LEVEL SPINE
CHIROPRACTIC

PERSONAL INFORMATION

Name: _____ SSN#: _____ Date: _____

Address: _____ Occupation: _____

City: _____ Home Phone: _____

State: _____ Zip/Postal Code: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: □ M □ F Cellular Carrier: _____

Circle One: Single Married Widow(er) Divorced Separated Email Address: _____

Name of Spouse (If applicable): _____ Preferred Contact Method: _____

Named individual(s) you authorize us to share your Personal Health Information with (Emergency Contact): □ Spouse and/or □ Other: _____

Emergency Contact Number: _____ **How'd you hear about us**: _____

Race/Ethnicity: □ African American or Black □ American Indian or Alaskan Native □ Asian □ Hispanic or Latino □ Native Hawaiian or Other Pacific Islander □ White □ Decline to Specify

Primary Care Physician: _____ Do you get regular check-ups? _____

Who is responsible for your bill, **You** and: □ Personal Insurance □ Medicare/Medicaid □ Auto Ins. □ Worker's Comp.

Primary Insurance Co.: _____ Policy Holder: _____ DOB _____

We file most insurance claims electronically each week. Who would you like statements sent to: □ Me (at address above)

□ Other: Name _____ Address _____

City _____ State _____ Zip _____ Phone _____ Email _____

CURRENT HEALTH CONDITION

Reason(s) for Visit: _____

What caused this pain (if known): _____

When did this pain begin? _____ Is this condition getting worse? □ No □ Yes

Severity of the problem: □ Mild □ Moderate □ Severe Has this condition occurred before? □ No □ Yes

Type of Pain: □ Sharp □ Dull □ Achy □ Throbbing □ Numb □ Stiff □ Other: _____

Does this pain affect your extremities? □ No □ Yes If yes, where? _____

How often symptoms occur? _____ Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: □ Sitting □ Standing □ Lifting □ Walking □ Lying Down □Turning/twisting

What makes it feel better: _____

What makes it hurt worse: _____

Other doctors seen for this condition: □ No □ Yes If Yes Whom? _____

Type of Treatment: _____ Results: _____

If this is a Job Related injury, have you made a report of your accident to your employer/insurance company? □ No □ Yes

CURRENT HEALTH CONDITION (cont.)

Prescriptions/Supplements you currently take (Please include doses): _____

_____

_____

Do you have any other diagnosis's (conditions) that we should be aware of? ☐ No ☐ Yes

If ***yes*** please explain:_____

PAST HEALTH HISTORY

Briefly Describe including Approximate Dates: (additional space on next page)

Major Surgery/Operations: _____

Major Accidents or Falls: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name _____ Date of Last Visit (approx): _____

Date of Last: Spinal X-ray _____ MRI _____ (region:_____) Physical Exam _____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect you overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES or SYMPTOMS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Thyroid Disorders
- ☐ Cancer (type: _____)
- ☐ Heart Disease
- ☐ Diabetes (type:_____)
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn/Reflux
- ☐ Black/Bloody Stool
- ☐ Irritable Bowel/Colitis/Chron's

NERVOUS SYSTEM

- ☐ Weakness in arms/legs/body
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness

C-V-R

- ☐ Chest Pain
- ☐ Short of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems/Congenital Defect
- ☐ Lung Problems/Congenital Defect
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

HEENT

- ☐ Vison Problems
- ☐ Sore Throat
- ☐ Ear Aches or Infection
- ☐ Ringing in the Ears/Tinnitus
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Sinus Infection
- ☐ Dental Problems

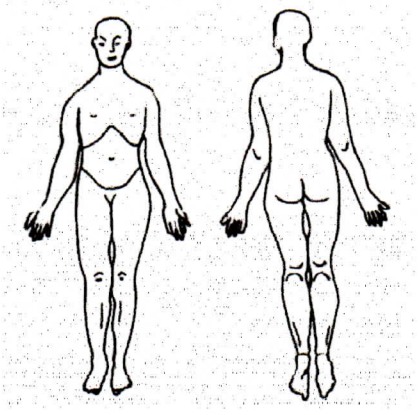
GENERAL SYMPTOMS

- ☐ Headaches
- ☐ Fever
- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Allergies: _____

_____

_____

Please outline on the diagram the area of your discomfort



PAST HISTORY (cont.)

NERVOUS SYSTEM (cont.)

- ☐ Tingling Extremities
- ☐ Cold or discolored extremities
- ☐ Fainting
- ☐ Convulsions or Seizures

MENTAL-EMOTIONAL

- ☐ Anxiety
- ☐ Psychotic Episodes
- ☐ Attempted Suicide
- ☐ Anger or Aggression Issues
- ☐ Attention Deficit
- ☐ Depression

GASTRO-INTESTINAL

- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Poor/Excessive Appetite

VITALS

My Blood Pressure is usually:

☐ High ☐ Normal ☐ Low

Height ____' ____"

Weight _____

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful or Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Stones

EXERCISE (Check all that apply)

- ☐ None
- ☐ Walker Distance:_____
- ☐ Runner Distance:_____
- ☐ Mild Intensity Exercises
- ☐ Moderate Intensity Exercises
- ☐ High Intensity Exercises
- ☐ Other:_____

EXERCISE FREQUENCY

- ☐ 1x/Week
- ☐ 2x/Week
- ☐ 3x/Week
- ☐ 4x/Week
- ☐ 5x/Week
- ☐ 6 or more

FLUIDS

- ☐ Water (oz or glasses/day) _____
- ☐ Alcohol (Drinks/week) _____
- ☐ Coffee (Cups/day) _____
- ☐ Other Caffeine Sources (describe)

_____

PERSONAL EATING HABITS

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

(Poor) (Great)

SMOKING HISTORY

- ☐ Never a smoker
- ☐ Current- Packs Per Day_____
  - Year Started_____
- ☐ Former- Year Quit _____
  - Years Smoked _____

FEMALES ONLY

Are you pregnant?

- ☐ No Last Period: _____
- ☐ Yes Due date: _____

FEMALE/MALE

- ☐ Menstrual Irregularity
- ☐ Unusual Menstrual Cramping
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other:_____

_____

FAMILY HISTORY

List family with the following illnesses:

Heart Disease

_____

Cancer

_____

Diabetes

_____

Stroke

_____

Neurological Disorders

_____

Other

_____

_____

Major sources of stress _____

Ways you handle your stress _____

Use this space to elaborate on any of the above if needed:

_____

_____

_____

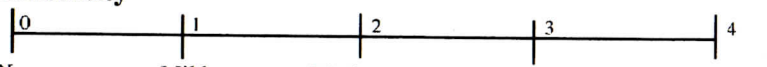
_____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

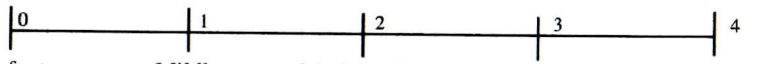
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity



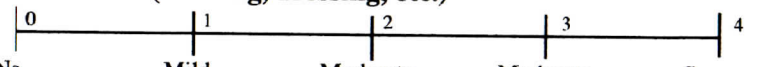
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



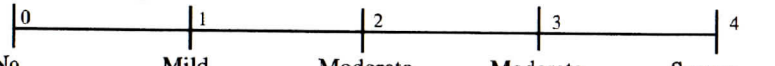
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)



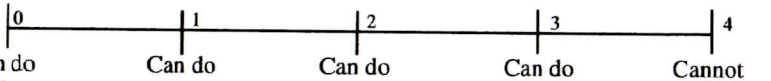
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)



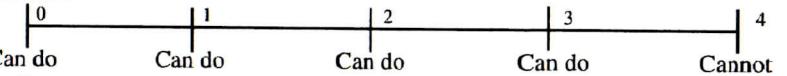
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



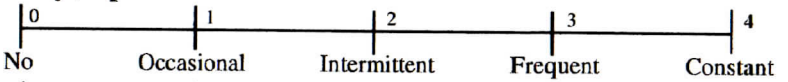
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



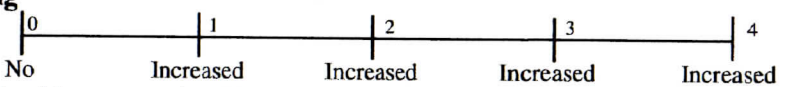
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain



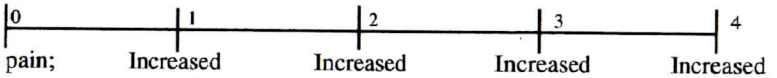
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



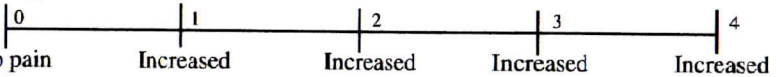
0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing



0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

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www.chiroevidence.com

Level Spine Chiropractic
Revised 4/13/17

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and the risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological function and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to; muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustments do not cause dissections in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand that there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future conditions for which I seek chiropractic care from this office.

_____ _____

Print Patient's Full Name Date

_____ _____

Patient or Legally Authorized Individual Signature D.O.B.

Level Spine Chiropractic
Revised 10/18/17

Terms of Acceptance

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below items. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above patient.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below, you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below, you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS AND FINANIAL POLICY: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below, you further acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below, you hereby assign benefits to be paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below, you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

Furthermore, in an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following Financial Policies: Our clinic has established a single fee schedule that applies to all patients for each service provided.

YOU MAY BE ENTITLED TO A NETWORK OR CONTRACTUAL DISCOUNT UNDER THE FOLLOWING CIRCUMSTANCES:

- If we are a participating provider in your health plan (Blue Cross, Avera, etc.).
- If you are covered by a State of Federal program with a mandated fee schedule (Medicare/Medicaid).
- If you are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization (DMPO) we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00/ per year and covers you and your dependents. See front desk for more information.

Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required. By signing below you acknowledge and accept our Financial Policy.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below, you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Print Patient's Full Name _____ Date _____

Patient or Legally Authorized Individual Signature _____ D.O.B. _____

Level Spine Chiropractic
Revised 10/18/17

Consent to Use Protected Health Information

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION: Your Protected Health Information will be used by Level Spine Chiropractic or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. Furthermore, there may be times our office may need to contact you regarding office matters. By signing below, you have authorized Level Spine Chiropractic to contact you for office related matters in the following manner: email or standard SMS/text messaging, in addition to or to replace leaving standard voicemails or phone calls, traditional postage mail. Contact regarding various aspects of your health care may include, but not limited to, exam findings, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/test messaging regarding my medical care might be intercepted and read by a third party. Phone messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile if he/she is indicated on the first page of the intake forms.

To **opt-out** of the following contact methods, please initial and indicate (circle all that apply): Please Initial Here: _____

Email SMS/text Voicemail Postal Mail

NOTICE OF PRIVACY PRACTICES: In accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this clinic is obliged to provide a full copy of the Notice of Privacy Practices to each new patient for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. A copy of this Policy is maintained at the front desk as well as online at LevelSpineChiro.com. By signing below, you have acknowledged that you have been offered a copy of this document.

If you would like to request your own full copy of the Notice of Patient Privacy Policy; Please initial here: _____

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION:

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

NOTICE OF TREATMENT IN SEMI-OPEN TREATMENT ROOMS: There are windows in the adjusting and exam rooms that may be open when you enter the room. If the patient wishes that these windows be covered, adequate privacy shielding will be available upon request.

REVOCATION OF CONSENT: You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Print Patient's Full Name Date

_____ _____
Patient or Legally Authorized Individual Signature D.O.B.