Advanced Chiropractic Clinic

Rebecca LaMaack Schwartz, D.C.
19641 E. Parker Square Drive, Ste. J
Parker, CO 80134
303-841-2524

Today's Date:_____ Name: _____

Male / Female (please circle) Birth Date: _____ Referred By: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Referred By: _____

Employer: _____ How long employed: _____

Employers Address: _____

City: _____ State: _____ Zip: _____Occupation: _____

Status: Minor / Single / Married / Divorced / Separated / Widowed (please circle)

Spouse's Name: _____ Children: _____ (If yes, how many?)

Insurance (Let us make a copy of your insurance card and you can skip this section)

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's ID #: _____ Group #: _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Account Information (Person ultimately responsible for account)

Name: _____ Relation: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

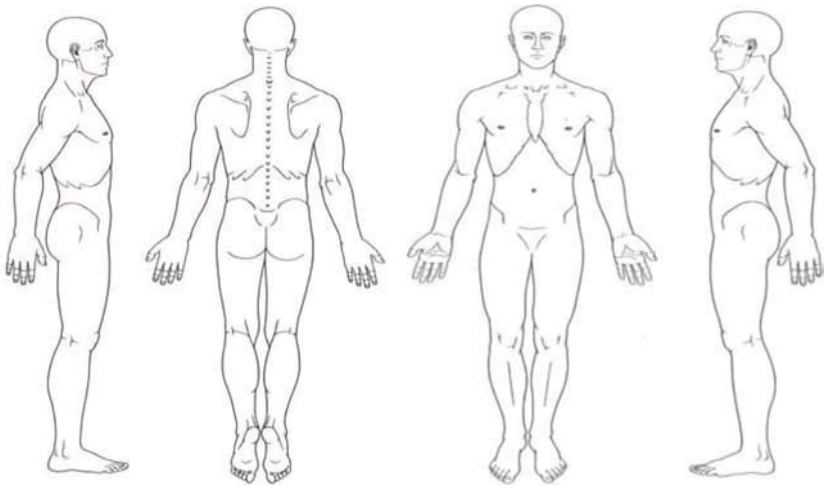
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

(1) Constantly (76-100% of the day)
(2) Frequently (51-75% of the day)
(3) Occasionally (26-50% of the day)
(4) Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

(1) Sharp (4) Shooting
(2) Dull ache (5) Burning
(3) Numb (6) Tingling

4. How are your symptoms changing?

(1) Getting Better
(2) Not Changing
(3) Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

(1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time

7. In general would you say your overall health right now is...

(1) Excellent (2) Very Good (3) Good (4) Fair (5) Poor

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8. Who have you seen for your symptoms?

(1) No One
(2) Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

(1) Xrays *date:* _____ (3) CT Scan *date:* _____
(2) MRI *date:* _____ (4) Other *date:* _____

9. Have you had similar symptoms in the past? (1) Yes (2) No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

(1) This Office
(2) Chiropractor
(3) Medical Doctor
(4) Physical Therapist
(5) Other

10. What is your occupation?

_____

(1) Professional/Executive
(2) White Collar/Secretarial
(3) Tradesperson
(4) Laborer
(5) Homemaker
(6) FT Student
(7) Retired
(8) Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

(1) Full-time
(2) Part-time
(3) Self-employed
(4) Unemployed
(5) Off work
(6) Other

Patient Signature _____ **Date** _____

PATIENT INTAKE FORM (Page 2)

11. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

12. What aggravates your problem?
_____

13. What concerns you the most about your problem; what does it prevent you from doing?
_____

14. What alleviates your problem?
_____

15. What is your: **Height**_____ **Weight** _____ **Age** _____ **Birth Date** _____

16. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

17. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

18 For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Visual Disturbances
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Dizziness
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Asthma
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Chronic Sinusitis
□	□ Arthritis	□	□ Hepatitis	**For Females Only**	
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Birth Control Pills
□	□ Cancer	□	□ General Fatigue	□	□ Hormonal Replacement
□	□ Tumor	□	□ Muscular Incoordination	□	□ Pregnancy
□	□ Other:_____				

19. List all prescription medications you are currently taking:
_____

20. List all of the over-the-counter medications you are currently taking:
_____

21. List all surgical procedures you have had:
_____

22. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

23. What activities do you do outside of work?
_____

24. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

25. Have you had significant past trauma? □ No □ Yes

26. Anything else pertinent to your visit today?_____

Patient Signature_____ ***Date:***_____

INFORMED CONSENT OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

ADVANCED CHIROPRACTIC CLINIC
19641 E PARKER SQUARE DRIVE SUITE J
PARKER, COLORADO 80134
(303) 841-2524

In this document, "I" and "my" refer to me, the patient, and "Chiropractor" refers to Advanced Chiropractic Clinic and/or Dr. Rebecca LaMaack Schwartz, her preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, or working or associated with, or serving as "back-up" for the above named persons.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, muscle work or myofascial release, on me (or the patient named below, for whom I am legally responsible) by Chiropractor. I have had an opportunity to discuss with Chiropractor and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on Chiropractor to exercise judgement during the course of the procedure which Chiropractor feels at the time, based upon the facts then known to him or her, is in my best interest.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal segmental dysfunction oriented toward improvement of spinal function relative to range of motion, muscular, and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of treatment in this clinic. I understand that Chiropractor will use his or her hands or a mechanical devise upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on Chiropractor to exercise professional judgment during the course of any procedures, which he or she feels at the time are in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and Chiropractor's interpretation thereof, as well as the Chiropractors judgment and expertise in working with like cases.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis, or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice e. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restrictions is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted at the above address. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I also authorize the provider and or managed care organization to release any information required to process insurance claims on my behalf. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims on my behalf and authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office). I understand the above information and guarantee this form was competed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____Date_____
Adult Patient, Parent/Guardian, or Spouse

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OFFICE POLICY-INSURANCE ASSIGNMENT

THIS CLINIC WILL TRY TO ASSIST THE PATIENT WHENEVER POSSIBLE:

1) Waiting for insurance payment is courtesy and may be withdrawn at any time.
2) Insurance payment should be made in 30 days. The maximum time limit the clinic extends is 45 days. The fees must be paid in full.
3) If additional forms are to be filled out there is a clerical fee **$5.00** per form-payable immediately.
4) The patient must stay current with their percentage of responsibility (i.e. Insurance pays 80% of the bill and the patient pays remaining 20%) This must be paid at least monthly.
5) If the patient discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately; regardless of any claims submitted.
6) All deductible amounts must be paid prior to insurance submittal.
7) When our clinic receives an insurance check you will be notified. If there is any balance due at that time the patient must pay the remaining balance due.
8) Patients from out of state are responsible for all fees incurred in our office at the time of service. Our office will supply you with the forms needed for you to submit to your insurance.
9) This office does not promise that an insurance company will pay, nor does this clinic promise that an insurance company will or should pay the fees as charged.
10) The clinic will not enter into a dispute with an insurance company over reimbursement of the amount of the reimbursement. This is the patient's obligation.
11) The fees charged at this clinic might be higher or lower than other clinics. A schedule of the services and fees may be secured from the receptionist. Please familiarize yourself with these.

THERE CAN BE NO EXCEPTIONS TO THE ABOVE POLICIES

WE ARE ONLY TOO HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE

I AGREE TO PAY $35.00 FOR ANY MISSED APPOINTMENTS IF I DON'T GIVE AT LEAST A 12-HOUR CANCELLATION NOTICE.

PATIENT SIGNATURE_____DATE_____

HIPPA NOTICE OF PRIVACY PRACTICES

ADVANCED CHIROPRACTIC CLINIC
19641 E PARKER SQUARE DRIVE SUITE J
PARKER, COLORADO 80134
(303) 841-2524

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage our health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review, activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked sign your name and indicate your physician. We may also 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 and remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. The situations include, as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and required Uses and Disclosures will be made only with your consent authorization or opportunity to object unless required by law.

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You may revoke this authorization, at any time, in writing except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation or for use in civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

Your physician is not required to agree to restrictions that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative location. You have the right to obtain a paper copy of the this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically)

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an account of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or at the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____Signature:_____Date: _____

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Print Name_____Signature_____Date_____

Modified Oswestry Neck Pain Disability Questionnaire[a]

This questionnaire has been designed to give your therapist information as to how your neck pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity
- ❑ I can tolerate the pain I have without having to use pain medication.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Personal Care (e.g., Washing, Dressing)
- ❑ I can take care of myself normally without causing increased pain.
- ❑ I can take care of myself normally, but it increases my pain.
- ❑ It is painful to take care of myself, and I am slow and careful.
- ❑ I need help, but I am able to manage most of my personal care.
- ❑ I need help every day in most aspects of my care.
- ❑ I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting
- ❑ I can lift heavy weights without increased pain.
- ❑ I can lift heavy weights, but it causes increased pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Reading
- ❑ I can read as much as I want with no pain in my neck.
- ❑ I can read as much as I want with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ I cannot read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of moderate pain in my neck.
- ❑ I cannot read at all.

Headaches
- ❑ I have no headaches at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

Concentration
- ❑ I can concentrate fully when I want with no difficulty.
- ❑ I can concentrate fully when I want with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want.
- ❑ I have a lot of difficulty in concentrating when I want.
- ❑ I have a great deal of difficulty in concentrating when I want.
- ❑ I cannot concentrate at all.

Work
- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

Driving
- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

Please complete questionnaire on other side.

Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours sleepless).

Recreation

- ❑ I am able to engage in all of my recreation activities with no pain in my neck.
- ❑ I am able to engage in all of my recreation activities with some pain in my neck.
- ❑ I am able to engage in most, but not all of my recreation activities because of pain in my neck.
- ❑ I am able to engage in only a few of my recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.

FOR OFFICE USE ONLY

Score: /50 x 100 = ____% points

Scoring: For each section the total possible score is 5: if the first statement is marked the section score = 0, if the last statement is marked it = 5. If all ten sections are completed the score is calculated as follows:

Example: 16 (total scored)
50 (total possible score) x 100 = 32%

If one section is missed or not applicable the score is calculated:

16 (total scored)
45 (total possible score) x 100 = 35.5%

Minimum Detectable Change (90% confidence): 10%points (Change of less than this amount may be attributed to error in the measurement.)

Name: _____ **Date: _____**

Source: Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale. *Physical Therapy*. 2001;81:776-788.

[a]Modified by Fritz & Irrgang with permission of The Chartered Society of Physiotherapy, from Fairbanks JCT, Couper J, Davies JB, et al. The Oswestry Low Back Pain Disability Questionnaire. *Physiotherapy*. 1980;66:271-273.