REGISTRATION & INFORMATION

PATIENT INFORMATION

DATE_____

PATIENT NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

EMAIL_____

SEX M F O U PREFERRED PRONOUN _____ DOB_____

MARRIED SINGLE DIVORCED WIDOWED MINOR

WHO MAY WE THANK FOR REFERRING YOU? ☐ INTERNET ☐NEWSPAPER ☐RADIO

☐ PERSONAL REFERRAL_____☐ OTHER_____

PHONE NUMBERS

HOME PHONE#_____ CELL#_____

WORK PHONE#_____EMPLOYER:_____

BEST TIME & PLACE TO REACH YOU_____

EMERGENCY CONTACT INFORMATION

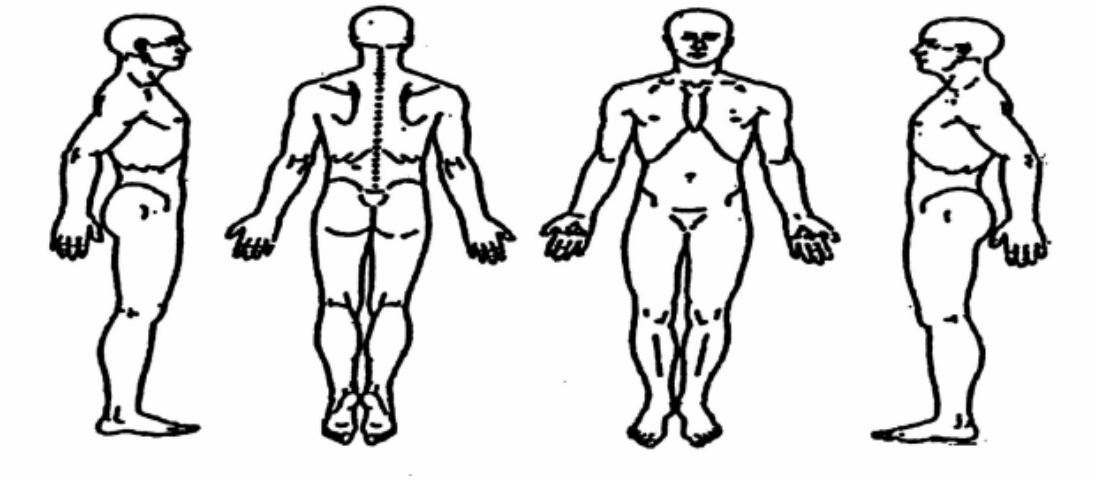
NAME_____
PHONE#_____RELATIONSHIP_____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. 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)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

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

_____

15. What is your: Height_____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

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

19. 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		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

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

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

22. List all surgical procedures you have had:
_____

23. 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

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

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

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

27. Anything else pertinent to your visit today?_____

Patient Signature X_____ **Date:**_____

FINANCIAL AGREEMENT

I understand that my insurance is a contract between myself and my insurance company and that Bartay Chiropractic will bill my insurance as a courtesy to me. I understand that I am responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay copayments, deductibles, and/or coinsurance at the time of service. If a referral and/or preauthorization is required by my insurance company, I will assist Bartay Chiropractic in obtaining the referral and/or preauthorization. Bartay Chiropractic may verify benefits on my behalf; however the final determination will be made by my insurance company at the time of payment. I understand that I am ultimately responsible for any balance on my account.

X_____(initial) **ASSIGNMENT OF BENEFITS**

I hereby assign to Bartay Chiropractic such insurance benefits to which are entitled under my insurance plan(s). If there is no insurance on file I understand that I am responsible for full amount.

X_____(initial) **RELEASE OF INFORMATION**

I hereby allow Bartay Chiropractic to furnish any information pertaining to my medical treatment to my insurance carrier, attorney, or other providers of service necessary to obtain payment of service and provide additional care.

X_____(initial) **CONSENT FOR TREATMENT**

I hereby allow Bartay Chiropractic to examine, treat, and perform diagnostic test and office procedures that the provider deems necessary.

X_____(initial) **NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT OF RECEIPT**

By signing below, I am stating that I have read and received a copy of the Notice of Privacy Practices for Bartay Chiropractic.

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information, and Consent For Treatment as listed above. My signature below also indicates that I have reviewed a copy of the Bartay Chiropractic Notice of Privacy Practices and I have indicated any restrictions on my protected health information above. Everything I have filled out is true to the best of my knowledge. Scanned Signatures suffice as originals.

X_____

Patient or Responsible Party **(Sign and print)** Date

X_____

Guardian of minor **(Sign and print)** Date

X-ray Consent Form

Patient name:_____ Date:_____

BOX 1 & 2 WOMEN ONLY

☐ I understand that if I am pregnant and have X-rays taken that expose my lower torso to radiation, it is possible to injure the fetus.

☐ I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-ray exams (low risk of pregnancy during that time).

With those factors in mind, I am advising my doctor:

I am pregnant ___Yes ____No ____Don't know

☐ **An X-ray may be performed on me with my consent.**

Signature:X_____Date:_____

PRIMARY CARE PHYSICIAN RELEASE

Please help us help you? We would like to contact your primary care physician with our opinion and findings, and let them know about your care in order to better serve you. Please fill out the form below with the proper information. Thank you!

Primary Care Physician/Medical Dr.:_____

Address:_____

Phone Number:_____

May we contact them in regards to your care? YES NO

REVISED LUMBAR DISABILITY INDEX

Name:_____ Date:_____ File #:_____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 - 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 moderately increasing
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would 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 increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase 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.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives 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, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only 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 ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain 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 ½ hour without increasing
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 - 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 night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- ☐ Pain has restricted my social life and I do not go much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9 - 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 compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 - Changing Degrees 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 slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

□ I avoid sitting because it increases pain immediately.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

NECK DISABILITY INDEX

Name:_____ Date:_____ File #:_____

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

□ I have no pain at the moment.
□ 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.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

□ I can look after myself normally without causing extra pain.
□ I can look after myself normally but it causes extra pain.
□ It is painful to look after myself and I am slow and careful.
□ I need some help but manage most of my personal care.
□ I need help every day in most aspects of self-care.
□ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

□ I can lift heavy weights without extra pain.
□ I can lift heavy weights but it gives extra pain.
□ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
□ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
□ I can lift very light weights.
□ I cannot lift or carry anything at all.

SECTION 4 - 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 can't read as much as I want because of moderate pain in my neck.
□ I can hardly read at all because of severe pain in my neck.
□ I cannot read at all due to pain.

SECTION 5 - Headaches

□ I have no headaches at all.
□ I have slight headaches that come infrequently.
□ I have moderate headaches that come infrequently.
□ I have moderate headaches that come frequently.
□ I have severe headaches that come frequently.
□ I have headaches almost all the time.

SECTION 6 - Concentration

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

SECTION 7 - Work

□ I can do as much work as I want to.
□ 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 can not do any work at all.

SECTION 8 - 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 can't 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 can't drive my car at all.

SECTION 9 - Sleeping

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

SECTION 10 - Recreation

□ I am able to engage in all my recreation activities with no neck pain at all.
□ I am able to engage in all my recreation activities, with some pain in my neck.
□ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
□ I am able to engage in a few of my usual recreation activities because of pain in my neck.
□ I can hardly do any recreation activities because of pain in my neck.
□ I can't do any recreation activities at all.

From Vernon H, Minor S. JMPT 1991; 14(7):409-415

Certification Information

Dear Patient: The US government is now requiring that we supply them with the following information

Patient Demographics:

Name: (Print clearly) _____ **Today's Date:** _____

Date of Birth: _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other_____

If the Government needs to contact you, how would you like this confidential communication to be received?

Phone Number: _____

Phone Call: ☐ Text Message: ☐

Home	Work	Cell

Email:_____

Smoking Status:	Smokes every day	Smokes some days	Former Smoker	Never Smoked

Prescribed Medicines

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued?**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**Dose Form:** i.e. Capsule	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:

Check here if you do not have any medicinal allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache

Have you been diagnosed with: (Please circle)

Asthma?	Diabetes?