

# Financial/Treatment Consent Form

Please sign and complete for treatment. Thank you.

## Patient Information

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

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_

Zip: \_\_\_\_\_ Marital Status: Married Single Widowed Divorced

Soc. Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? Friend/Family Patient Health Fair Internet Other \_\_\_\_\_

Preferred Reminders: Phone Call Email Text – please list cell carrier \_\_\_\_\_

Email: \_\_\_\_\_

## Insurance Information

Circle One: Insurance Self-Pay Accident Work

Insurance Company \_\_\_\_\_ Effective Date \_\_\_\_\_

Member ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name (if self, note self) \_\_\_\_\_ Policy Holder's Birthdate \_\_\_\_\_

Relationship to Insured: Self Spouse Child

## Statement of Financial Responsibility and Authorization to Treat

I understand that I am financially responsible for all services rendered to me or my dependent at the Chiropractic Care & Wellness Center. I hereby authorize the Chiropractic Care & Wellness Center or its successors to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf, I understand that I am financially responsible for any remaining balance.

I further authorize my insurance company to direct payment to the Chiropractic Care & Wellness Center on my behalf.

I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan.

**If an appointment is not cancelled at least 24 hours in advance you will be charged a \$30 fee; this will not be covered by your insurance company.**

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_



Chiropractic Care  
wellness center

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy (or on the patient named below, for whom I am legally responsible:

\_\_\_\_\_ ) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Chiropractic Care & Wellness Center and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Mallory Wales, Dr. Anne Venderley, and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

The **HIPAA Privacy Rule** gives you a fundamental right to be informed of the privacy practices of our health plans, as well as to be informed of your privacy rights with respect to your personal health information. By signing this document, I acknowledge I have received a copy of the Notice of Patient Private Policy.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

To be completed by the patient's representative,

(e.g. If the patient is a minor or is physically or mentally incapacitated.)

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Representative

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

Physician Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**PAIN CHART**

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

Mark the areas on the diagram where you feel the described sensations. Use the indicated symbols and include all affected areas.

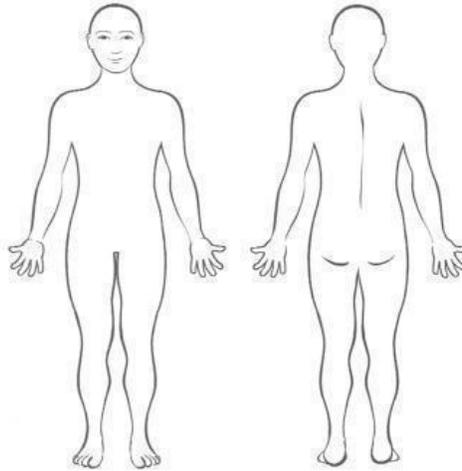
Numbness  
 -----

Pins & Needles  
 OOOOOOOO

Burning  
 XXXXX

Aching  
 \*\*\*\*\*

Stabbing  
 /////



Please indicate the area or region of the body, then circle the corresponding numerical value that indicates how much pain or discomfort you feel in that area.

**Area #1:** \_\_\_\_\_

No Discomfort    1    2    3    4    5    6    7    8    9    10    Worst Pain Imaginable

**Area #2:** \_\_\_\_\_

No Discomfort    1    2    3    4    5    6    7    8    9    10    Worst Pain Imaginable

**Area #3:** \_\_\_\_\_

No Discomfort    1    2    3    4    5    6    7    8    9    10    Worst Pain Imaginable

**Area #4:** \_\_\_\_\_

No Discomfort    1    2    3    4    5    6    7    8    9    10    Worst Pain Imaginable

**Please List Any Current Allergies, Medications, or Vitamins You Are Taking:**

**Allergies**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Vitamins**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History**

**Cigarette Smoking:** Never Former: Quit Date \_\_\_\_\_ If you no longer smoke, how long did you smoke? \_\_\_\_\_  
Current: Packs/Day \_\_\_\_\_ How long have you been smoking? \_\_\_\_\_

**Do you drink Alcohol?** No Yes Drinks per week? \_\_\_\_\_

**Exercise Habits?** Daily Weekly Never If yes, what type of exercise? \_\_\_\_\_

**Do you drink caffeine (coffee, tea, soft drinks)?** No Yes How many per day? \_\_\_\_\_

**Work habits include mostly:** Heavy Labor Light Labor Sitting Standing

**Females Only:**

Mammogram \_\_\_\_\_

Pap Smear/Female Exam: \_\_\_\_\_

**Please Answer the Following Questions:**

- Are you currently pregnant or is there a chance you may be pregnant? **Yes No**
- Are you currently on any type of birth control? **Yes No**
- Are you currently trying to get pregnant? **Yes No**
- Start date of your last menstrual cycle: \_\_\_\_\_

## Review of Systems

Please mark with a **P (presently have)** or **H (have had)** in front of the health issue(s) you either currently have or have experienced in the past. Leave blank if you have not experienced that health issue.

### General

- \_\_\_ Fever/Chills
- \_\_\_ Fainting
- \_\_\_ Fatigue
- \_\_\_ Night Sweats
- \_\_\_ Scoliosis
- \_\_\_ Weight Loss/Gain

### Skin

- \_\_\_ Eczema
- \_\_\_ Psoriasis
- \_\_\_ Rashes
- \_\_\_ Non-Healing Sores

### Eyes/Ears/Nose/Throat

- \_\_\_ Poor Vision
- \_\_\_ Deafness/Hearing Loss
- \_\_\_ Decreased Smell
- \_\_\_ Difficulty Swallowing
- \_\_\_ Dizziness
- \_\_\_ Double Vision
- \_\_\_ Hoarseness
- \_\_\_ Ringing in Ears
- \_\_\_ Vertigo

### Respiratory

- \_\_\_ Asthma
- \_\_\_ Difficulty Breathing
- \_\_\_ Coughing Up Blood
- \_\_\_ Persistent Cough

### Neurological

- \_\_\_ Difficulty Walking
- \_\_\_ Epilepsy/Seizures
- \_\_\_ Muscle Weakness
- \_\_\_ Paralysis
- \_\_\_ Strokes
- \_\_\_ Tremors

### Endocrine

- \_\_\_ Diabetes
- \_\_\_ Excessive Thirst
- \_\_\_ Heat/Cold Intolerance
- \_\_\_ Hypoglycemia
- \_\_\_ Thyroid Disease

### Vascular

- \_\_\_ Ankle Swelling
- \_\_\_ Calf Pain
- \_\_\_ Chest Pain
- \_\_\_ Heart Disease
- \_\_\_ High Blood Pressure
- \_\_\_ High Cholesterol
- \_\_\_ Low Blood Pressure
- \_\_\_ Poor Circulation

### Urinary

- \_\_\_ Change in Bowel/Bladder Habits
- \_\_\_ Frequent UTI
- \_\_\_ Kidney Stones
- \_\_\_ Urinary Incontinence

### Gastrointestinal

- \_\_\_ Abdominal Pain
- \_\_\_ Bloating/Gas
- \_\_\_ Blood in Stool
- \_\_\_ Celiac Disease
- \_\_\_ Constipation
- \_\_\_ Crohn's Disease
- \_\_\_ Diarrhea
- \_\_\_ Gall Bladder Disease
- \_\_\_ Heart Burn
- \_\_\_ Irritable Bowel Syndrome
- \_\_\_ Liver Disease
- \_\_\_ Ulcers

### Conditions

- \_\_\_ Anemia
- \_\_\_ Cancer/Tumor
- \_\_\_ Gout
- \_\_\_ Fibromyalgia
- \_\_\_ Hepatitis
- \_\_\_ HIV/AIDS
- \_\_\_ Migraines/Headaches
- \_\_\_ Multiple Sclerosis
- \_\_\_ Osteoarthritis
- \_\_\_ Osteoporosis
- \_\_\_ Parkinson's Disease
- \_\_\_ Prostate Disease
- \_\_\_ Rheumatoid Arthritis
- \_\_\_ Transient Ischemic Attack

### Past Medical History

Past Injuries	Description	Date
• Car Accidents:	_____	_____
• Dislocation/Fractures:	_____	_____
• Head Injuries:	_____	_____
• Hospitalization:	_____	_____
• Surgeries:	_____	_____
• Trauma:	_____	_____

### When did you last have the following?

General Check-Up: \_\_\_\_\_

Who is your current family doctor? \_\_\_\_\_

### Family History

Please indicate if anyone in your family has had the following conditions, using the following key:

**M** (mother), **F** (father), **B** (brother), **S** (sister), **MGM** (maternal grandmother), **MGF** (maternal grandfather),  
**PGM** (paternal grandmother), **PGF** (paternal grandfather)

____ High Blood Pressure	____ Lung Disease	____ Osteoarthritis
____ Heart Disease	____ Emphysema	____ Rheumatoid Arthritis
____ High Cholesterol	____ Asthma	____ HIV/AIDS
____ Stroke	____ Mental Illness	____ Celiac Disease
____ Diabetes	____ Kidney Disease	____ Ulcers/Stomach Problems
____ Thyroid Disease	____ Liver Disease	____ Multiple Sclerosis
____ Seizures/Convulsion	____ Cancer	____ Lupus

# 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

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is 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 get no 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.

## Sitting

- Ⓐ I can sit in any 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 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓡ I avoid sitting because it increases pain immediately.

## Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer 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 minutes without increasing pain.
- Ⓡ I avoid standing because it increases pain immediately.

## Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with 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.

## Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓟ Because of the pain I am unable to do some washing and dressing without help.
- Ⓡ Because of the pain I am unable to do any washing and dressing without help.

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

## Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓡ Pain restricts all forms of travel.

## 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 significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓡ I have hardly any social life because of the pain.

## 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 is gradually worsening.
- Ⓡ 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

# 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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