSONAL CARE</b></p> <p>A. I wouldn't have to change my way of washing or dressing in order to avoid pain.          B. I don't normally change my way of washing or dressing even though it causes some pain.          C. Washing &amp; dressing increases the pain, but I manage not to change my way of doing it.          D. Washing &amp; dressing increases the pain &amp; I find it necessary to change my way of doing it.          E. Because of the pain, I am unable to do some washing &amp; dressing without help.          F. Because of the pain, I am unable to do any washing or dressing without help.</p>	<p><b>SECTION 7-SLEEPING</b></p> <p>A. I get no pain in bed.          B. I get pain in bed, but it doesn't prevent me from sleeping well.          C. Because of pain, my normal night's sleep is reduced by less than a quarter.          D. Because of pain, my normal night's sleep is reduced by less than half.          E. Because of pain, my normal night's sleep is reduced by less than ¾.          F. Pain prevents me from sleeping at all.</p>
<p><b>SECTION 3-LIFTING</b></p> <p>A. I can lift heavy weights without extra pain.          B. I can lift heavy weights, but it gives extra pain.          C. Pain prevents me from lifting heavy weights off the floor.          D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.          E. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.          F. I can only lift very light weights, at the most.</p>	<p><b>SECTION 8-SOCIAL LIFE</b></p> <p>A. My social life is normal and gives me no pain.          B. My social life is normal, but increases the degree of my pain.          C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.          D. Pain has restricted my social life &amp; I don't go out very often.          E. Pain has restricted my social life to my home.          F. I have hardly any social life because of the pain.</p>
<p><b>SECTION 4-WALKING</b></p> <p>A. Pain doesn't prevent me from walking any distance.          B. Pain prevents me from walking more than one mile.          C. Pain prevents me from walking more than ½ mile.          D. Pain prevents me from walking more than ¼ mile.          E. I can only walk while using a cane or crutches.          F. I am in bed most of the time and have to crawl to the toilet.</p>	<p><b>SECTION 9-TRAVELING</b></p> <p>A. I get no pain while traveling.          B. I get some pain while traveling, but none of my usual forms of travel make it any worse.          C. I get some pain while traveling, but it doesn't compel me to seek alternative forms of travel.          D. I get extra pain while traveling which compels me to seek alternative forms of travel.          E. Pain restricts all forms of travel.          F. Pain restricts all forms of travel except that done lying down.</p>
<p><b>SECTION 5-SITTING</b></p> <p>A. I can sit in any chair as long as I like without pain.          B. I can only sit in my favorite chair as long as I like.          C. Pain prevents me from sitting more than one hour.          D. Pain prevents me from sitting more than ½ hour.          E. Pain prevents me from sitting more than 10 minutes.          F. Pain prevents me from sitting at all.</p>	<p><b>SECTION 10-CHANGING DEGREE OF PAIN</b></p> <p>A. My pain is rapidly getting better.          B. My pain fluctuates, but overall is definitely getting better.          C. My pain seems to be getting better, but improvement is slow at present.          D. My pain is neither getting better nor worse.          E. My pain is gradually worsening.          F. My pain is rapidly worsening.</p>

# NECK DISABILITY QUESTIONNAIRE

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

**PLEASE READ:** This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your 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 MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

<p><b>SECTION 1 – PAIN INTENSITY</b></p> <p>A. I have no pain at the moment.          B. The pain is very mild at the moment.          C. The pain is moderate at the moment.          D. The pain is fairly severe at the moment.          E. The pain is very severe at the moment.          F. The pain is the worst imaginable at the moment.</p>	<p><b>SECTION 6-CONCENTRATION</b></p> <p>A. I can concentrate fully when I want to, with no difficulty.          B. I can concentrate fully when I want to, with slight difficulty.          C. I have a fair degree of difficulty in concentrating when I want to.          D. I have a lot of difficulty in concentrating when I want to.          E. I have a great deal of difficulty in concentrating when I want to.          F. I cannot concentrate at all.</p>
<p><b>SECTION 2-PERSONAL CARE (Washing, Dressing)</b></p> <p>A. I can look after myself normally, without causing extra pain.          B. I can look after myself normally, but it causes extra pain.          C. It is painful to look after myself and I am slow and careful.          D. I need some help, but manage most of my personal care.          E. I need help every day in most aspects of self care.          F. I do not get dressed; I wash with difficulty and stay in bed.</p>	<p><b>SECTION 7-WORK</b></p> <p>A. I can do as much work as I want to.          B. I can do my usual work, but no more.          C. I can do most of my usual work, but no more.          D. I cannot do my usual work.          E. I can hardly do any work at all.          F. I can't do any work at all.</p>
<p><b>SECTION 3-LIFTING</b></p> <p>A. I can lift heavy weights without extra pain.          B. I can lift heavy weights, but it gives extra pain.          C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.          D. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.          E. I can lift very light weights.          F. I cannot lift or carry anything at all.</p>	<p><b>SECTION 8-DRIVING</b></p> <p>A. I can drive my car without any neck pain.          B. I can drive my car as long as I want, with slight pain in my neck.          C. I can drive my car as long as I want, with moderate pain in my neck.          D. I can't drive my car as long as I want, because of moderate pain in my neck.          E. I can hardly drive at all, because of severe pain in my neck.          F. I can't drive my car at all.</p>
<p><b>SECTION 4-READING</b></p> <p>A. I can read as much as I want to, with no pain in my neck.          B. I can read as much as I want to, with slight pain in my neck.          C. I can read as much as I want to, with moderate pain in my neck.          D. I can't read as much as I want, because of moderate pain in my neck.          E. I can hardly read at all, because of severe pain in my neck.          F. I cannot read at all.</p>	<p><b>SECTION 9-SLEEPING</b></p> <p>A. I have no trouble sleeping.          B. My sleep is slightly disturbed (less than 1 hr sleepless).          C. My sleep is mildly disturbed (1-2 hrs sleepless).          D. My sleep is moderately disturbed (2-3 hrs sleepless).          E. My sleep is greatly disturbed (3-5 hrs sleepless).          F. My sleep is completely disturbed (5-7 hrs sleepless).</p>
<p><b>SECTION 5-HEADACHES</b></p> <p>A. I have no headaches at all.          B. I have slight headaches that come infrequently.          C. I have moderate headaches that come infrequently.          D. I have moderate headaches that come frequently.          E. I have severe headaches that come frequently.          F. I have headaches almost all the time.</p>	<p><b>SECTION 10-RECREATION</b></p> <p>A. I am able to engage in all my recreation activities, with no neck pain at all.          B. I am able to engage in all my recreation activities, with some neck pain.          C. I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.          D. I am able to engage in few of my recreation activities, because of pain in my neck.          E. I can hardly do any recreation activities, because of pain in my neck.          F. I can't do any recreation activities at all.</p>

## NOTICE OF PRIVACY PRACTICES (MEDICAL)

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

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following right with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to request restriction. We must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complain with our office, or with the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Ave, S.W.  
Washington, D.C. 20201  
(202)619-0257  
Toll free 1-877-696-6775

OFFICE POLICY & CONSENT FORM

**THIS DOCUMENT STANDS TO INFORM THE PATIENT ON POLICIES THAT FOX CHIROPRACTIC CENTER MAINTAINS FOR BETTERMENT OF THE PATIENT’S HEALTHCARE EXPERIENCE AT OUR OFFICE.**

**Mission Statement:** To educate and adjust as many families and people as possible toward optimum health through natural “Chiropractic Care”. Our goal is to serve you with exceptional friendly and prompt services and provide the very best care available. In return, you will receive restored health.

**FINANCIAL:**

**Accepting Group Health insurance assignment, and waiting for payment is a courtesy that may be withdrawn if circumstances warrant it.**

- We bill insurance weekly
- Your insurance will be billed in 30 days. All balances are payable no later than 60 days after the date of billing.
- You pay your deductible and your percentage of responsibility as you go along (i.e. if insurance pays 80%, you pay 20% at each visit). Patient co-insurances are due at the time of visit.
- Assignment of benefits- I authorize payment of benefits directly to Fox Chiropractic Center. I authorize release of any medical information necessary to process any claims.
- Our office doesn’t guarantee that your insurance will pay. If your insurance claim is denied, you are responsible for your full bill. It must be understood the contract is between you and your insurance company, and you are responsible for any amount not covered by your insurance. Your insurance benefits are an agreement between you and your insurance company. This office serves as an intermediary as a courtesy.
- Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
- In the case of managed care, there may be limitations that the carrier will provide. If you decide to continue treatment after this point, you will be responsible for the balance of your treatment in full at the time of treatment.
- Worker’s compensation, personal injury, and auto accident insurance may take additional time to process, and charges may accrue for “operational fees”.

**PATIENT CONSENT**

I understand the Health Insurance Portability & Accountability Act of 1996 (HIPAA) provides certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at Fox Chiropractic Center (423 Hamilton St., Geneva, IL 60134) to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient (if minor): \_\_\_\_\_

Date: \_\_\_\_\_

# **FOX CHIROPRACTIC CENTER**

## **REGARDING YOUR X-RAYS**

In order to provide the standard of care you deserve, this office commonly requests that your x-rays be interpreted by a Board Certified Chiropractic Radiologist. This second qualified opinion is for the benefit and safety of your health.

The fees for this service will be submitted to your insurance company, if applicable. In the case where your insurance company or billed party does not cover the expense, the patient remains ultimately responsible for this fee.

Our office has made this procedure as convenient as possible for all patients by making payments to the radiologist directly for his services. It is the patient's obligation to reimburse the office.

I have read and understand the above policy.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print name: \_\_\_\_\_