

Stubbendieck Chiropractic & Rehabilitation Registration and History

Patient Information (Social Security#: _____) Patient HR#: _____	
LastName _____ FirstName _____	
Address _____ City/State/Zip _____	
Home Phone (#) _____ Email _____ Driver's License # _____	
Cell Phone (#) _____ Cell Phone Provider _____	
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birth date _____ <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
Employer _____ Occupation _____	
Spouses Name _____ DOB _____ Spouses Employer _____	
Primary Care Physician? _____ Address/Phone _____	
Permission to send Health information to this Provider? Y/N	
Whom may we thank for referring you to this office? _____	
Insurance Assignment and Release *(Must provide copy of Insurance Card and Photo ID; Copies provided _____)	
Primary Insurance _____ Secondary Insurance _____	
I certify that I, and/or my dependent(s), have coverage with the Insurance company listed above and assign directly to Stubbendieck Chiropractic, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. The above-named entity may share my health information with the above-named Insurance Company(ies) for the purpose of obtaining payment and determining benefits for related services. X _____	
As a courtesy, we will verify your benefits. We highly encourage you to double-check your benefits as we are often misquoted by customer service representatives. X _____	

Person to contact in case of emergency:

Name: _____
 Phone: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Stubbendieck Chiropractic, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature _____ Date _____

Health History

Is the condition due to an accident? ☐ Yes* ☐ No Date: _____ Type? ☐ Auto ☐ Work ☐ Home ☐ Other
 (*If yes, must complete PI or Work Comp Forms)

To whom have you made a report? ☐ Auto Insurance ☐ Employer ☐ Workers Comp ☐ Other

Claim Number _____ Insurance Phone Number _____ Attorney Name _____

Have you received any of the following treatments for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other: _____

Name and Address of other doctor(s) who have treated your condition _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____ Spinal Exam _____ Chest X-ray _____

Urine Test _____ Dental X-ray _____ MRI, CT-Scan, Bone Scan _____

Please Circle to indicate if you have had any of the following:

AIDS/HIV	Appendicitis	Arthritis	Asthma	Bleeding Disorders
Bronchitis	Cancer	Diabetes	Emphysema	Epilepsy
Fractures	Gout	Heart Disease / (HBP)	Hepatitis	Hernia
Herniated Disc	Herpes	High Cholesterol	Kidney Disease	Liver Disease
Migraines	Miscarriage	Multiple Sclerosis	Osteoporosis	Pacemaker
Parkinson's	Pinched Nerve	Pneumonia	Polio	Prosthesis
Psychiatric Care	Rheumatoid Arthritis	Stroke	Thyroid Problems	Tonsillitis
Tuberculosis	Tumors, Growths	Typhoid Fever	Ulcers	Metal, Mechanical, Electrical Implants
Other (write in):				

Family History please check all that apply: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke

☐ Rheumatoid Arthritis ☐ Other _____

Social History please check all that apply:

Exercise

☐ None ☐ Moderate
☐ Light ☐ Heavy
☐ Coffee/Caffeine Cups/Day _____

Work Activity

☐ Sitting ☐ Standing
☐ Light Labor ☐ Heavy Labor

Habits

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Any Challenges with Pregnancy? _____

Head Injuries _____

Broken Bones/Dislocations _____

Illness/Disease _____

Surgeries (include year) _____

Other

Please list any/all that apply below or provide a list:

Medications	Allergies	Vitamins/Herbs/Minerals

Patient Name: _____ Date: _____ HR#: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary: _____ Secondary: _____

Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____

When is the problem at its worst?(check) ___AM ___PM ___Mid-day ___Late PM

How long does it last? _____ It is constant _____ (OR) I experience it on and off during the day _____

(OR) It comes and goes throughout the week _____

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ___No ___*Yes (*If yes,) When: _____ (date)

Type of Treatment _____

How long were you under care: _____ What were the results _____

Have you ever been under Chiropractic Care? Y N If Yes, Name of Dr. _____

When/Purpose/Results? _____

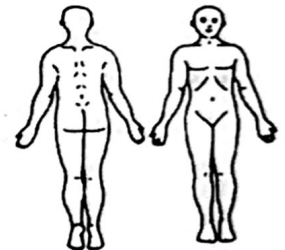
What relieves your symptoms? _____

What makes your symptoms feel worse _____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

Describe your symptoms/onset/injury: _____



LIST RESTRICTED ACTIVITY

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

Additional Restrictions: _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

Patient Name: _____ Date: _____ HR#: _____

Stubbendieck Chiropractic and Rehabilitation Centers

257 S. Court St., Suite 5-A, Medina, OH 44256 Phone: (330) 725-4060 Fax: (330) 722-4582

197 N. Pardee St., Wadsworth, OH 44281 Phone: (330) 334-1641

Patient Name: _____ Date: _____ HR#: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. **There are often** topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Stubbendieck Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

***Women Only:**

*To the best of my knowledge (I am / am NOT) pregnant and (give my permission / don't give permission) to x-ray me for diagnostic interpretation. (Circle one above) (Circle one above)

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit. Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged \$30 - \$60

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [] No []

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Back Index

Form BI100

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

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ 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

Form N1-100

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

- ① I have no pain at the moment.
- ② The pain is very mild at the moment.
- ③ The pain comes and goes and is moderate.
- ④ The pain is fairly severe at the moment.
- ⑤ The pain is very severe at the moment.
- ⑥ The pain is the worst imaginable at the moment.

Sleeping

- ① I have no trouble sleeping.
- ② My sleep is slightly disturbed (less than 1 hour sleepless).
- ③ My sleep is mildly disturbed (1-2 hours sleepless).
- ④ My sleep is moderately disturbed (2-3 hours sleepless).
- ⑤ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑥ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ① I can read as much as I want with no neck pain.
- ② I can read as much as I want with slight neck pain.
- ③ I can read as much as I want with moderate neck pain.
- ④ I cannot read as much as I want because of moderate neck pain.
- ⑤ I can hardly read at all because of severe neck pain.
- ⑥ I cannot read at all because of neck pain.

Concentration

- ① I can concentrate fully when I want with no difficulty.
- ② I can concentrate fully when I want with slight difficulty.
- ③ I have a fair degree of difficulty concentrating when I want.
- ④ I have a lot of difficulty concentrating when I want.
- ⑤ I have a great deal of difficulty concentrating when I want.
- ⑥ I cannot concentrate at all.

Work

- ① I can do as much work as I want.
- ② I can only do my usual work but no more.
- ③ I can only do most of my usual work but no more.
- ④ I cannot do my usual work.
- ⑤ I can hardly do any work at all.
- ⑥ I cannot do any work at all.

Personal Care

- ① I can look after myself normally without causing extra pain.
- ② I can look after myself normally but it causes extra pain.
- ③ It is painful to look after myself and I am slow and careful.
- ④ I need some help but I manage most of my personal care.
- ⑤ I need help every day in most aspects of self care.
- ⑥ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- 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.
- ⑥ I cannot lift or carry anything at all.

Driving

- ① I can drive my car without any neck pain.
- ② I can drive my car as long as I want with slight neck pain.
- ③ I can drive my car as long as I want with moderate neck pain.
- ④ I cannot drive my car as long as I want because of moderate neck pain.
- ⑤ I can hardly drive at all because of severe neck pain.
- ⑥ I cannot drive my car at all because of neck pain.

Recreation

- ① I am able to engage in all my recreation activities without neck pain.
- ② I am able to engage in all my usual recreation activities with some neck pain.
- ③ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ④ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ⑤ I can hardly do any recreation activities because of neck pain.
- ⑥ I cannot do any recreation activities at all.

Headaches

- ① I have no headaches at all.
- ② I have slight headaches which come infrequently.
- ③ I have moderate headaches which come infrequently.
- ④ I have moderate headaches which come frequently.
- ⑤ I have severe headaches which come frequently.
- ⑥ 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