



Vaughn Chiropractic

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248-674-4898

PATIENT INFORMATION

Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ Date of Birth _____ Age _____

Marital Status _____ Sex _____ M _____ # Number of Children _____

Occupation _____ Employer _____

Spouse's name _____ Spouse's Employer _____

Email address _____

How did you hear about the office(referred by)? _____

PHONE NUMBERS

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ best time and place to reach you is _____

May we identify ourselves and office in phone messages? _____ yes _____ No

INSURANCE INFORMATION

Do you have health insurance? _____ yes _____ No Insurance Company _____

Subscriber's name _____ Subscriber's Date of birth _____

Subscribers Relationship to Patient _____

Is patients covered by additional insurance? _____ yes _____ No If yes please complete the following:

Insurance Company _____ Subscriber's Name _____

Subscriber's Date of Birth _____ Relationship to patient _____

ACCIDENT INFORMATION

Are you here due to an _____ auto accident _____ on the job injury _____ other _____:

If so, please complete the following: Date of accident _____

To whom have you reported the accident? _____ auto insurance _____ workers comp _____ other _____

HEALTH HISTORY

Have you has any previous chiropractic care? _____ Yes _____ No if yes, Where? _____

When was your last adjustment? _____ could you be pregnant? _____ yes _____ no

What are your MAJOR/PRIMARY complaints?

How long have they been bothering you?

1) _____

1) _____

2) _____

2) _____

Have you has any falls, auto accidents, or injuries? _____ yes _____ No if yes, please describe.

Month/Year _____ Type of accident _____ Describe injury _____

Month/Year _____ type of accident _____ Describe injury _____

Have you ever had surgery? _____ yes _____ No if yes, please describe

Month/Year _____ Type of surgery _____ comments _____

Month/year _____ type of surgery _____ Comments _____

Are you currently taking any medications or vitamins? _____ yes _____ No if yes, please list

Name _____ Doses per day _____ for how long _____

Name _____ doses per day _____ for how long _____

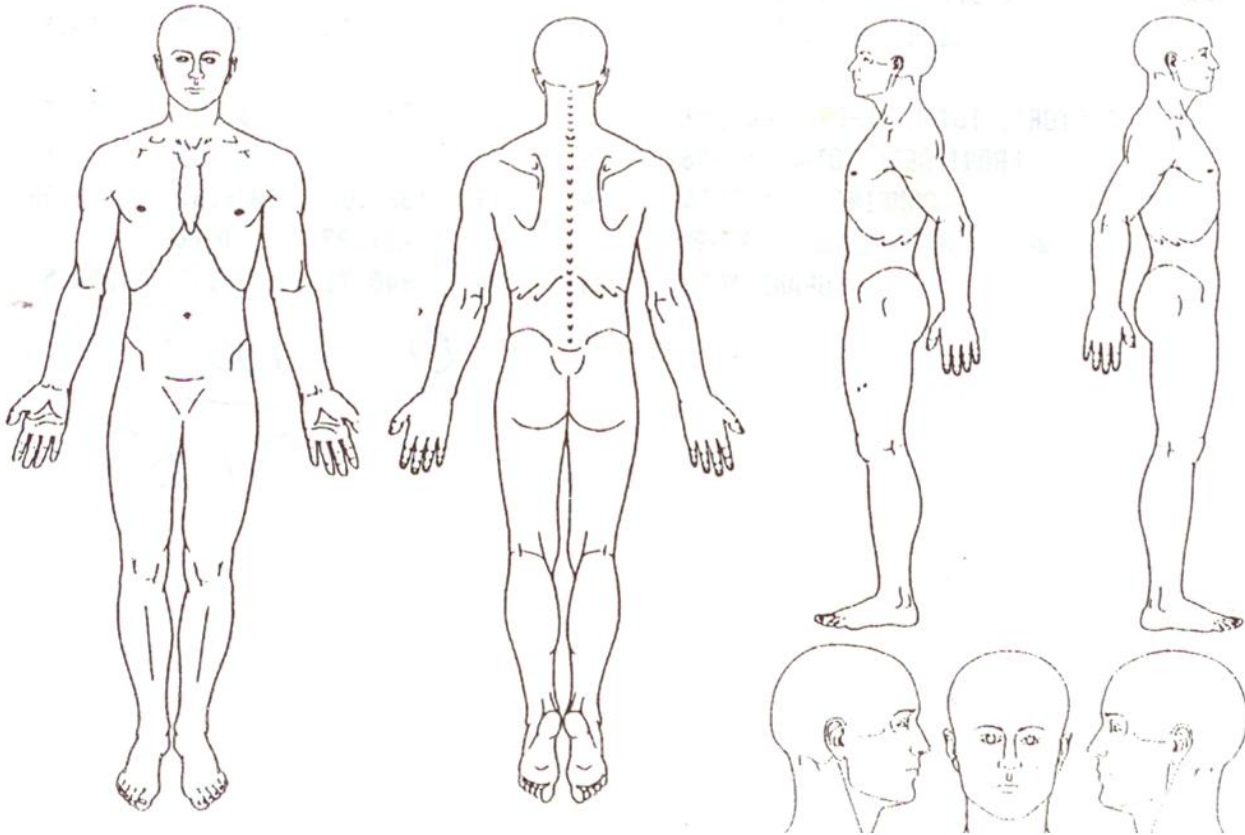
Please check any of the following that you have experienced within the last 6

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Shooting head pain | <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Pain in legs or feet | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Cold feet and toes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Hip pain | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Grinding in neck | <input type="checkbox"/> Painful joints | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Tightness in shoulders and arms | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Pins and needles in arms or hands | <input type="checkbox"/> Constipation | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold hands or fingers | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Numbness in legs or feet | <input type="checkbox"/> HIV + | <input type="checkbox"/> Smoker |

PAIN DISABILITY INDEX QUESTIONNAIRE

Name _____ Date _____

On the diagram below, please indicate where you are experiencing any pain at this time. Use the code at the bottom to describe your pain. Please complete both side of this form.



A=Ache **B=Burning** **N=Numbness**
P=Pins & needles **S=Stabbing** **o=other**

1: How often do you experience your symptoms?

- Constantly (76-100%)
- Frequently(51-75%)
- Occasionally(26-60%)
- Intermittently(0-25%)

2. What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling

3. How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

4. Have you had similar symptoms in the past?

- Yes
- No

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

_____ Chiropractor _____ Medical Doctor _____ Physical Therapist _____ Other

This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each section by circling **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but just circle the one which closely describes your problem **RIGHT NOW**.

SECTION 1-PAIN INTENSITY

- A. I have no pain at the moment
- B. The pain is mild at the moment
- C. The pain comes and goes and is moderate
- D. The pain is moderate and does not vary much
- E. The pain is server but comes and goes
- F. The pain is server and does not vary much

SECTION 6- CONCENTRATION

- A. I can concentrate fully when I want to with no difficulty
- B. I can concentrate fully when I want to with a light difficulty
- C. I have a fair degree of difficulty concentrating when I want to
- D. I have a lot of difficulty concentrating when I want to
- E. I have a great deal of difficulty concerning when I want to
- F. I cannot concentrate at all

SECTION 2- PERSONAL CARE

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

SECTION 7- WORK

- A. I have no pain at work
- B. I can do my usual work, but no more
- C. I can do most of my usual work with little pain
- D. I can do usual work with moderate pain
- E. I can hardly do my usual work at all
- F. I cannot do any work at all.

SECTION 3- LIFTING

- A. I can lift heavy weight without extra pain
- B. I can lift heavy weights, but it causes extra pain
- C. pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights
- F. I cannot lift or carry anything at all

SECTION 8- DRIVING

- A. I can drive my car without neck or back pain
- B. I can drive my car as long as I want with slight pain
- C. I can drive my car as long as I want because of moderate pain
- D. I cannot drive my car as long as I want because of moderate pain
- E. I can hardly drive my car at all because of severe pain
- F. I cannot drive my car at all.

SECTION 4- READING

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck
- C. I can read as much as I want with moderate pain in my neck
- D. I cannot read as much as I want because of moderate pain in my neck
- E. I cannot read as much as I want because of severe pain in my neck
- F. I cannot read at all.

SECTION 9- SLEEPING

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless)
- C. my sleep is mildly disturbed (1-2 hours sleepless)
- D. My sleep is moderately disturbed (2-3 hours sleepless)
- E. My sleep is greatly disturbed (3-5 hours)
- F. My sleep is completely disturbed (5-7 hours sleepless)

SECTION 5- HEADACHE

- A. I have no headaches at all
- B. I have slight headaches which come infrequently
- C. I have slight headaches which come frequently
- D. I have moderate headaches which come frequently
- E. I have server headaches which come frequently
- F. I have headaches almost all the time.

SECTION 10- RECREATION

- A. I am able to engage in all recreational activities with no pain at all.
- B. I am able to engage in all recreational activities with some pain
- C. I am able to engage in most, but not all recreational activities because of pain
- D. I am able to engage in a few of my usual recreational activities because of pain
- E. I can hardly participate in any recreational activities because of pain
- F. I cannot participate in any recreational activities at all.

Signature: _____ Date: _____

Terms of Acceptance

When we accept you as a patient, it's important that you understand the objectives of your care. Chiropractics provide a unique service that other healthcare providers do not offer. Chiropractors specialize in the location and correction of vertebral subluxations for the purpose of improving the health and function of your spine and nervous system.

A Vertebral Subluxations is a misalignment or distortion of your spinal column and/or related structures that can affect your health and overall body functioning. Chiropractors spend year studying how to locate and correct this destructive condition. The correction is preformed using specialized techniques called "chiropractic or spinal adjustments" over a period of time. When your spine is free of the nerve and musculoskeletal stress caused by subluxations your body can function more efficiently and your and your body's natural ability to heal can work more optimally.

It is not our objective to medically diagnose or treat any disease, symptom or condition. If you desire diagnosis or medical treatment for a specific symptom, or treatment of a specific symptom, diseases or condition or advice on taking or stopping medications we recommend you consult a healthcare provider who specializes in that area.

If we discover unusual findings during the course of your chiropractic examination(s) we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other health professionals. We will cooperate with you and them in your goals.

Summary- the purpose of chiropractic care is not to treat diseases or conditions, nor to suppress symptoms, nor to perform surgery or prescribe medications but rather to improve the healthy and function of your spine and nerve system to help your body and it's optimum health and healing potential. It is our objective to improve and maintain the health and normal function of your spine and nerve system to the maximum degree possible to you.

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 tom fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

Vaughn chiropractic utilizes open adjustment areas, wherein the patient may be in the same room as another patient. If you prefer a private adjustment room, please alert the front desk for that arrangement.

I have read, or have had read to me, the above content. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition.

Patient Signature _____ **Date** _____

Female Patients:

- 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 menstrual period are generally considered safe x-ray exams (low risk of pregnancy during that time).

My last menstrual period began _____

I have begun/completed menopause
_____ Yes _____ No

With these factors in mind, I am advising my doctor:
I am pregnant ___yes ___No ___ Don't know
I could be pregnant ___ yes ___No ___ Don't know
My menstrual period is late ___yes ___No
I am taking oral contraceptives ___yes ___No
I have an IUD ___yes ___No
I have has a tubal ligation ___yes ___No
I have had a hysterectomy ___ yes ___No
I have irregular menstrual periods ___ yes ___ No
An x-ray may be preformed with my consent

Signature _____ Date _____

Consent for Purposes of treatment, Payment & healthcare Operations

I acknowledge that Vaughn Chiropractic/ Vaughn Marshall Chiropractic’s “Notice of Privacy practices” has been provided to me.

I understand that I have a right to review Vaughn Chiropractic/ Vaughn Marshall Chiropractic’s Notice of Privacy policies prior to signing this document. Vaughn Chiropractic/ Vaughn Marshall Chiropractic’s Notice of Privacy Practices has been provided to me. The Notice of privacy practices describes the types of uses & 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 Vaughn Chiropractic/ Vaughn Marshall Chiropractic. This Notice of privacy practices also describes my rights & Vaughn Chiropractic/ Vaughn Marshall Chiropractic duties with respect to my protected health information. This Notice of privacy practices for Vaughn Chiropractic/ Vaughn Marshall Chiropractic is provided on request at the main administration desk of this office.

Vaughn Chiropractic/ Vaughn Marshall Chiropractic reserve the right to change the privacy practices that are described in the Notice of privacy Practices. I may obtain notice of privacy practices by calling the office and requesting a revised copy sent in the mail or asking for one at the time of my next appointment.

Signature of patient or personal representative

Date

Description of personal representative if Applicable

FINANCIAL POLICIES

1. It is the policy of these offices that all services rendered are charged directly to you, the patient and that ultimately, the patient is responsible for all services, including those not reimbursed by third party payers.
2. All payments are expect3ed at the time of service. If payment is not made at the time a service a billing statement will be sent via mail including a \$5 billing statement charge. Patient balances may not exceed \$100.00 at any time.
3. All insurance patients must pay their deductible in full, and the co-payment at the time of service. Insurance patient’s balances must not exceed \$200.00 at any time.
4. Returned checks and balances over 30 days may be subject to additional collection fee and interest charges of \$7.00 per month. Charges may also be made for missed appointments and those cancelled without 24 hour notice.
5. A fee will be charged to any patient that fails to give a 24 hour notice when canceling an appointment or fails to show up entirely with no notice.

The privilege of insurance assignment begins when the offices receive all of your insurance forms. All deductible payments MUST be made prior to your insurance submittal. You are considered to be a CASH patient until the office “qualifies” your coverage. We cannot be held responsible for any mis-information that an insurance company gives us while trying to “qualify” your coverage. Your insurance contract is between you and your insurance company. These office do not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter a dispute with an insurance company over the amount of reimbursement.

Signature of patient or personal representative

Date