Patient Information

Date:_____/_____/_____

Name: DOB:

Address:

Town: State: Zip:

Home Phone: Cell #:

E-mail address:

Social Security # - -

Marital Status:

Emergency Contact:

Relation: Phone:

Occupation:

Primary Care MD:

Permission to send treatment notes: Yes NO

Office Policies - Health First Rehab, Inc.

Informed Consent to Treatment

By signing below, I consent to the services being rendered during this visit by Dr. Joshua Lindauer, DC or any other chiropractic physician who now or in the future treat me while employed by, working or associated with or covering for Dr. Lindauer, DC. I am informed that there are some rare but potential risks to chiropractic manipulative therapy, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on 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. I have been informed of possible alternative therapies. No guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Privacy Notice Acknowledgement

In accordance with the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***, by signing below, I acknowledge that a copy of the Notice of Privacy Practices for Protected Health Information for this office has been made available to me. I am advised to read this document carefully, for it outlines the use and limitations of the disclosure of my health information and my rights as a patient. I have been given the opportunity to ask any questions that I may have regarding these policies.

Authorization to Release Medical Information

I authorize my healthcare provider(s) to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my information to this provider for continuing care.

Massage Therapy Non-Covered Service Waiver

Massage therapy services performed by a licensed massage therapist in this office are not a covered benefit under your current health plan, as these procedures are not performed directly by a participating physician/provider.

There is a fee of ***$8.00*** per visit for this service. **_____Initial**

Authorization for Direct Payment of Insurance Benefits

I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering any services during this visit of any insurance benefits otherwise payable to me.

Health Insurance/Patient Payment Policy

We will to file your insurance claims for you. However, we cannot guarantee or take responsibility for what your health insurance will or will not cover. Ultimately, all services rendered to you are charged directly to you and you are personally responsible for payment. Payment for all services, including copays, coinsurance and deductibles, are expected at the time of service unless prior arrangement are made with us. **If you have a cash balance with our office greater than *45 days*, there will be a finance charge of *5% per month applied to your account***.

Treatment Compliance. Appointment Cancellation Policy

We require a 24 hour notice for appointment cancellations. Health First Rehab, Inc. reserves the right to charge ***$40.00*** for the missed visit if this policy is abused. This amount is not covered by any insurance plan and will be the patient's responsibility. Further, **greater than 2 missed appointments will be considered non-compliance and subject to discharge from care**.

_____Initial

I have read the Health First Rehab, Inc. office policies and will honor them:

_____	_____	_____
Print Name	**Patient Signature**	**Date**

WORK INJURY QUESTIONNAIRE

NAME: _____ Date of Injury:

Occupation: _____ Employer: _____

Describe the accident in your own words:

(ie. What you were doing, extenuating circumstance, environmental hazards, be detailed and specific)

Did you feel pain immediately following accident? □ Yes □ No

Please describe: _____

Was anyone else involved in this incident? □ Yes □ No Name(s): _____

Were there any witnesses present? □ Yes □ No Name(s):

_____

Has injury been reported? □ Yes □ No To Whom: Name: _____Title:

_____

Were you taken to the hospital? □ Yes □ No Were you admitted? □ Yes □ No if yes, how long? _____

If you went to hospital, when? □ At time of accident □ Next day

How did you get to hospital? □ Ambulance □ Police Car □ Private Transportation

Name of Hospital:_____

Attended by Dr. _____

é What treatment was given?

☐ none ☐ placed in a cervical collar ☐ X-rays ☐ Bandage/ Stitches: region _____

☐ given pain medication/muscle relaxants: please list:_____

☐ given home instructions: explain:_____

Referral: ☐ Orthopedist/Surgeon ☐ Neurologist ☐ Physical Therapy ☐ Primary Care

Name of Physician: _____

Have you seen any other doctor as a result of this accident? □ Yes □ No

Physician:	Date (s) of Service:	Treatment Given:
1.		
2.		
3.		

Are you still under care of any of these physicians: □ Yes □ No Whom? _____

Have you lost any time from work due to your injuries? □ Yes □ No

If yes, please give dates: _____

Are your work activities presently restricted due to this accident? □ Yes □ No

If yes, please describe: _____

Are your daily activities presently restricted due to this accident? □ Yes □ No

If yes, please describe: _____

PAST MEDICAL AND ACCIDENT HISTORY

Have you ever had a work comp claim previously? □ Yes □ No
If yes, please describe: _____
_____

Have you ever had same or similar symptoms? □ Yes □ No
If yes, please describe: _____
_____

Have you had previous injuries or accidents? □ Yes □ No
If yes, Date and Description of previous Accident(s), if applicable:

Date:_____ Injuries: _____ Treatment: _____
Date:_____ Injuries: _____ Treatment: _____
Date:_____ Injuries: _____ Treatment: _____

Do you have any residual pain from the previous injury? □Yes □No
How much better did you feel prior to current accident/condition? (Example 100%, 80% etc.) _____%

Please provide a description of past medical history: (give dates and treatment received)
□ None
Major injuries: _____
Major Illnesses: _____
Surgeries: _____

Are there any additional comments/concerns regarding your condition which you wish to discuss? □Yes □No
If so, please explain: _____
_____

Patient Signature: _____ Date:

Health First Rehab, INC

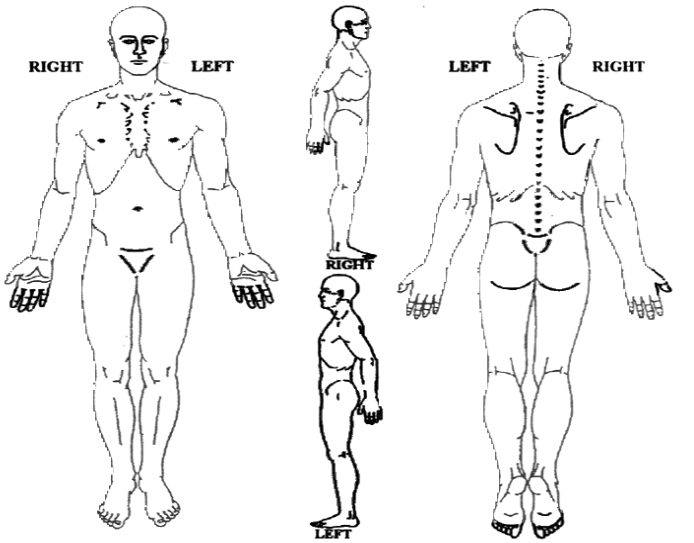
PATIENT PAIN FORM

Patient: _____ **Date of Birth:** _____ **Today's Date:** _____

Date of Injury (if applicable): _____

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



Problem List: **(This Section for Office Use Only)**

MOI:

1. _____
NRS: /10
Px w/ cough:
RR:
N/T/W:
BB fxn:

2. _____
NRS: /10
Px w/ cough:
RR:
N/T/W:
BB fxn:

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Pain)

_____
Patient Signature

I experience the above symptoms: ☐ Constantly ☐ Very Often ☐ Occasionally ☐ Infrequently

I feel that my symptoms are: ☐ Getting Better ☐ Getting Worse ☐ Staying About the Same

My symptoms are: ☐ Sharp/Stabbing ☐ Dull, Achy ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Burning ☐ Other:

Symptoms radiate/refer to my: ☐ head ☐ shoulders ☐ arms ☐ Hips ☐ buttocks ☐ Legs

Symptoms are worse with: ☐ Standing ☐ Sitting ☐ Driving ☐ Bending ☐ Lifting ☐ Work Activity ☐ Other, please explain:

Symptoms are relieved with: ☐ Rest/Lying down ☐ Ice ☐ Heat ☐ Stretching ☐ Movement ☐ Other, please explain:

I am unable to perform the following activities due to pain:

List current medications/Supplements: ☐ See current medication list provided

1. 2. 3. 4. 5.

I am experiencing the following symptoms (please check all that apply) :

☐ Shortness of breath	☐ Nausea /Vomiting	☐ Difficulty sleeping
☐ Difficulty breathing	☐ Fevers / Chills	☐ Difficulty concentrating
☐ Pain with coughing	☐ Light-headed, dizziness	☐ Memory problems
☐ Bowel/bladder changes	☐ Visual changes	☐ Mood swings, irritability
☐ Urinary incontinence	☐ Hearing changes	☐ Loss of appetite/Weight loss
☐ Blood in stool	☐ "Foggy/Hazy" feeling	☐ Fatigue
☐ Other symptoms:		

Neck Index

ChiroCare of Wisconsin, Inc.

ChiroCare use Only rev 1/15/99

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

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ 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.

Personal Care

- ☐ 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 I 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.

Sleeping

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

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, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty concentrating when I want.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☐ I can only do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

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.

Calculate Score

Neck Index Score

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

Back Index

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/15/99

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

- ☐ 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 very severe and does not vary much.

Sleeping

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

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 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Standing

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

Walking

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

Personal Care

- ☐ I do 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 increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases 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.

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 can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

Traveling

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

Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect 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.

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.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Calculate Score

Back Index Score

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