Case History

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail:_____Cell Phone:_____ Work Phone:_____

Sex: M / F Birth Date:_____ Marital Status: M S W D Spouse Name:_____

Occupation:_____ Employer:_____

Name of Emergency Contact:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

May we have your permission to update your medical doctor regarding your care at this office? Yes_____No____

How would you like us to confirm appointments? E-mail ____Text ____Name of Cell phone carrier _____

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

PRESENT AND PAST ILLNESS:

What is your major symptom: _____

When did symptoms start: _____

Cause: Auto___ Work____ Unknown_____Other_____

How frequent is the condition? Constant_____ Daily_____ On/Off_____ Night Only_____

Does your pain radiate? Yes/No If so where_____

What makes the problem better (B) or worse (W)? Standing ___ Sitting ___ Bending ___ Lifting ___ Twisting ___

Other _____

When does it feel better (B) or worse (W)? Morning___ Afternoon ___ Evening___ As the day progresses ____

No Change___

Have you had any broken bones? Yes/No If yes please list and give dates:_____

List any major accidents you have had other than those that might be mentioned above:_____

To your knowledge, have you had any diseases, major illnesses or injuries not indicated on this form either in the past or the present? Yes/ No If yes, please explain:_____

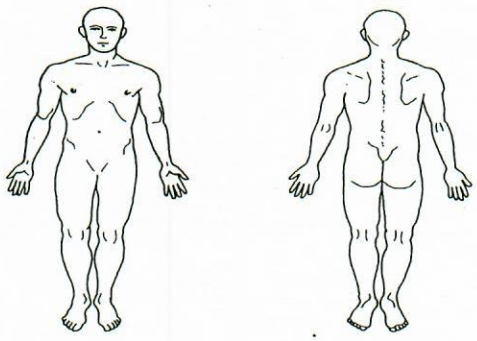
WOMEN ONLY: Are you pregnant? Yes / No / Uncertain

Are you presently taking any prescription medication? No___ Yes___ Please list

_____

TELL US WHERE YOU HURT

A = ACHE	B = BURNING	SP=SPASM	SH=SHARP
N = NUMBNESS	S = STABBING	ST=STIFFNESS	
P = PINS & NEEDLES	W=WEAKNESS	TH=THROBBING	



My pain right now is:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

My pain when it hurts the worst:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

My average pain level is:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Have you had or do you now have any of the following symptoms/conditions:

N = Now P = Previously

Headaches	_____	Stroke	_____
Neck Pain/Stiffness	_____	Cancer	_____
Mid Back Pain/Stiffness	_____	Osteoporosis	_____
Low Back Pain/Stiffness	_____	Arthritis	_____
Muscle Spasms	_____	Diabetes	_____
Dizziness	_____	Heart Disease	_____
Numbness	_____	High/Low B P	_____
Weakness	_____	Seizures/Epilepsy	_____
Arm/Leg Pain	_____	TMJ	_____
Joint Pain/Swelling	_____	Bladder Problems	_____
Loss of Smell	_____	Stomach Problems	_____
Loss of Taste	_____	Hearing Problems	_____
Loss of Memory	_____	Vision Problems	_____
Weight Loss/Gain	_____	Breathing Problems	_____

Habits

Exercise None___ Weekly___ Daily___ Walks____ Runs _____
Alcohol None___ Casual___ Moderate___ Heavy___
Tobacco Never___ Current___ Former___
Caffeine None___ # Cups per day_____

Past Surgeries

List any surgeries and dates?

_____

_____

FAMILY HISTORY

Has any member of your family had any of the following diseases?

__Diabetes __Kidney __Arthritis __Heart __Cancer __Lung __Stomach __Other_____

I certify the information provided is accurate to the best of my knowledge:

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

I hereby authorize the doctor to examine me and treat my condition as he deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature:_____ **Date:**_____

Guardian's Signature Authorizing Care:_____ **Date:**_____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient 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

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
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

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 I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

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 off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

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

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

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

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

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

Headaches

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient 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

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

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

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score _____

INFORMED CONSENT

Patient Name:_____

Clinic Name: Atlantic Shore Chiropractic

Doctor Name: Dr. Kenneth W. Tobey, DC

Address: 1325 Warren Ave. Suite 8 Spring Lake, NJ 07762

Phone: 732-359-7716 Fax: 732-359-7718

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

_____ DATE _____

Signature

_____

Signature of Parent or Guardian (if a minor)

CREDIT GUARANTEE
INSURANCE ASSIGNMENT

PERSONAL BALANCES

INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 30 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

FILING PROCEDURE

Claims for initial services are submitted within 48 hours after your first visit.

On Day 30, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. You will be sent a payment voucher. Any payments made on these claims thereafter will be immediately refunded to you.

PERSONAL BALANCES

Estimated personal portions are paid at the time of service unless you prefer to pay weekly. Weekly payments also require this credit card guarantee, and any personal balance not paid by Friday will also be automatically charged to your designated card below.

CREDIT CARD: ❒ VISA ❒ MC ☐ Discover ☐ Amex

CARDHOLDER NAME: _____

CARD #: _____ **V-CODE:** _____ **EXP. DATE:** ____/____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 60 days after submission of my claim, or should I terminate care before being dismissed by your physician, I will be charged the amount due.

_____ _____

SIGNATURE **DATE**