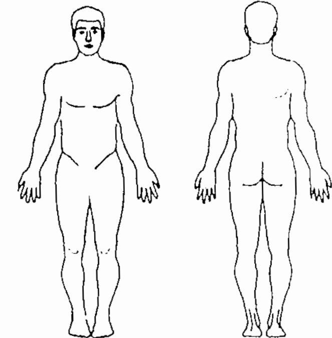
ADVANCED BACK & NECK CARE
LOCATED AT THE FALLS OF OCOTILLO

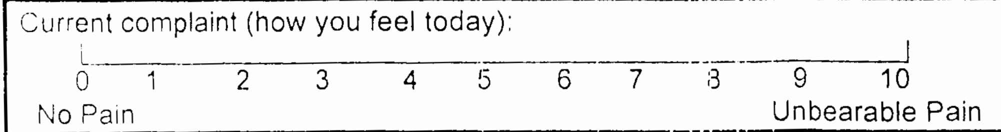
INITIAL HEALTH STATUS
Chiropractic

Patient Name________________________ Birthdate________________ Sex: M / F
Address________________________ City________________
State______ Zip__________ Phone (____)__________ Patient Primary Language________________
Occupation______________ Employer______________ Work Phone______________
Address______________ City______________ State________ Zip________
Subscriber Name________________________ Health Plan________________________
Subscriber ID #______________ Group #______________ Spouse Name______________
Spouse Employer______________ City______________ State________ Zip________
Primary Care Physician Name________________________ PCP Phone______________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other________________________
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began________________________
How Problem Began


Current complaint (how you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain — Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken______________ **What areas were taken?**______________

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)______________
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)______________
____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)______________

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks__________
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries______________
____
☐ Tobacco Use - Type______________
Frequency______________/Day
☐ Medications______________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature________________________ **Date**______________

1055 W. Queen Creek Rd. #3 Chandler, AZ 85248 Phone: 480-814-7115 Fax: 480-814-7702

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Advanced Back and Neck Care to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. 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 staff member of Advanced Back and Neck Care responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many 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 advised about the potential risks related to your care to allow you to be fully informed before consenting 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 your 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 rare 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. These are rare, but if it occurs you should report it to your doctor or a staff member at Advanced Back and Neck Care.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37, No2, June, 1993) estimate that the incidence of this type of stroke is 1 in every 3 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.

If you have any questions concerning this form or the above statements, please ask your doctor.

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

____

Patient Signature Date

____

Parent/Legal Guardian Signature Date

Confidential Patient Information

Name: ______________________________ Date: __________

Complaint Information

What is your major complaint(s)? ______________________________

____

How long have you had this condition(s)? ______________________________

____

Using the symbols in the Pain Index box below, mark the areas on the illustrations where you are experiencing pain, followed by a number for 1 to 10 indicating the extent of the pain (1 being minor, 10 being severe)

Pain Index

S Sharp/Stabbing

B Burning

For example: If you are experiencing moderately severe, stabbing pain in the back of your neck, write "**S8**" on the neck of the illustration.

Right Left Right

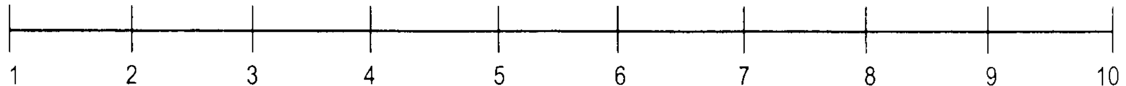
If this is an injury, describe what happened: ______________________________

____

____

____

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



Have you experienced similar symptoms in the past? Yes No If yes, when? __________

These symptoms developed from? Auto Accident Work-related Other: __________

Have you reported it to your: Insurance company? Yes No Your employer? Yes No

What aggravates the pain/symptoms? __________

What decreases the pain/symptoms? __________

Have you seen a doctor for this condition? Yes No If yes, Doctor's name __________

Date consulted: __________ Diagnosis: __________

Does this condition interfere with your sleep? Yes No How many times do you wake up in pain each night? ______

In what position do your sleep? Back Side Stomach

Do you sleep with a pillow? Yes No If yes, how many? __________

Does heat affect the pain? Yes No If yes, how? __________

Does cold affect the pain? Yes No If yes, how? __________

Do you wear a heel lift? Yes No If yes, which side? Right Left

Does it cause pain to sneeze, cough or grunt? Yes No If yes, where is the pain? __________

Which of the following activities cause you difficulty or pain?

____ Bending backward	____ Sexual activity	____ Pushing	____ Kneeling
____ Bending forward	____ Getting in/out of car	____ Pulling	____ Sleeping
____ Walking	____ Turning over in bed	____ Reaching	____ Sneezing
____ Climbing	____ Lying flat on stomach	____ Stooping	____ Standing for periods over one hour
____ Coughing	____ Lying on back	____ Gripping	
____ Dressing self	____ Lying on side with knees bent	____ Sitting	____ Other __________

Fill out the next three sections as they apply to you:

Neck Pain

If you have a neck injury, does it affect (circle all that apply) hearing vision balance cause ringing in your ears

Do you hear grating sounds? Yes No Do you feel pressure or pain behind your eyes? Yes No

Do you feel ripping or tearing? Yes No If yes, where?______________________________

Do you have difficulty turning or lifting your head? Yes No If yes, in which direction? Right Left Up Down

Lower Back Pain

Do you ever experience ripping or tearing sensations in your back? Yes No If yes, where?__________________

Does pain radiate to the abdomen? Yes No

Do you ever have impairment of bowel or urinary function? Yes No If yes, explain:__________________

Headaches

Do you have a family history of headaches? Yes No Do you get headaches? Yes No If yes, how often?________

Do you experience any of the following with your headaches: Pain or cracking in your jaw? Yes No

Abnormal blood pressure? Yes No If yes, High Low Nausea, vomiting or visual disturbances? Yes No

When was your last eye exam by a doctor? 1-6 months 6-12 months 1-2 years over 2 years Results:__________

If female, are you pregnant? Yes No Not Sure If yes, when is your due date?____________________

List all medications you are taking now, including over-the-counter: ______________________________

____

Are you allergic to any medications? Yes No Not Sure If yes, please list:____________________

Have you ever been hospitalized or had surgery? Yes No If yes, please list:____________________

Type of hospitalization/surgery:	Date:	Type of hospitalization/surgery:	Date:
____________________	________	____________________	________
____________________	________	____________________	________

Have you been x-rayed in the last 12 months? Yes No If yes, when? ____________________

Have you ever been seen by a chiropractor before? Yes No If yes, please list below:

Name of Chiropractor:	Dates:	Name of Chiropractor:	Dates:
____________________	________	____________________	________

Do you have a family physician? Yes No If yes, doctor's name: ____________________Phone: __________

Address: ______________________________ City/State/Zip:______________________________

Additional Complaints

Please check all additional complaints that you have at this time:

- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Neck Motion Restricted
- ❑ Upper Back Stiffness/Pain
- ❑ Mid-Back Stiffness/Pain
- ❑ Lower Back Stiffness/Pain
- ❑ Shoulder Pain Right/Left
- ❑ Arm Pain Right/Left
- ❑ Leg Pain Right/Left
- ❑ Pins & Needles Arms/Legs
- ❑ Headache
- ❑ Loss of Concentration
- ❑ Heavy Feeling of Head
- ❑ Memory Loss
- ❑ Dizziness
- ❑ Ringing in Ears
- ❑ Loss of Balance
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Eyes Sensitive to Light
- ❑ Pain Behind Eyes
- ❑ Vision Problems
- ❑ Fainting
- ❑ Palpitation
- ❑ Sinus Trouble
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Irritable
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia
- ❑ Fatigue
- ❑ Flushed Face
- ❑ Excess Perspiration
- ❑ Digestive Trouble
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Cold Hands
- ❑ Cold Feet
- ❑ Jaw Pain
- ❑ Cancer
- ❑ Hypertension
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Convulsion
- ❑ Allergies (Please List)
  ____
  ____
  ____
- ❑ Anemia
- ❑ Heart Disease
- ❑ Arthritis
- ❑ HIV (Aids)
- ❑ Other (Please List)
  ____
  ____
  ____

Please Specify Location:

Numbness ______________
Swelling ______________
Cuts ______________
Bleeding ______________
Broken Bones ______________
Bruising ______________

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If yes, please list: ______________

____

Is there anything else you would like the doctor to know about before beginning care at Advanced Back and Neck? ______________

____

Personal History

Name: ______________________

Address: ______________________

City/State/Zip: ______________________

Home Phone: ______________________

E-Mail: ______________________

Birthday: __________ Age______ Gender F M

Social Security #: ______________________

Employer: ______________________

Business Phone: ______________________

Type of Work: ______________________

Circle One: Married Single Widowed Divorced Separated

Spouse's Name: ______________________

Spouse's Employer: ______________________

Spouse's Type of Work: ______________________

Spouse's Social Security #: ______________________

Spouse's Business Phone: ______________________

Name & Ages of Children: ______________________

____

Referred By: ______________________

Emergency Contact Name and Phone #: ______________________ Relationship: ______________

Who is responsible for your bill? You and Spouse Worker's Comp Auto Insurance Medicare Medicaid

Health Insurance Company: ______________________ ID# ______________

With all the rescources at our disposal to make dramatic improvements in our patient's health, to make appropriate recommendations based on your health goals, we need to know the following:

On a scale of 1-10 with 10 being the highest, how would you rate your health as a priority in life? ______________

What is your committment level (1-10) to making the necessary changes to reach your health goal? ______________

With regard to quality of life, lifestyle, sports, hobbies, activity level, etc., What would you most like to see improve? ______________

____

Advanced Back & Neck Care

1055 West Queen Creek Road, #3 · Chandler, Arizona 85248
(480) 814-7115 · (480) 814-7792/fax

Patient Financial Agreement

(Equitable Lien/Benefit Assignment Contract and Indemnification Agreement)

Please read the following very carefully as it concerns your financial responsibility to Health Care or Service4 Provider from whom you are about to receive services.

I, the undersigned Patient, hereby agree to establish a lien/assignment of benefits or claim in favor of **Advanced Back & Neck Care** by this contract and pursuant to any state statues that apply in the state where I reside. I give my permission for **Advanced Back & Neck Care** and/or their agent, to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from the accident which occurred ________________(**date**) and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so I have entered into a contract with the above named health care or service provider. **This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy,** settlement, compromise, judgment, verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in such sums necessary to fully compensate the health care or service provider from whom I have received care. The lien/assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority from the time and date on which said documents are actually filed, or recorded or served on the liable parties, over any subsequent liens or assignments of my interests in claims arising from this accident.

In exchange for providing necessary medical care without requiring payment in full at the time service is received, I agree to be responsible for all charges associated with my care, regardless of the insurance companies' reimbursement, settlement or compromise. Charges for which I agree to be responsible include any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and/or serving notice of this lien/assignment upon any liable parties and their insurance companies. Also included are any collection charges or legal costs and fees incurred by the provider while attempting to collect the medical bills related to this claim should such activity becomes necessary.

I further understand that as part of the process of recording a lien/assignment, I will receive certified mail with a copy of the lien/assignment enclosed and that this copy is for my own records and do not require any response on my part.

______________________________ ____________________
Patient's Signature Date
(If patient is a minor, have guardian sign and indicate)

Cancellation Policy

Hour massage appointments are subject to our 24 hour cancellation policy.; In the event you fail to cancel within 24 hours, or do not show up for a scheduled appointment, you will be subject to a $15.00 fee. This fee goes directly to the therapist and may be paid in cash, check, or credit card.

______________________________ ____________________
Patient Signature Date

Some insurance policies require that the patient or policy-holder receive payment and/or Explanation of Benefits (EOB). Upon receipt the policy-holder will forward all information to the physician. Your contract with the insurance company requires that you will forward any payments to the physician immediately.

Once the insurance notifies the physician of the payment, they usually have a limitation on how long it takes the physician to receive their payment. Failure to forward payment may result in garnishment, legal action, and termination of your insurance policy and coverage. (It is also important to understand that insurance companies devote a great deal of resource to find and pursue payments).

To avoid any problems, ADVANCED BACK AND NECK CARE likes to take a proactive approach to this potential situation.

So that we can continue to bill your insurance company and keep your financial records accurate and current please forward any and all correspondence (including checks) directly to our office.

We would like to thank you in advance for your careful consideration of this serious matter.

Your support is greatly appreciated.

Respectfully,

Mark Ector
Office Manager
ADVANCED BACK & NECK CARE

I have read and agree to the above terms.

480-814-7115
1055 W. Queen Creek Rd., Suite 4
Chandler, AZ 85248
www.advancebackandneck.com