# Patient Health Questionnaire

Name: _____ Sex: M / F Height: ____'___ Weight: _____

Dominant Hand R / L Date of birth: _____/_____/_____Occupation:_____

Physical Address:_____

Mailing Address: _____

Phone Number(s): _____/_____ Marital Status: S / M / D / W

Email Address(s): _____/_____

Name of your medical doctor: _____ Last visit date: _____

List any current medical conditions and/or medications: _____

_____

Have you ever been to a chiropractor? □Yes □No Name of last chiropractor visited: _____

Date of last chiropractic treatment: _____ Reason for changing chiropractors: _____

Please list <u>all</u> surgeries you have had:_____

_____

Initial Here: _____ Are you Pregnant? Y / N How many weeks?: _____ Date of last menstrual cycle: _____
Do you smoke? Y / N How long?: _____ How many per day?: _____Have you tested HIV positive? Y / N
Do you consume: alcohol (#_____ drinks per week) caffeinated drinks (#_____ drinks per day)
Would you say your health is: ____poor ____fair ____good ____excellent
Do you exercise? Y / N Type of exercise: _____ Hours per week: _____
Any significant family history of heart disease, cancer, stroke, Alzheimer's, diabetes, etc.? (list family member and condition):_____

_____

Describe your pain/symptoms (please be specific): _____

_____

_____

Cause of symptoms: _____Date symptoms began: _____

What makes symptoms better? _____Worse: _____

What other treatments have you sought to alleviate symptoms? _____

_____

Have you recently been involved in an auto accident? Y / N Is this a work related injury? Y / N

Please check any of these symptoms you have <u>ever experienced</u>:

O Chest Pains O High Blood Pressure O Stroke O Cancer O Infertility O Blood Clots
O Diabetes O Asthma O Heart Attack O Dizziness O Shortness of Breath

Initial Here: _____

How did you hear about our office? _____

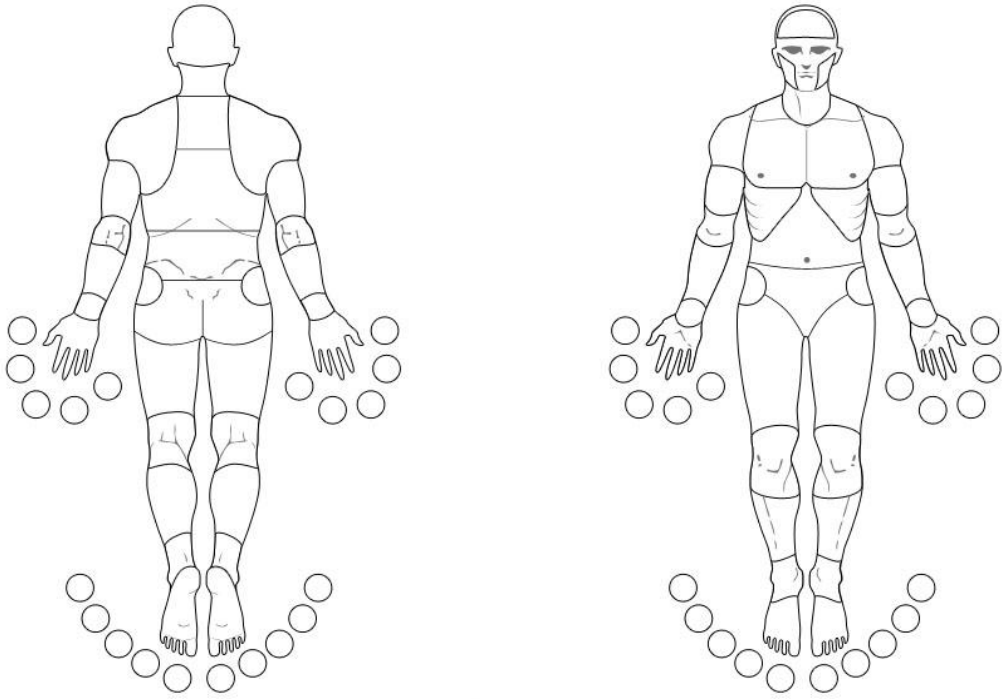
Please check any of these symptoms you are currently experiencing or have experienced in the last 3 months:

O Headaches **#____ per week**
O Neck Pain
O Low Back Pain
O Mid-back pain
O Shoulder Pain **R / L**
O Pain in Hands or Arms **R / L**
O Numbness in Hands or Arms **R / L**
O Pain in Legs or Feet **R / L**
O Numbness in Legs or Feet **R / L**
O Stiffness: **Neck / Mid-Back / Lower Back**

O Painful Urination
O Constipation
O Stomach Upset
O Diarrhea
O Depression
O Lights Bother Eyes
O Unintended Weight Loss **#___lbs.**
O Irritability
O Sleeping Problems

O Menstrual Cramps
O Loss of Smell or Taste
O Fatigue
O Allergies
O Loss of Balance
O Loss of Memory
O Fever
O Nervousness
O Joint Swelling
O Sinus Problems

Please indicate any areas of pain on the drawing by placing a number from 1 through 10 on each location of discomfort.
1= Minimal Pain / 10 = Extreme Pain



**For Office Use Only**

**Doctor's Initials**

**Patient Name_____ Date_____Activities of Daily Living**

Within each section, please indicate how your current symptoms are affecting your daily living by selecting one of the options.

**Self Care/Hygiene**

[__] I can provide for myself on most of my personal care.
[__] I can provide for myself, but it creates extra pain.
[__] I can provide for myself, I am slow, careful, and it is painful.
[__] I manage most of my personal care, but it requires some help.
[__] In most accommodations of my daily care, I require extra help.
[__] It is too difficult to care for myself, I stay in bed and do not perform these tasks.

**Communication**

[__] I can communicate in a normal fashion.
[__] I can communicate, but it causes some pain.
[__] My communication abilities are normal, but always painful.
[__] My communication abilities are restricted by pain.
[__] Pain seriously limits my communication except for emergencies.
[__] Pain prevents communication abilities completely.

**Normal Living - Sitting**

[__] I am able to assume a sitting position for an indefinite period of time without pain.
[__] I can sit down for an indefinite period of time, but it causes some pain.
[__] I am restricted to one hour of sitting due to pain.
[__] Due to pain, I am only able to sit for 30 minutes.
[__] Pain restricts sitting for longer than 10 minutes.
[__] I am unable to sit due to pain.

**Normal Living - Standing**

[__] I am able to stand as long as I like without pain.
[__] I am able to stand for an indefinite period of time, but it causes pain.
[__] I am restricted to one hour of standing due to pain.
[__] Due to pain, I am only able to stand for 30 minutes.
[__] Pain restricts standing for longer than 10 minutes.
[__] I am unable to stand due to pain.

**Normal Living - Lifting**

[__] I am able to lift heavy objects without pain.
[__] I am able to lift heavy objects, but it causes some pain.
[__] I am unable to lift heavy objects off the floor, however, I can manage if they are at table height.
[__] Due to pain, I am not able to lift heavy objects. However, light to medium weight objects are manageable.
[__] Pain restricts lifting only very lightweight objects.
[__] I am unable to lift any objects of any weight at all.

**Ambulation**

[__] I am able to walk any distance without pain restrictions.
[__] I am limited to walk one mile due to pain restrictions.
[__] I am limited to ½ mile of walking due to pain.
[__] Due to pain, I am restricted to walking less than ¼ mile.
[__] I require the use of crutches or a cane to assist walking.
[__] I remain in bed most of the time due to pain.

**Pain Frequency**

[__] I have INTERMITTENT symptoms occurring less than 25% of my wake time.
[__] I experience OCCASIONAL symptoms between 25% and 50% of my awake time.
[__] Pain is FREQUENT, and occurs between 50% and 75% of my awake time.
[__] I have CONSTANT pain occurring between 75% and 100% of my awake time.

Initial Here: _____

**Travel**
[__] I am able to travel without pain restrictions.
[__] I am able to travel almost anywhere, but it causes pain.
[__] I can manage 2 hours of travel, but pain is present and severe.
[__] Due to pain, I am limited to less than an hour of travel time.
[__] Only short, urgent trips are possible due to pain limitations.
[__] I am restricted in travel due to pain, other than emergencies of short distances (hospital, doctor visit).

**Non Specialized Hand Activities**
[__] I can grasp in a normal fashion.
[__] I can utilize grip and tactile discrimination, but there is some pain.
[__] My grasp and grip capabilities are normal, but always painful.
[__] Grasping, grip strength can tactile sensations are restricted by pain.
[__] prevents grip strength, grasping and tactile discrimination completely.
[__] Pain prevents grip strength, grasping and tactile discrimination completely.

**Sexual Function**
[__] I am able to engage in normal sexual activities without pain.
[__] I am able to participate sexually, but it creates some pain.
[__] I engage normally in sexual activities, but it is very painful.
[__] I am restricted in sexual activities due to pain.
[__] Pain has created a near absent sex life.
[__] Due to pain, I abstain from any sexual activities.

**Sleep**
[__] I sleep well in a normal fashion.
[__] I sleep well at night, as long as I use sleeping pills.
[__] I fail to accomplish more than 6 hours of sleep.
[__] I fail to accomplish more than 4 hours of sleep.
[__] I fail to accomplish more than 2 hours of sleep.
[__] Pain prevents sleep.

**Social & Recreational Activities**
[__] I am enjoying a normal, active social life without pain restrictions.
[__] The presence of pain affects only the more energetic activities of my social life (golfing, sports, etc.).
[__] I participate in a normal social life, but pain is increased during most activities.
[__] Pain restricts all of my social activities; therefore, I do not go as often.
[__] I am restricted to social activities at home due to pain.
[__] Due to pain, I do not participate in any social activities.

**The Effects Of Medication**
[__] I am able to tolerate pain; therefore, I do not use any pain medication.
[__] I use pain medication and experience complete relief from pain.
[__] I use pain medication and experience moderate relief from pain.
[__] Pain medication offers only very little relief from pain.
[__] Pain medication fails to offer relief; therefore, I no longer take them.

**Pain Intensity**
[__] My pain is MINIMAL and tolerated, it is annoying, but does not limit my physical performance.
[__] Pain is SLIGHT and tolerated; it causes some limitations on my physical performance.
[__] I experience MODERATE pain, which causes a significant limitation on my physical performance of activities.
[__] I experience SEVERE pain, which reduces my capability to perform any activity.

# NORTH GEORGIA SPINAL CARE

**650 Henderson Drive, Suite 109 Cartersville, GA 30120**
**(770) 387-2265**

## WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures.

**All Patients**: All Patients are responsible for full payment at the time of service. All credit must be pre-authorized, in writing, prior to treatment.

**Insurance Patients**: Patients who carry health insurance should remember that professional services are rendered and charged to your insurance company on your behalf. It is your responsibility to be aware of and understand your insurance benefits, both in and out of network. We may verify your benefits as a courtesy to you; however, if we are quoted incorrect benefits, you will be responsible for whatever your actual benefits are. It is a good idea to speak with your insurance company yourself to be advised of your benefits. Any services not covered by your insurance are ultimately your responsibility. Our office accepts billing on some individual or group insurance policies, authorized Personal Injury claims, and authorized Workman's Compensation claims. We are not a Medicare Provider and we do not submit claims to Medicare. We do not accept patients who are covered by Medicare: it is your responsibility to inform us if you are currently on Medicare or become a Medicare patient so that we can refer you to a Medicare Provider for chiropractic care. By choosing to receive care in this office you are stating that you are not covered by Medicare and/or do not want any claims submitted to Medicare related to your treatment in this office. In some cases, certain insurance companies may send payments for services rendered in this office directly to the patient. In the event this happens, the patient will be responsible for the amount the insurance pays, in addition to co-pays and deductibles.

Insurance is a contract between you and your insurance company. You are a customer of your insurance company, we are not. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc, other than to supply factual information as necessary.

**Limited Release of Medical Information**: I authorize North Georgia Spinal Care to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

**Authorization to Process Drafts**: I agree that North Georgia Spinal Care shall be appointed as my agent to endorse drafts or to sign my name on any checks for payment of my bill for chiropractic services rendered. I hereby authorize and direct all payments for services to be made directly to North Georgia Spinal Care.

**Overdue Accounts**: All accounts are billed daily and are considered past-due after ten days or if prearranged regular monthly payments are not met. Insurance accounts become the patient's responsibility after 90 days. All accounts are subject to interest and late fees. In the event that it is necessary to refer this account to collections, you will be responsible to pay all costs of collection including, but not limited to, reasonable attorney's fees and interest permitted by law.

**Patient's Financial Arrangements:**_____

Co-pay:_____Deductible:_____

Will be Paid: _____ Self-Pay Fee:_____

Insurance checks will be sent to patient? Y / N

I have read and understand and agree to the terms discussed above:

_____ _____

Responsible Party Signature Date

**INFORMED CONSENT TO CHIROPRACTIC TREATMENT**
We would like to inform you about the possible risks of receiving or refusing chiropractic care.

**The nature of the chiropractic adjustment:** The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. I also use some physical therapy techniques in my practice.

**Analysis / Examination / Treatment**
As part of the analysis, examination, and treatment, you are consenting to procedures including, but not limited to: spinal manipulative therapy (an adjustment), electrical muscle stimulation, hot or cold therapy, mechanical traction, therapeutic exercises, x-rays, range of motion testing, palpation, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis, and vital signs.

**The material risks inherent in chiropractic treatment:**
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Some patients will feel some stiffness and soreness following the first few days of treatment. Complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I will make every reasonable effort during the examination to screen you for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**The probability of those risks occurring:**
Fractures are rare occurrences and generally result from some underlying weakness of the bones which I check for during the taking of your history and during examination and X-ray. There are reported cases of stroke associated with visits to medical doctors and doctors of chiropractic. Research and scientific evidence does not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and doctors of chiropractic when they are in the early stages of a stroke. In essence, there is a stroke already in progress. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The availability and nature of other treatment options:**
Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest, medical care and prescription drugs, hospitalization, or surgery. If you choose one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers of remaining untreated:**
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND THE ABOVE**

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have had the opportunity to discuss any questions or concerns with Rob Buchkowski, D.C., and have had my questions answered to my satisfaction. I understand that results are not guaranteed. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient or Legal Guardian signature _____Date _____

Patient Name (please print) _____Witness:_____

- **PATIENT NOTIFICATION OF ISSUES RELATING TO PRIVACY**

***Per Federal HIPPA (Health Insurance Portability and Accountability Act) Privacy Rules *April, 2001****

With your consent, North Georgia Spinal Care may use and disclose protected health information (PHI) about you to carry out treatment, payment, insurance and health care operations.

Our Examination and Treatment rooms are private with walls that are 8 feet high, or reach the ceiling. Treatment rooms have doors; however they may remain open. Your treatment may also be performed in an open room with several therapy tables which may be in use by other patients.

On the day of your visit, your Patient Treatment file may be placed in insecure locations where your name is exposed (such as in a wall bin inside the Treatment Room).

We may disclose PHI about you to (1) our doctors, technicians, massage therapists, and staff members. (2) to people outside our practice who may be involved in your health care, such as other doctors providing services that are part of your care. (3) to a family member or friend who is involved in your health care or someone who helps pay for your care. (4) in a credit card dispute of charges, we may need to supply information that proves that the charges were appropriate for the care provided and that the care was in fact provided to the patient. (5) If you are involved in a lawsuit or similar proceeding, we may disclose your health information in response to a court or administrative order, in response to a subpoena, discovery requests, requests from insurance adjusters or for another lawful process by someone involved in the dispute. You have the right to request a list of persons who have access to your PHI. Make this request in writing to the office manager.

North Georgia Spinal Care may call your home or office and leave a message in reference to any items that assist the practice in carrying out health care operations such as appointment reminders and insurance items. North Georgia Spinal Care may mail to your home or office any items that assist the practice in carrying out health care operations such as appointment reminders, patient statements, promotions, postcards, etc. You have the right to request in writing that communications be restricted in a certain way (example: only call at work, never call cell phone, mail items to a different address) *We are not required to agree to your request, but if we do, we are bound by our written agreement.*

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment, and/or health care operations*. We are not required to agree to your requested restrictions, but if we do, we are bound by our written agreement with you.*

You have the right to: (1) inspect and obtain a copy of your health information. Submit your request for copies or inspection in writing. There is a fee associated with copying, printing, or mailing information. The fee is an administrative fee of $25, a copying fee per single-sided page and the actual cost for certified mailing of the records. Requests will be responded to within 30 days. We are not always able to send or receive faxes. US mail is our primary and preferred method for sending and receiving information pertaining to health records. (2) You may request us, in writing, to amend your health information if you believe it is incorrect or incomplete. Requests may be denied with a written response and reasons.

If you believe your privacy rights have been violated, you may file a complaint with the practice, (Dr. Robin Buchkowski, DC, or the office manager) (770)387-2265 or with the Department of Health and Human Services. All complaints must be submitted in writing to insure clear communication.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. Your signature also provides your agreement to receive treatment in the clinic including the privacy issues outlined above. This consent may be revoked in writing to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may be forced to decline to provide treatment for you.

Signature of Patient or Legal Guardian_____ Date_____

Patient's Name (printed)_____