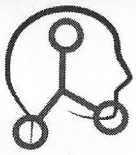


THE HEAD AND NECK
CENTERS OF EXCELLENCE
FOCUSED CARE FOR HEAD, NECK, & TMJ COMPLAINTS

The Head & Neck Centers Of Excellence Patient Qualification Intake Form

Welcome to The Head & Neck Centers Of Excellence by Dr. Smith Chiropractic. To accurately assess you and to determine if you are a true candidate for our care, it is important that you fill out this form as thoroughly as possible. Thank You.

Today's Date _____

PERSONAL INFORMATION

Name _____ Age _____ Birthday _____ Sex M F

Address _____ Social Security Number _____

City_____ State _____ Zip Code _____

Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Place to Reach You (circle one) Home / Work / Cell May we leave a voicemail message for you? Yes No

Employer _____Occupation_____ Length of Employment _____

Marital Status S M W D Spouses Name _____

REFERRAL

How did you hear about The Head & Neck Centers Of Excellence ? _____

INSURANCE INFORMATION

Do you have health insurance? ☐ No ☐ Yes - if yes, please continue

Insurance Company _____ Address _____

Group Number _____ Member ID: _____ Ins. Phone Number _____ - _____ - _____

Are you covered by any additional insurance? ☐ No ☐ Yes - if yes, please continue

Policy holder's name _____ DOB ____/____/____

Insurance Company _____ Address _____

Group Number _____ Member ID: _____ Ins. Phone Number _____ - _____ - _____

Payment acknowledgement (please sign). I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and myself. I also understand that this office will prepare any forms and reports necessary to assist me in making a collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on my receipt. However, I clearly understand and agree that all services rendered to 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 treatment, any fees for professional services rendered to me or my dependent will be immediately due and payable.

Patient's Signature _____ **Date** _____

Insured's Signature _____ **Date:** _____

THE HEAD AND NECK CENTERS OF EXCELLENCE

FOCUSED CARE FOR HEAD, NECK, & TMJ COMPLAINTS

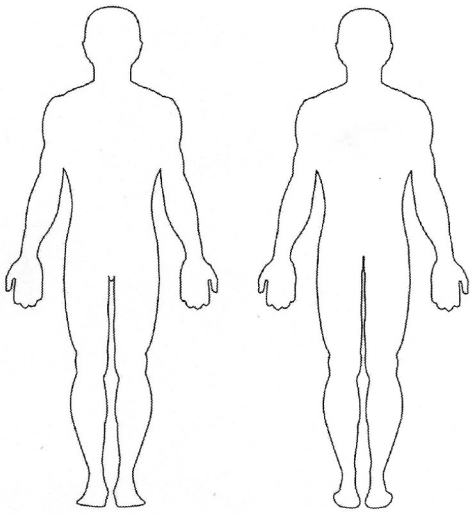
What symptoms are you experiencing? _____

Would you consider this problem to be (circle one):

MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

Please indicate areas of pain using the chart below:

Front Back



1. What do you think is causing the pain?

_____

_____

2. Since your pain became this severe what are some activities that you are not able to do?

_____

_____

3. How has your life changed since your condition became a problem?

_____

_____

THE HEAD AND NECK CENTERS OF EXCELLENCE

FOCUSED CARE FOR HEAD, NECK, & TMJ COMPLAINTS

4. What kind of treatments have you received?

Physical Therapy: How Long _____ When(approx) _____

Medication(s): _____ When(approx) _____

Surgery: Type_____ When(approx) _____

Other_____

5. When did you receive these treatments and for how long?

_____

_____

6. Did any of these treatments work? If so which one(s)? For how long?

_____

_____

7. What activities/movements are guaranteed to make it worse?

_____

_____

8. Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...)

_____

_____

9. Is it worse in the morning or is it worse as the day progresses?

_____

_____

10. When is the VERY FIRST time you recall having this problem?

_____

_____

THE HEAD AND NECK CENTERS OF EXCELLENCE

FOCUSED CARE FOR HEAD, NECK, & TMJ COMPLAINTS

Due to Your Main Problem.....

Have you lost any time from work?

_____

How much time and what tasks have been limited?

_____

Have you been able to complete chores/tasks at home?

_____

Have you lost any time with your family?

_____

Have you been able to partake in your leisure activities? (Hobbies, Travel, Sports, etc...)

_____

Considering the amount of pain/discomfort you have had THIS week, how long has your problem been this severe?

_____

Average pain intensity:

Last 24 hours: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

List ANY surgeries that you have had and the corresponding dates:

_____

_____

List ANY medications you are currently taking, along with their dosages:

_____

_____

Signature: _____ **Date:** _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

MEDICAL HISTORY

Please check the appropriate symptoms or conditions that you are experiencing now.

GENERAL
- ☐ Allergies
- ☐ Weight loss
- ☐ Weight gain
- ☐ Skin irritation
- ☐ Sweats
- ☐ Tremors
- ☐ Chills
- ☐ Fever

NEUROLOGICAL
- ☐ Convulsions
- ☐ Dizziness
- ☐ Nausea
- ☐ Numbness
- ☐ Tingling/burning
- ☐ Nervousness
- ☐ Depression
- ☐ Headaches
- ☐ Muscle weakness

MUSCLE & JOINT
- ☐ Shoulder
- ☐ Mid-back pain/stiffness
- ☐ Knee
- ☐ Hip
- ☐ Elbow
- ☐ Neck pain/stiffness
- ☐ Ankle/foot
- ☐ Spinal curvature
- ☐ Hand/wrist
- ☐ Low-back pain/stiffness

GENITO-URINARY
- ☐ Kidney stones
- ☐ Urinary tract infections
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Inability to control urination

GASTROINTESTINAL
- ☐ Gallbladder
- ☐ Liver trouble
- ☐ Vomiting blood
- ☐ Hernia
- ☐ Blood in stool
- ☐ Other_____

_____

RESPIRATORY
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Spitting up blood
- ☐ Asthma
- ☐ Coughing
- ☐ Other_____

_____

CARDIOVASCULAR
- ☐ Hardening of arteries
- ☐ Poor circulation
- ☐ High blood pressure
- ☐ Cold extremities
- ☐ Swelling of ankles
- ☐ Other_____

_____

EYES, EARS, NOSE, & THROAT
- ☐ Enlarged glands
- ☐ Deafness/loss of hearing
- ☐ Enlarged thyroid
- ☐ Trouble speaking
- ☐ Difficulty swallowing
- ☐ Poor balance
- ☐ Blurred vision
- ☐ Other_____

_____

FOR WOMEN ONLY
- ☐ Hot flashes
- ☐ Irregular menstrual cycle
- ☐ Menopausal symptoms
- ☐ Lumps in breasts
- ☐ Other_____

_____

Are you pregnant?
☐ Yes ☐ No
If yes, are you breastfeeding?
☐ Yes ☐ No

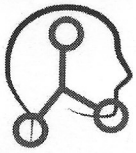
OTHER (specify any additional or unmentioned symptoms/conditions)

_____
_____
_____
_____
_____
_____
_____

Please circle any of the following conditions you presently have, or have had in the past.

ALCOHOLISM	EMPHYSEMA	RHEUMATIC FEVER	CANCER	TUBERCULOSIS
PNEUMONIA	ULCERS	POLIO	ANEMIA	OTHER - specify
STROKE	ARTERIOSCLEROSIS	GOUT	EPILEPSY	_____
HEART DISEASE	OSTEOPOROSIS	ARTHRITIS	DIABETES	_____

Signature_____ **Date**_____



THE HEAD AND NECK CENTERS OF EXCELLENCE

FOCUSED CARE FOR HEAD, NECK, & TMJ COMPLAINTS

Notice of Privacy for: Patient's Protected Health Information

This notice describes how health care information about you may be used, disclosed and how you can get access to this information. Please review carefully.

This office abides by the terms described in this policy:

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies for Workers Compensation to verify that treatment has been rendered.
- To determine a patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Emergency situations
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-in sheets may be disclosed to verify office visits.
- To send out birthday cards and newsletters.

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization in writing at any time by specifying what you want to be restricted and to whom.
- Speak to our privacy officer regarding privacy issues.
- Inspect, copy, and amend your protected health information.
- To render a complaint to our privacy officer.

This office reserves the right to change the terms of this notice and make new notice provisions for all protected health information that it maintains. Patients may also request an updated copy at any time upon request from a staff member.

I acknowledge that I have received and reviewed this notice with full understanding.

Patient's Signature _____ **Date** _____

Patient Name _____ **File No:** _____

(Staff use only)

THE HEAD AND NECK CENTERS OF EXCELLENCE

FOCUSED CARE FOR HEAD, NECK, & TMJ COMPLAINTS

ASSIGNMENT OF BENEFITS

I authorize and direct that payment be made directly to Dr. Andrew Smith for any and all insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance or pre-paid healthcare plan.

_____ _____

Date Patient / Legal Guardian Signature

AUTHORIZATION AND CONSENT

I authorize the release of any information concerning my health and health care services to my insurance company(s), pre-paid health plan, or Medicare.

_____ _____

Date Patient / Legal Guardian Signature

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance company(s) or pre-paid health plan will cover or pay for all my charges. No withstanding denials, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

_____ _____

Date Patient / Legal Guardian Signature

THE HEAD AND NECK
CENTERS OF EXCELLENCE
FOCUSED CARE FOR HEAD, NECK, & TMJ COMPLAINTS

INFORMED CONSENT

Doctor - Patient Relationship in Chiropractic

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, osteopathy, and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such complexes are found, Chiropractic adjustments and ancillary procedures may be given to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherited recuperative powers. Due to the complexities of nature, no doctor can promise you specific results.

DIAGNOSIS

Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, though they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her total condition. Your doctor may express an opinion as to whether you should take this step or not, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

The patient seeking Chiropractic care gives the doctor full permission to care for the patient in accordance with all testing, diagnosis and analysis performed. Chiropractic adjustments and other clinical procedures offered are generally successful. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor will not perform a Chiropractic adjustment or any other procedure if he/she is aware of any such risk. It is the full responsibility of the patient to make it known, or seek health care procedures to determine, whether he/she is suffering from: latent pathological defect, illnesses, or deformities which the Chiropractor would not otherwise be aware of. The patient should seek the appropriate specialist for any diagnostic and clinical procedures. The doctor of Chiropractic is licensed in a specialized practice and may collaborate with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic care is to promote natural health through the reduction of VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficiency of the Chiropractic procedures. In most cases, the response is gradual. Chiropractic and medicine may never be exact in providing answers to all conditions, but will make strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or concerns you may have with the doctor. Your signature below indicates that you have read, understand, and agree with the terms of the doctor-patient relationship in chiropractic.

Patient's Signature _____ **Date** _____