

Patient Information

Today's Date _____ How did you hear about us? _____ S.S. # _____
Name _____ D.O.B. _____
Address _____ City _____ State _____ Zip _____
Home # _____ Cell # _____ Work # _____
Email address _____
Occupation _____ Employer _____
Employer Address _____ City _____ State _____ Zip _____
Marital Status _____ Spouse's Name _____
Emergency Contact _____ Relationship _____
Emergency Contact Phone # _____ Cell # _____

Insurance Information

Primary Insurance

Company _____
Address _____
City _____ State _____ Zip _____
Phone # _____
Policy # _____ Group # _____
Insured's Name _____
Insured's D.O.B. _____
Relationship: self spouse child

Secondary Insurance

Company _____
Address _____
City _____ State _____ Zip _____
Phone # _____
Policy # _____ Group # _____
Insured's Name _____
Insured's D.O.B. _____
Relationship: self spouse child

Accident Information

Is condition due to an accident? yes no Date of incident _____
Type of accident Auto* Work Home Other
To whom have you made a report of your accident?
 Your Auto Insurance Other Auto Insurance Worker Comp. Other
Attorney Name (if applicable) _____ Phone # _____
**If this is a recent automobile accident, we need a copy of the police report.*

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand **Plus Care 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 **Plus Care Chiropractic** will be credited to my account on receipt. However, I am 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 signature _____ Date _____

Parent/Guardian _____ Date _____

Name _____ Date _____

What is your main complaint today? _____

How long have you had this condition? _____

How did this condition begin? _____

Is there anything that will make this condition better? _____

Is there anything that will make this condition worse? _____

Is there any part of the day that your condition is better? _____

Is there any part of the day that your condition is worse? _____

Has your condition been constant or does it come and go? _____

Is your condition interfering with: work sleep daily routine other _____

Have you ever been in any type of auto accident? _____ When? _____

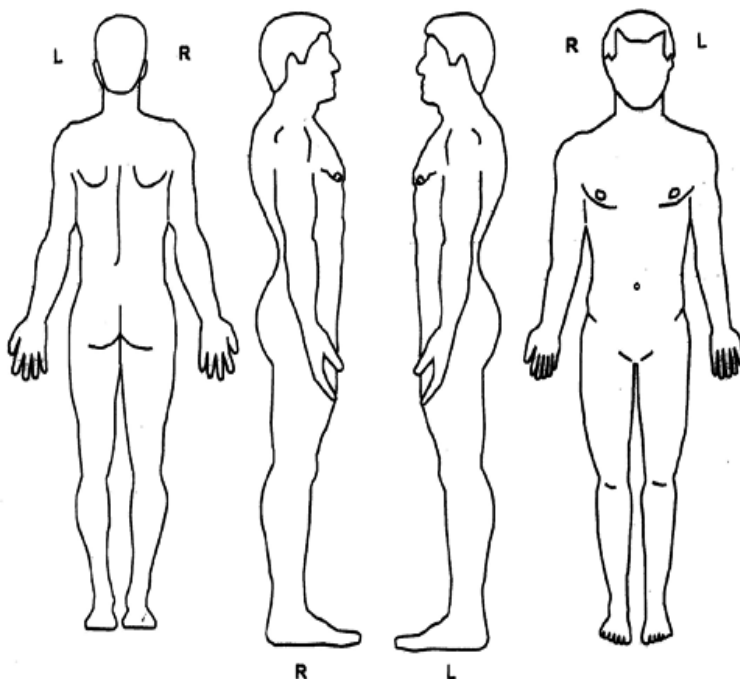
Describe _____

Have you ever had any mental or emotional disorders? _____ Explain _____

Have you seen any other health care practitioner for this condition? If so, who and when? _____

Is this pain: Sharp Stabbing Dull Achy Throbbing Tingling Stiff Burning Numb

Please indicate the area of complaint on the drawing.



Neck Index

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

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain comes and goes and is moderate.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless).

Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I cannot read as much as I want because of moderate neck pain.
- I can hardly read at all because of severe neck pain.
- I cannot read at all because of neck pain.

Concentration

- I can concentrate fully when I want with no difficulty.
- I can concentrate fully when I want with slight difficulty.
- I have a fair degree of difficulty when I want.
- I have a lot of difficulty concentrating when I want.
- I have a great deal of difficulty concentrating when I want.
- I cannot concentrate at all.

Lifting

- I can lift heavy weights with out extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything at all.

Personal Care

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself & I'm slow and careful.
- I need some help but I manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight neck pain.
- I can drive my car as long as I want with moderate neck pain.
- I can drive my car as long as I want b/c of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I cannot drive my car at all because of neck pain.

Recreation

- I can engage in all my recreation activities without pain.
- I can engage in all my usual activities with some neck pain.
- I can engage in most but not all my usual activities b/c of neck pain.
- I can only engage in a few of my activities b/c of neck pain.
- I can hardly do any recreation activities b/c of neck pain.
- I cannot do any recreation activities at all.

Work

- I can do as much work as I want.
- I can only do my usual work but no more.
- I can only do most of my usual work but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

Please indicate on the scale your level of pain in your neck.

No Pain |-----| Extreme Pain

Back Index

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

- The pain comes and goes and is very mild.
- The pain very mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is very severe and does not vary much.

Sleeping

- I don't get pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal sleep is reduced by less than 25%.
- Because of pain my normal sleep is reduced by less than 50%.
- Because of pain my normal sleep is reduced by less than 75%.
- Pain prevents me from sleeping at all.

Personal Care

- I don't have to change my way of washing or dressing to avoid pain.
- I don't change washing or dressing even though it causes pain.
- Washing and dressing increases pain but I don't change ways.
- Washing and dressing increases pain and I change my ways.
- I'm unable to do some washing or dressing alone b/c of pain.
- I'm unable to do any washing or dressing alone b/c of pain.

Traveling

- I have no pain while traveling.
- I get some pain traveling, but it doesn't make pain worse.
- I get extra pain traveling, but don't seek alternate forms of travel.
- I get extra pain traveling which makes me seek alternate travel plans.
- Pain restricts all forms of travel except that done while lying down.
- Pain restricts all forms of travel.

Lifting

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

Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow.
- My pain is neither getting better or worse.
- My pain gradually worsening.
- My pain is rapidly worsening.

Sitting

- I can sit in a chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 30min.
- Pain prevents me from sitting more than 10 min.
- I avoid sitting because it increases pain immediately.

Walking

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

Standing

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

Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no affect on social life except energetic interests.
- Pain has restricted my social life and I don't go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of pain.

Please indicate on the scale your level of pain in your back.

No Pain |-----| Extreme Pain

Informed Consent

I hereby consent to the performance of chiropractic adjustment and other procedures deemed necessary by the practicing doctor of chiropractic. I understand that results are not guaranteed and that there are slight risks to treatment, including but not limited to muscle strains and sprains, disc injuries, and strokes, or other possible complications unforeseen. I intend this consent to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment.

Signed _____ Date _____

I hereby give my consent to allow Plus Care Chiropractic clinic and it's representatives to take x-rays as deemed appropriate.

Signed _____ Date _____

FEMALES ONLY: I declare that to my knowledge, I am NOT pregnant.

Signed _____ Date _____

Acknowledgement of Receipt of Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Plus Care Chiropractic's "NOTICE OF PRIVACY PRACTICES," revision date April 14, 2003.

As required by the Privacy Regulations, _____, from Plus Care Chiropractic, has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Plus Care Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information
 - I wish to file a "Request for Alternative Communications" of my Protected Health Information
 - I wish to object to the following in the "Notice of Privacy Practices:" _____
- _____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Signature _____ Date _____

Print Name _____

(OFFICE USE ONLY)

Signed form received by _____ Date _____



Plus Care Chiropractic

1809 E. 10th Street
Jeffersonville, IN 47130
812-282-8977

RELEASE OF MEDICAL RECORDS

DATE _____

ATTENTION (Doc. Office) _____

ADDRESS (Doc. Office) _____

CITY & STATE _____

Patient's DOB _____ Patient's SS# _____

I, _____ hereby authorize you to release to Plus Care Chiropractic, copies of all medical records and/or x-rays as indicated below. I am also authorizing a copy of my signature to be used in place of the original to obtain the following information.

_____ MEDICAL RECORDS

_____ X-RAYS

PATIENT'S SIGNATURE _____

DATE _____

PATIENT'S ACCOUNT # _____

1809 East 10th Street Jeffersonville, IN 47130
812-282-8977

NOTICE OF PRIVACY PRACTICES
Effective: April 14, 2003

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.

Plus Care Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare options. (Example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Plus Care Chiropractic.”

“It is our policy to provide a substitute health care provider, authorized by Plus Care Chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (Example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Plus Care Chiropractic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below: (Example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation, or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Plus Care Chiropractic sponsored fund-raising events.”

Change Ownership

In the event that Plus Care Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Plus Care Chiropractic is not required to agree to the restrictions that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that Plus Care Chiropractic amend your protected health information. Please advise, however, that Plus Care Chiropractic is not required to amend your health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Plus Care Chiropractic.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Plus Care Chiropractic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains until such amendment is made, Plus Care Chiropractic is required by law to comply with this notice.

Plus Care Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact April Simmons by calling this office at 812-282-8977. If April Simmons is not available, you may make an appointment for a personal conference in person or by telephone within 2 days.

Complaints

Complaints about your privacy rights, or how Plus Care Chiropractic has handled your health information should be directed to April Simmons by calling this office at 812-282-8977. If April Simmons is not available, you may make an appointment for a personal conference in person or by telephone within 2 days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509 F HHH Building
Washington, DC 20201

I have read the Privacy Notice, received a copy and understand my rights of this notice. By way of my signature, I provide Plus Care Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

*****THIS PRIVACY NOTICE IS YOURS TO KEEP FOR YOUR RECORDS*****