

**MAYSVILLE / GEORGETOWN**  
**Family Chiropractic Case History/Patient Information**

Date: \_\_\_\_\_ Patient # \_\_\_\_\_ Doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Age: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Marital: M S W D Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Spouse: \_\_\_\_\_ Spouse Occupation: \_\_\_\_\_ Spouse Birth Day: \_\_\_\_\_

How many children? \_\_\_\_\_ Names and Ages of Children: \_\_\_\_\_

Name of Nearest Relative: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_ When doctors work together it benefits you.

May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_ YES \_\_\_\_\_ NO

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company (if any): \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

Chief Complaint: Purpose of this appointment: \_\_\_\_\_

Date symptoms appeared or accident happened: \_\_\_\_\_

Is this due to: Auto \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

Have you ever had the same or a similar condition?  Yes  No If yes, when and describe: \_\_\_\_\_

\_\_\_\_\_

Days lost from work: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

<input type="checkbox"/> Broken/Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Depression
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Coughing Blood			

Do you have a history of stroke or hypertension? \_\_\_\_\_

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year?  Yes  No If yes, describe: \_\_\_\_\_

\_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Do you have any allergies to any medications?  Yes  No If yes, describe: \_\_\_\_\_

Do you have any allergies of any kind?  Yes  No If yes, describe: \_\_\_\_\_

Please list any other health problems you have, no matter how insignificant they may be: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY:**

Do you drink alcoholic beverages? \_\_\_\_\_ If so, how much per week? \_\_\_\_\_ Do you use any tobacco products? \_\_\_\_\_ Do you smoke? \_\_\_\_\_

If so, packs per day: \_\_\_\_\_ Do you take vitamin supplements? \_\_\_\_\_ If so, please list: \_\_\_\_\_

Do you consume caffeine? \_\_\_\_\_ If so, how much per day: \_\_\_\_\_ Do you exercise? \_\_\_\_\_ If yes, what is the frequency and type of exercise? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting \_\_\_\_\_ sitting \_\_\_\_\_ bending \_\_\_\_\_ working at a computer \_\_\_\_\_

**FAMILY HISTORY:**

Parents:

Father: living \_\_\_ deceased \_\_\_ Current age if still living: \_\_\_ Cause of /age at death if deceased: \_\_\_\_\_

Mother: living \_\_\_ deceased \_\_\_ Current age if still living: \_\_\_ Cause of /age at death if deceased: \_\_\_\_\_

Check if applicable to you: \_\_\_\_\_ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: \_\_\_\_\_

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

\_\_\_ Tuberculosis    \_\_\_ Cancer    \_\_\_ Mental Illness    \_\_\_ Diabetes    \_\_\_ Asthma    \_\_\_ Heart Disease    \_\_\_ Lung Disease    \_\_\_ Arthritis  
\_\_\_ Kidney Disease    \_\_\_ Stroke    \_\_\_ Liver Disease    \_\_\_ Other \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case:

- Major Medical       Medicaid       Medicare       Worker's Comp       Auto Accident       Medical Savings Account & Flex Plans
- Other \_\_\_\_\_

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

\_\_\_ INITIAL

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: <http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf>

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment. 2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions. 3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services. 4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. 5. Patients have the right to file a formal complaint with our privacy official about any suspected violations. 6. This office has the right to refuse treatment if the patient does not accept the terms of this policy. \_\_\_ INITIAL

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays. The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor. \_\_\_ INITIAL

By initialing and signing this form, the patient states to the best of their knowledge there is no pregnancy, neither confirmed nor suspected at the time this service was rendered. \_\_\_ INITIAL

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time. \_\_\_ INITIAL

Patient understands that they are responsible for payment to Family Chiropractic and that they are responsible for any and all collection costs in addition to their bill that may arise, including collections fees, court costs and reasonable attorney fees should action be taken. Accounts 90 days past due are subject to interest of 1 ½% per month on the unpaid balance. Patient hereby releases and forever discharges the aforesaid Doctor of Chiropractic from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment.

\_\_\_ INITIAL

By initialing and signing this form, the patient gives their permission to be contacted via Telephone, Text Message and/or Email for Appointment Reminders, Promotions and Well-Wishes. We will keep this information private for the sole use of Healing Hands, Inc.

\_\_\_ INITIAL

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

# Neck Pain and Disability Index (Vernon-Mior)

Patient Name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

## 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, for example 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 lift very light weights.
- I cannot lift or carry anything at all.

## SECTION 4 – READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want to 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.

## SECTION 5 – HEADACHES

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which 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't 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 pain in my neck.
- 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.

Pain Severity Scale: Rate the Severity of your pain by checking one box of the following scale.

No Pain

0	1	2	3	4	5	6	7	8	9	10
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Excruciating Pain

Patient Signature \_\_\_\_\_

# Low Back Pain and Disability Questionnaire (Revised Oswestry)

Patient Name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

## 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 moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

## SECTION 2 – PERSONAL CARE

- 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 causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I 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.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than half hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

## SECTION 6 - STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

## SECTION 7 – SLEEPING

- I get not 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, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

## SECTION 9 – TRAVELLING

- I get no pain whilst travelling.
- I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

## SECTION 10 – CHANGING DEGREE 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 improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Pain Severity Scale: Rate the Severity of your pain by checking one box of the following scale.

No Pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Excruciating Pain

Patient Signature \_\_\_\_\_

**ASSIGNMENT OF MEDICAL BENEFITS &  
INFORMED CONSENT**

I understand that **my doctor is submitting my x-rays to Midwest Radiology Consultants for radiological evaluation.** I also understand that the fee for such services will be submitted to my insurance company, workers' compensation carrier, or my attorney.

**I authorize my insurance company to pay directly to Midwest Radiology Consultants for services rendered.**

In the event my insurance company, attorney, or workman's compensation carrier does not reimburse for the fee in full, or if I do not have insurance coverage, **I agree that I am directly responsible for the charges or any unpaid portion.** Returned checks for insufficient funds will be assessed a \$20.00 service charge. *Accounts delinquent by 90 days from the time of my 1<sup>st</sup> billing statement may be placed with a legal collection agency. I am fully responsible for all collection costs unless prior payment arrangements have been made with Midwest Radiology Consultants.*

I understand that Dr. Doran L. Nicholson is not a participating provider in my insurance plan and that his services may not be covered by my insurance. *I also understand that this service is not covered by Medicare or Medicaid.*

**In the event that my insurance company sends payment directly to me, I agree to promptly remit such payments to Midwest Radiology Consultants.**

**Patient Signature:**

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(Patient, Parent or Guardian)

**Date:** \_\_\_\_\_

**MIDWEST RADIOLOGY CONSULTANTS**  
706 NE Langsford Rd.  
Lee's Summit, MO 64063  
Phone: 816 525-2822  
800-454-2822  
Doran L. Nicholson, D.C., D.A.C.B.R.

**MIDWEST  
RADIOLOGY  
CONSULTANTS**

**706 N.E. LANGSFORD RD. (P.O. BOX 1122)  
LEE'S SUMMIT, MO 64063  
PHONE: 816 525-2822 FAX: 816 525-4540**

**Doctor Information:**

**Maysville Family Chiropractic  
Dr. Rita Goldman  
1335 Southgate Plaza  
Maysville, KY 41056**

**Results Requested:**  Phone: 606-564-4213

Fax: 606-564-4406

E-Mail \_\_\_\_\_

<p><b>Trauma? Y <input type="checkbox"/> N <input type="checkbox"/> Explain:</b></p> <p><b>Malignancy? Y <input type="checkbox"/> N <input type="checkbox"/> Explain:</b></p> <p><b>Areas of Concern:</b></p>
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**Payment:**  Payment Enclosed  Bill Patient  Insurance  Work Comp  PI  Auto Accident

(Date of Accident: \_\_\_/\_\_\_/\_\_\_)

**CONFIDENTIAL**

PATIENT INFORMATION		INSURED PARTY
Name:		Name:
Street:		Street:
City/State/Zip:		City/State/Zip:
Phone:	M <input type="checkbox"/> F <input type="checkbox"/>	Phone:
Soc. Sec. #	Date of Birth:	Relation to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

INSURANCE INFORMATION		SECONDARY INSURANCE	
Company & Adjustor Name:		Company & Adjustor Name:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone #	Claim #	Phone #	
Group #	Policy / ID #	Claim #	Group#

ATTORNEY INFORMATION		WORKER'S COMPENSATION CARRIER	
Name		Company Name:	
Street:		Street:	
City/State/Zip:		City/State/Zip:	
Phone:		Phone	Claim#