ONEHEALTH Chiropractic

Patient Name: _____ DOB: _____

Reason for today's visit:
☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness ☐ Auto Accident ☐ Accident at work

Chief Complaint:

_____

_____

Other Complaints:

_____

_____

When did symptoms begin? _____

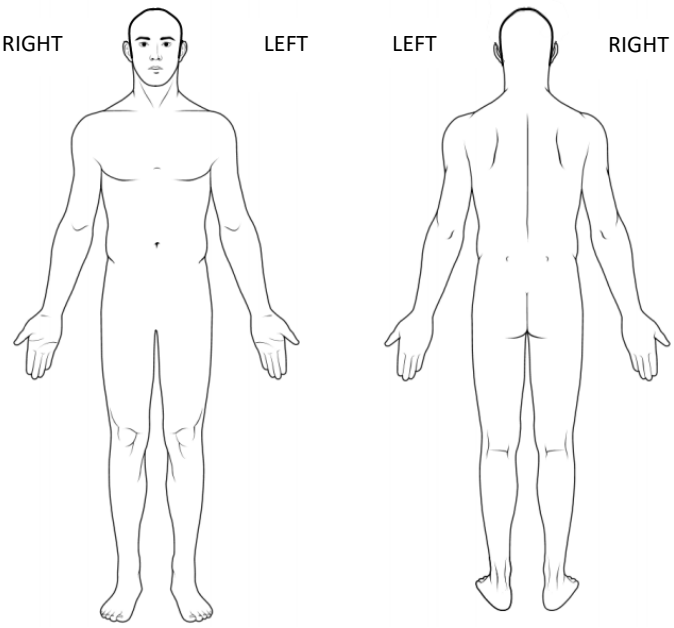
PAIN DIAGRAM

Please complete the "Pain Diagram" by using letters to indicate your areas of pain.

P- Pain T- Tingling N- Numbness B- Burning S- Stiffness

FRONT BACK

RIGHT LEFT LEFT RIGHT



Circle which best describes your pain.
0 is no pain and 10 is extreme pain.

Neck	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Upper Back	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Mid Back	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Lower Back	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Headaches	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
TMJ	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Shoulders	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Arms/Elbows	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Knees	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Legs/Ankle	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10
Other	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

1. Symptoms you have experienced in the past 6 months:
   - ☐ Low Back Pain ☐ Pain between shoulder blade ☐ Neck Pain ☐ Tension/Migraine Headache
   - ☐ Tired/Fatigue ☐ Tension across top of shoulders ☐ Numbness/Tingling in Arms or Hands
   - ☐ Dizziness ☐ Ringing in Ears ☐ Numbness/Tingling in legs or feet
   - ☐ Nervous ☐ Difficulty Sleeping ☐ Allergies ☐ Digestive Problems
   - ☐ Weight Problems ☐ Other_____

2. How often do you experience your symptoms?
   - ☐ Constantly (76-100% of the time ☐Occasionally (26-50% of the time)
   - ☐ Frequently (51-75% of the time ☐ Intermittently (1-25% of the time)

3. How are your symptoms changing with time?
   - ☐ Getting worse ☐ Staying the same ☐ Getting Better

4. How much has the problem interfered with your work?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

5. Who else have you seen for this problem?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER Physician ☐ Orthopedist ☐ Physical Therapist
☐ Massage Therapist ☐ Other: _____ ☐ No one

6. How do you think your problem began? _____

7. What makes your problem worse? _____

8. What makes your problem better? _____

9. **Activities of Daily Living**
How does this condition currently interfere with your life and ability to function?

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting				
Rising out of chair				
Standing				
Walking				
Lying down				
Bending over				
Climbing stairs				
Using a computer				
Getting in/out of car				
Driving a car				
Looking over shoulder				
Caring for family				
Grocery shopping				
Household chores				
Lifting objects				
Reaching overhead				
Showering/bathing				
Dressing myself				
Love life				
Getting to sleep				
Staying asleep				
Concentrating				
Exercising				
Yard work				

10. How much sleep do you average per night? _____hours

11. What is your occupation? _____

12. List any surgeries _____

13. What are your personal goals for care?

_____

_____

Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the condition that you've HAD or currently HAVE.

Musculoskeletal
☐Osteoporosis ☐Arthritis ☐Scoliosis ☐Neck Pain ☐Back Problems ☐Hip disorder ☐Knee Pain
☐Foot/ankle pain ☐Poor Posture ☐Elbow/wrist pain ☐Shoulder Problems

Neurological
☐Anxiety ☐Depression ☐Headache ☐Dizziness ☐Pins/needles ☐Numbness

WOMEN ONLY: Are you pregnant? YES / NO

CHIROPRACTIC PATIENT REGISTRATION AND HISTORY

Today's Date: _____/_____/_____ Date Symptoms began: _____/_____/_____

Is your condition due to an accident? ◯ Yes ◯ No Type: ◯ Auto ◯ Work ◯ Home ◯ Other

Name : _____
Last First Middle

Address: _____
Street City State Zip

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Sex: ◯ Male ◯ Female Current Age:_____ How did you hear about us? _____

◯ Married ◯ Single ◯ Widow(er) ◯ Divorced ◯ Minor

Permanent Mailing Address (if different): _____
Street City State Zip

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____ Preferred number Cell_____ Work _____ Home_

How would you prefer your appointment reminders? ◯ Text Message ◯ Email

Cellular Provider: ◯ AT&T ◯ SPRINT ◯ T-MOBILE ◯ US CELLULAR ◯ VERIZON ◯ Other _____

Email Address (please print clearly) _____@ _____. _____
___

I**n Case Of Emergency, Contact**: _____
Last First Middle

Relationship to Patient: _____

Contact #: _____

Please list anyone that you will allow us to discuss your account with _____

Name of Employer:_____Phone: (_____)_____

PCP Name: _____ PCP Phone: _____

PCP Address: _____

May we contact your PCP to advise them of your progress? _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____Name of Patient _____Date

For further information regarding this notice, please contact our Doctor at (405)-478-1507

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and we accept them for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTIC OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:

_____ (signature) _____ (date)

OneHealth Chiropractic Financial Agreement

Dear Patient:

OneHealth Chiropractic will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to OneHealth Chiropractic.
We wish to make it very clear that your health is your sole responsibility. These policies apply only to the services actually performed, and in no way obligates the patient to continue the course of care recommended.

I choose the following method of payment for my care at OneHealth Chiropractic:
(Initial one)

_____ **CASH** - Payment is due at the time of services. All patients who wish to file their own insurance may receive the same cash price by paying for the service at the time of the service and waiting for reimbursement from their insurance company.
_____ **MEDICARE** - Payment for co-pays and deductibles is due at time of service.
_____ **WORKERS COMPENSATION** - My employer has agreed to pay for the services rendered by OneHealth Chiropractic. I understand that I am responsible for any portion of this bill that my employer or their insurance carriers may refuse to pay.
_____**PERSONAL INJURY** – We will file your claim with the appropriate insurance carrier (**your** health insurance and/or auto med-pay), and the third party carrier (other person's insurance) as you are treated and file a Physician's Lien to assure payment. The third party carrier will usually not pay until settlement is reached. To prevent your premium from being affected due to a claim being made, even if you were not at fault, you may need to inform the third party insurance carrier to subrogate upon settlement of your claim; any balance will be forwarded to you. You agree **not** to allow your attorney to reduce our fees for their/your profit. When released, a 90 day time period is allowed for settlement. If you have not settled with the third party carrier within this time, or if you have suspended/terminated care without your doctor's approval, the balance of your account is due immediately.
_____**INSURANCE POLICY COVERAGE** – Group insurance is an agreement between you and your insurance company, not between your insurance company and your doctor. As a courtesy to our patients, our office will complete and file your claims on standard forms at no charge. We are credentialed as In-Network providers by most insurance plans. The amount they pay varies from one policy to another. Because of the difference between policies, we request that each patient pay the deductible, percentage, and/or co-pay as stated in your policy.

Responsible Party Name (*print)*
_____Date:_____

Responsible Party Name (sign)_____ Date_____