SCHRODER CHIROPRACTIC

Confidential Patient Information

Date _____

Personal Information

First Name _____ Last Name _____ Preferred _____

Address _____

City / State / Zip _____

Home Phone _____ Work Phone _____

Mobile Phone _____ Mobile Phone Provider _____
(i.e. ATT, Verizon, Sprint)

(we ask for your Mobile Phone Provider company name so that we can text you for appointment reminders or special office closings)

Social Security # _____ Birth Date _____ Age _____ Sex ☐M ☐F

Email _____ Drivers License # _____

Occupation _____ Employer's Name _____

Work Phone _____ Work Address _____

Marital Status ☐ S ☐ M ☐ D ☐ W Spouse's Name _____ # of Children _____

INSURANCE INFORMATION

Insurance Company _____ Phone # _____

Insured's Name _____ Insured's ID # _____

Subscribers Name & DOB (If different from patient) _____

How were you referred to us? _____

May we leave personal medical information on your voicemail if necessary? ___ Yes ___ No

Do you give our office permission to discuss your medical information with your family members? ___ Yes ___ No (If yes, please provide their information)

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

History

Have there been any accidents or injuries in the past?" (car, motorcycle, bicycle, sporting, recreational, etc) If so when and what happennd?

_____

_____

_____

If female, are you pregnant? ☐ Yes ☐ No ☐ Not Sure Any allergies? _____

Do you take supplements / vitamins? _____

Have you had any surgeries or hospitalizations? ☐ Yes ☐ No

Type of Hospitalization / Surgery Date

_____ _____

_____ _____

Do you smoke? ☐ Yes ☐ No

How often? _____ How many years _____

Do you have a family physician? ☐ Yes ☐ No

Name of physician _____

Phone _____

Do you have or is there a family history of stroke, cancer, or diabetes? ☐ Yes ☐ No

If yes please list whom this applies to Date

_____ _____

_____ _____

_____ _____

_____ _____

Which medications are you currently taking? _____

_____

How long have you been taking each medication? _____

_____

Major Complaint Information

List your chief complaints **in order of severity**

1 _____ When did condition begin? ____ / ____ / ____ Is it getting worse? Yes No Constant Comes and Goes

2 _____ When did condition begin? ____ / ____ / ____ Is it getting worse? Yes No Constant Comes and Goes

3 _____ When did condition begin? ____ / ____ / ____ Is it getting worse? Yes No Constant Comes and Goes

4 _____ When did condition begin? ____ / ____ / ____ Is it getting worse? Yes No Constant Comes and Goes

1. On a scale of 1-10 with 10 being the worst please rate your pain for your primary complaint. _____
2. On a scale of 1-10 with 10 being the worst please rate your pain for your secondary complaint. _____
3. On a scale of 1-10 with 10 being the worst please rate your pain for your third complaint. _____
4. On a scale of 1-10 with 10 being the worst please rate your pain for your fourth complaint. _____

If you wish to give any more details please use these lines to do so: _____

_____

_____

_____

Does any of your complaints interfere with: ❒ Work ❒ Sleep ❒ Daily Routine? If so which complaints and describe how it interferes

_____

Have you had similar complaints in the past? ❒ Yes ❒ No If so which area of complaint and explain _____

_____

_____

Have you been treated by a medical doctor for this? ❒ Yes ❒ No If yes, by whom? _____

Have you been treated by a chiropractor? ❒Yes ❒No If yes, by whom? _____

Does the pain spread or radiate? ❒ Yes ❒ No If yes, where? _____

_____

Is there pain when you cough or sneeze? ❒ Yes ❒ No If yes, where? _____

_____

Is there pain when you go from sitting to standing? ❒ Yes ❒ No If yes, where? _____

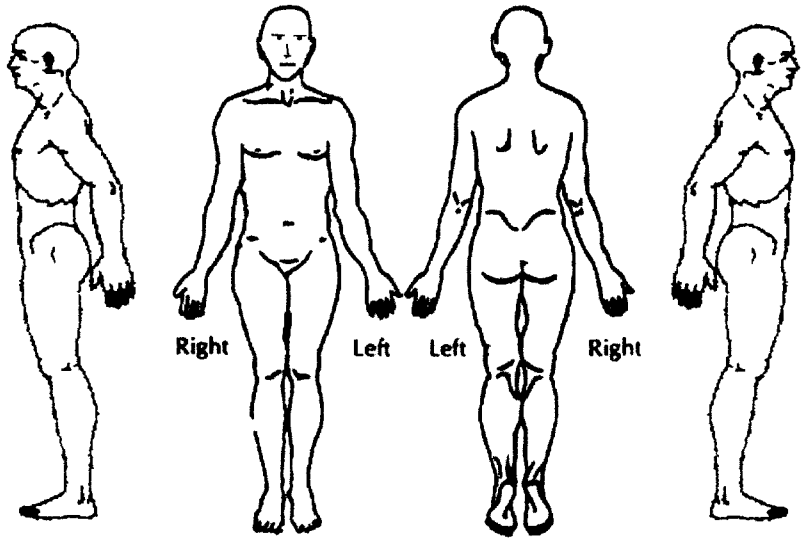
_____

Do you get headaches? ❒ Yes ❒ No If yes, mark all that apply: ❒Tension ❒Sinus ❒Migraines ❒Throb ❒Other

Indicate any function(s) below that aggravates, or are aggravated by your condition:

❒Walking ❒Running ❒Step climbing ❒Driving ❒Recreation ❒Other _____

Using the symbols provided in the Pain Index, mark the areas in the illustration below where you are experiencing pain



Pain Index

X	Aches
^	Burning
⊗	Sharp / Stabbing
–	Numbness / Tingling
O	Pins and Needles

Please use this space to describe your condition further if needed.

_____

_____

_____

On a scale of 1 - 10, how do you feel now? (1 being best, 10 being worst)

Very Mild — Moderate — Severe

1 2 3 4 5 6 7 8 9 10

Check those activities below during which you experience difficulty or pain

❍ Lying on back	❍ Lying flat on stomach	❍ Pushing	❍ Stooping	❍ Walking
❍ Lying on side	❍ Getting out of car	❍ Pulling	❍ Sitting	❍ Sneezing
❍ Standing for long periods	❍ Dressing Self	❍ Reaching	❍ Bending forward	❍ Coughing
❍ Turning over in bed	❍ Sexual Activity	❍ Kneeling	❍ Bending backward	❍ Other _____

IMPAIRMENT WITH ACTIVITIES OF DAILY LIVING

Dear Patient/Claimant,

Please be aware that the purpose of this is to determine your level of impairment. Impairment is defined as the loss of, loss of use of, or derangement of any part, system, or function. Disability is the limiting loss or absence of the capacity of an individual to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements.

**** Please read the following directions and complete the impairment check list. In terms of a normal day where you active 16 hours and sleep 8 hours, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day. Please mark on the next page how the specific injury(s) you are being examined for now impair your life in a normal day.***

Continued on Next Page ...

... Continued from Previous Page

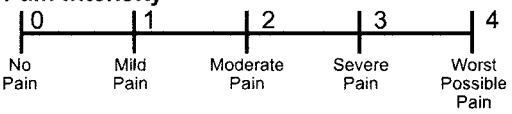
ACTIVITIES OF DAILY LIVING — IMPAIRED

	Not at All	Occasionally	Frequently	Continuously
Self Care & Personal Hygiene	( )	( )	( )	( )
Normal Living Postures (sitting, lying down, etc.)	( )	( )	( )	( )
Travel	( )	( )	( )	( )
Sexual Function	( )	( )	( )	( )
Social & Recreational Activities	( )	( )	( )	( )
Communication	( )	( )	( )	( )
Ambulation (moving around)	( )	( )	( )	( )
Non-specialized hand activities	( )	( )	( )	( )
Sleep	( )	( )	( )	( )
Writing	( )	( )	( )	( )

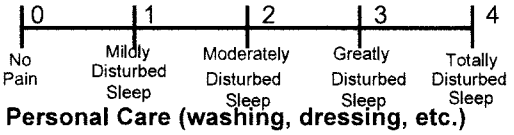
Functional Rating Index

In order to assess your condition, we must understand how much your **current condtion/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.**

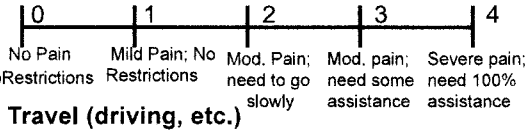
1. Pain Intensity



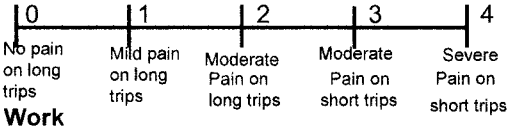
2. Sleeping



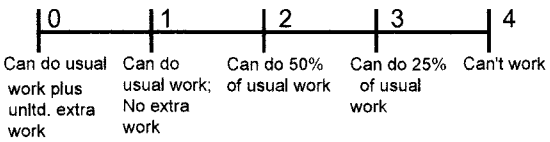
3. Personal Care (washing, dressing, etc.)



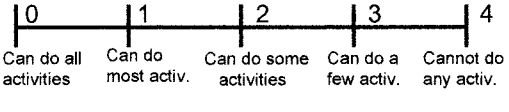
4. Travel (driving, etc.)



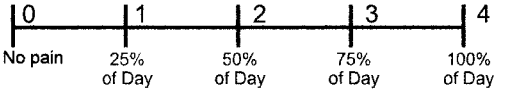
5. Work



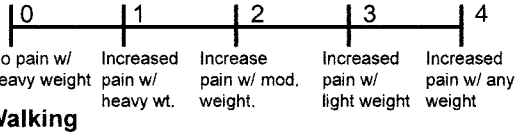
6. Recreation



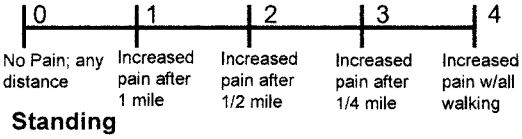
7. Frequency of Pain



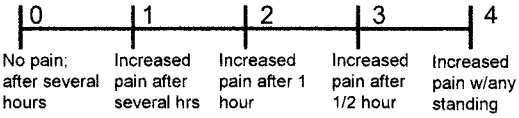
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____ PRINTED _____ Signature

Date _____

Check Any Of The Following You Have Had In The Past Six Months

GENERAL CODE

❒ Fatigue ❒ Allergies ❒ Loss of sleep ❒ Fever ❒ Headaches

MUSCULOSKELETAL CODE

❒Low back pain ❒Pain between the shoulders ❒Neck pain ❒Arm pain ❒Difficulty chewing / Clicking jaw
❒Joint pain / Stiffness ❒Walking problems ❒General stiffness

FAMILY PROBLEMS

The following members who have had the same or similar problem(s)

❒Mother ❒Father ❒Brother ❒Sister ❒Spouse ❒Child

NERVOUS SYSTEM CODE

❒Nervous ❒Numbness ❒Confusion / Depression ❒Paralysis ❒Fainting ❒Stress

❒Dizziness ❒Convulsions ❒Forgetfulness ❒Cold / Tingling in extremities

Only fill out the following section if you are being treated in our office for injuries sustained in a Car Accident

Date of accident:_____ Vehicles Involved:_____ Accident Type: __ Rear Ended __ Head-on __ Struck on Left/Right side of car Your speed:_____ Other vehicles speed:_____ Damage to your vehicle: $_____ Other vehicle damage: $_____
You were the: __ Driver __ Passenger **Sitting**: Front/Back seat (circle) Seat belted/no seat belt (circle) **Impending Collision**: Aware/ unaware (circle) Braced for impact/not braced (circle) **Your Head:** Struck object/did not strike object (circle) (If head struck object what did it strike?) _____
Did you experience: Shock/Loss of Consciousness/Flash of Light Seen Upon Impact/None of these (circle all that apply) Air bag deployed Y/N

Describe accident:_____

State your Emotions & Physical State *Immediately Following* the accident:_____

State your Emotions & Physical State *after the first few days following* the accident:_____

Immediately Following the Accident:
(please check all that apply)
__ Ambulance-Paramedics Called
__ Treated at Scene
__ Transported to Hospital by Ambulance
__ Went to Hospital on your Own
__ Diagnostics Performed at Hospital
__ Treatment at Hospital
__ Medication Prescribed
__ Follow-up Recommended

Other Doctors Seen for the accident
(please check all that apply)
__ Orthopedist
__ Pyschiatrist
__ Massage Therapist
__ Neurologist
__ Physical Therapist
__ Chiropractor

List the types of Diagnostic Testing that has been performed for this problem
(please check all that apply)
__ X-rays __ Discogram
__ CT Scan __ Bone Scan
__ Myelogram __ EMG
__ MRI

Please mark each that apply to your Daily Activities

__ I stay at home most of the time due to the problem
__ I change position frequently to try and get comfortable
__ I walk slower than usual because of the problem
__ Doesn't do jobs around the house because of the problem
__ I have to use handrails to get up stairs, etc
__ Must lie down & rest frequently due to the problem
__ Must hold onto something to sit or stand from a chair
__ Have to get other people to do things for you
__ I have difficulty getting dressed due to the problem
__ I can only stand for short periods due to the problem
__ Have diffulty bending or kneeling due to the problem
__ Have difficulty turning over in bed due to the problem
__ Have a loss of appetite due to the problem
__ Can only walk short distances because of the problem
__ Have difficulty sleeping because of the problem
__ Must have someones help to get dressed
__ Have to sit most of the day because of the problem
__ Have been more irritable because of the problem
__ Have difficulty climbing stairs
__ Have to stay in bed most of the day because of the problem

HIPAA AND OUR PATIENTS

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and accompanying regulations controls the use and disclosure of what is known as protected health information (PHI). Implementation of and compliance with HIPAA is not an option for Schroder Chiropractic.

Please read and familiarize yourself with the attached material. It is your copy so feel free to take it with you. Sign the Acknowledgement Form indicating that you have received a copy. It will be a permanent part of your medical record. If you are a parent or personal representative of a patient, we will an Acknowledgement Form signed by you on behalf of the patient.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge Schroder Chiropractic has provided me with a copy of its Notice of Privacy Practices, which contains a detailed description of the uses and disclosures allowed by this Privacy Notice, as well as the rights I have regarding my protected health information.

Printed Name of Patient	Patient Social Security Number
Signature of Patient or Personal Representative	Patient Date of Birth
Description of Personal Representative's Authority	Patient Social Security Number

Authorization & Assignment

I authorize **Schroder Chiropractic** to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint **Schroder Chiropractic** authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, fees for professional service rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date	Patient's Signature	Witness

Informed Consent

I hereby authorize physicians and staff at **Schroder Chiropractic** to treat any condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of **Schroder Chiropractic** responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before continuing to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise you doctor if you experience soreness or discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury - Manual adjustments to the thoracic spine, in some cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns - Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a
staff member

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper
cervical adjustments.

Other Problems - There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

WOMEN ONLY - To the best of my knowledge I am NOT pregnant & give permission to take X-rays for diagnostic purposes. **Please initial -** _____

Having carefully read the above, I hereby give my informed concent to have chiropractic treatment administered.

Date	Patient's Signature	Witness

SCHRODER CHIROPRACTIC
1113 Murfreesboro Road, Suite 410
Franklin, TN 37064

615-791-9917

Consent to use PHI

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 Schroder 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.

Notice of Privacy Practices

You should review the Notice of Privacy Practices 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. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

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 Open or Common Areas

We utilize an open adjustment area in our practice. Therefore, it is possible that other patients may see you get adjusted and/or overhear a conversation you are having with our doctors or staff. Private areas are available on 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.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date