CHIROPRACTIC CASE HISTORY

PATIENT INFORMATION

Name:______________________________

Address:______________________ **City:**__________ **State:**____ **Zip:**________

Phone: **Home:**__________ **Work:**__________ **Cell:**__________

Email:______________________ **SS#:**__________

Date of Birth:__________ **Gender:** M/F **Marital Status:** Single / Married / Other **Student:** Full / Part

Employer:______________________ **Occupation**__________

Employer Address:______________________________

Referred By:______________________

EMERGENCY CONTACT

Full Name:______________________ **Home:**__________ **Cell:**__________

Relationship: Child / Parent / Spouse / Other:__________

Primary Care Physician:______________________ **Doctor's Phone:**__________

FINANCIAL INFORMATION

___ **Insurance** ___**Self-Pay (Cash)** ___**Worker's Comp** ___**Personal Injury/Auto** ___**Other:**__________

Primary Insurance

Name:______________________

ID#:______________________

Relation to Insured: Self/Spouse/Parent/Child/Other

Other than Self:

Insured's Name:______________________

Secondary Insurance

Name:______________________

ID#:______________________

Relation to Insured: Self/Spouse/Parent/Child/Other

Other than Self:

Insured's Name:______________________

MEDICAL HISTORY

Purpose of this Appointment:______________________________

Other Doctor seen for this Condition:______________________ **Date of Last Physical:**__________

Surgeries (Date, Type, Reason):______________________________

List of Medications:______________________________

Have you ever suffered from:

_____ Dizziness	_____ Arthritis	_____ Digestive Disorders	_____ Backaches
_____ Headaches	_____ Numbness	_____ Nervousness	_____ Sinus Trouble
_____ Heart Trouble	_____ Asthma	_____ Anemia	_____ Hernia
_____ Diabetes	_____ Neuritis	_____ Rheumatic Fever	_____ Cancer

Patient's Signature:______________________ **Date:**__________

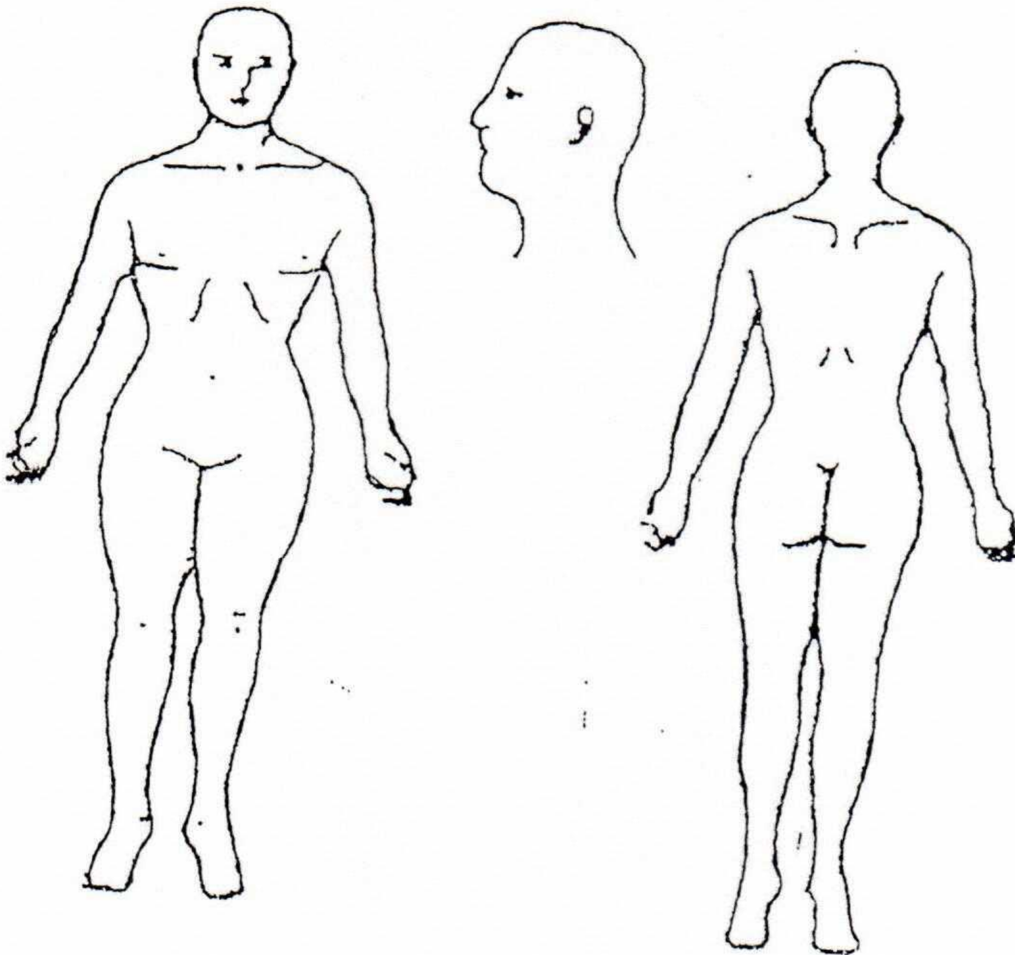
Guardian's Signature Authorizing Care:______________________ **Date:**__________

SYMPTOM DIAGRAM

Name ______________________________ Date ________________

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

Aches /\/\/\/\ Numbness oooo Pins/Needles •••• Burning xxxx Stabbing ////



Reference. Randsloro, Spine, Vol. 1, No 2, June 1976

Neck Index

Form N1-100

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.

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).

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.

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.

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.

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.

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.

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.

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.

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

Form BI100

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.

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

Back Index Score

LYNK CHIROPRACTIC CENTER
322 Fairview Avenue
Hudson, NY 12534

Telephone: (518) 828-7600
Fax: (518) 828-7611

PATIENT CONSENT AUTHORIZATION/HIPPA

ASSIGNMENT OF BENEFITS: I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. 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. I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for changes not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

CONSENT FOR TEATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include, but are not limited to billing, collection, quality assessment activities, investigations, oversight or staff performance reviews, licensing, communications about a product or service, and conducting or arranging for other health care related activities. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may 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. For example, we will contact you at your home telephone number to remind you of your next appointment and/or mail a postcard appointment reminder to your home address. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe might benefit you.

LEGAL PROCEEDINGS: We may disclose protected health insurance information during any judicial or administrative proceeding, in response to a court order of administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

WORKER'S COMPENSATION: We may disclose your protected health information to comply with worker's compensation laws and other similar legally established programs.

____
Patient's Name

____
Patient's Signature

____
Witness

Lynk Chiropractic Center
Financial Policy

PATIENT FINANCIAL INFORMATION

"On The Job" Injury:

Worker's Compensation pays in full for Chiropractic Care. Upon being released from care, a 3-month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

Personal Injury Or Automobile Accidents:

Please present your auto insurance forms as soon as possible. If an attorney is handling your caase, please notify the insurance department right away. Although your are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services are due immediatley.

Group Or Individual Insurance:

We are not certain if your insurance covers chiropractic, although most policies **do** provide coverage. The amount they pay varies from one policy to another. Your insurance is an agreement between you and your insurance company, not between your insurance company and this chiropractic center. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file them with your company to help you collect. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible for charges incurred at this office, including co-pays, deductibles and charges denied or not covered by the insurance company.

Care may be subject to pre-certification by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review all doumentation submitted by Lynk Chiropractic Center for review for medical necessity and base their approval/denial upon this documentation.

This office agrees to noify you as soon as possible if a service is not covered or if

your care is not approved by the insuracne company. This office may seek payment from you for any services your health insurance plan determines to be not medically neccessary. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering actute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

When all insurance checks are received, we will refund any overpayment to you.

Medicare:

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover. For Chiropractors this includes only manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met and the patient will be required to pay the remaining 20%. The patient is also responsible for payment in full of all non-covered services. Our office will complete the neccessary forms and file them with the Medicare provider at no charge.

Patients Without Insurance:

We request that 100% of the first visit be paid at the time of the first visit. We are happy to accept cash, check or credit/debit card.

I have read and understand my obligations and financial responsibility for charges incurred at this office.

____
Print Patient Name

____
Signature (patient or guradian)

____
Date

LYNK CHIROPRACTIC CENTER
Dr. Gary Lynk

CREDIT CARD GUARANTEE

Dear Patient,

For your convenience you may pay your account balance with your credit card. Please complete the information below.

Patient Name: ______________________________

I authorize Lynk Chiropractic Center to charge my credit card account for patient care. By signing this form, you are authorizing Lynk Chiropractic Center to consider this credit card "on file" to be used to guarantee payment of past due balances.

Credit Card Type: ____Visa ____ MasterCard ____ Discover ____ Amex

Name as Appears on Credit Card: ______________________________

Credit Card #: ______________________________ **Exp. Date**: __________

3 Digit Card Verification # (on back of card): __________

Billing Address: ______________________________

City: ______________________________ **State**: __________ **Zip Code**: __________

I understand that this form is valid for one year unless I cancel the authorization with written notice to Lynk Chiropractic Center.

Cardholder Signature: ______________________________ **Date**: __________

322 Fairview Avenue, Hudson, NY 12534 P (518) 828.7600 F (518) 828.7611