Vaughn
Chiropractic

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Waterford, MI 48329
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____________________

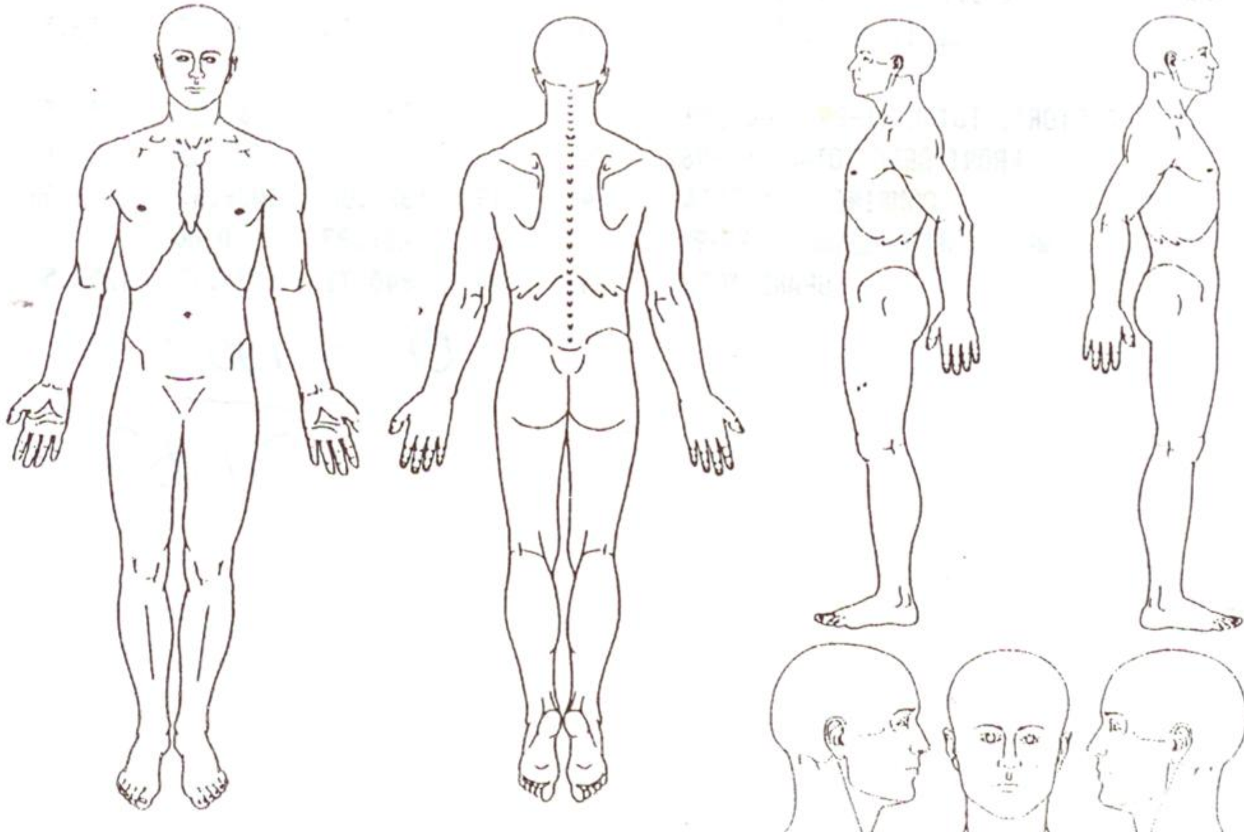
Please check any of the following that you have experienced within the last 6

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

PAIN DISABILITY INDEX QUESTIONAIRE

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?

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

2. What describes the nature of your symptoms?

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

3. How are your symptoms changing?

- o Getting better
- o Not changing
- o Getting worse

4. Have you had similar symptoms in the past?

- o Yes
- o 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 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 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 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 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 6- CONCENTRATION
A. I can concentrate fully when I want to with no difficulty
B. I can concentrate fully when I want to with alight 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 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 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 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 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 deductable 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