Confidential Patient Health Record

Date	I. D. #

Please complete this questionnaire. This confidential history will be part of your permanent records.

First Name: _____**M.I**._____ **Last** _____Nick Name: _____

Address: _____City: _____ State: ___ Zip: _____

Social Security #: _____ Sex: ☐ M ☐ F _____ Marital Status: ☐ M ☐ S ☐ D ☐ W

Spouse's Name: _____ Language ☐ English ☐ Spanish ☐ Other _____

Ethnicity ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Choose not to specify ☐ Other _____

Birthday _____ **Phone:** _____ **Cell:** _____ **Receive text alerts:** Yes ☐ No ☐

Email: _____ Contact Method *(check one)* ☐ Primary Phone ☐ Cell ☐ Email

Name and Number of Emergency Contact: _____ Relationship _____

Who referred you to us? _____How else did you hear about us? _____

Payment ☐ Cash ☐ Insurance ☐ Auto ☐ Medicare ☐ Medicaid ☐ Work Comp

1.Insured Persons Name: _____ Birthday _____ Relationship ☐ Self ☐ Spouse ☐ Parent

2.Insured Persons Name: _____ Birthday _____ Relationship ☐ Self ☐ Spouse ☐ Parent

Name of Family Physician _____

Current Medications, Including Dosage if known. If on blood thinners, check here: ☐

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List any known Allergies you have had to any medications. If **NO** allergies are known, check here: ☐

1. _____ 3. _____
2. _____ 4. _____

List any surgeries.

1. _____ 3. _____
2. _____ 4. _____

FAMILY HISTORY: Have You or Any Member of Your Family Ever Been Told They Have:

Family	Headaches	Back Problems	Neck Problems	High Blood Pressure	Diabetes	Heart Problems	Lung Problems	Cancer	Other
Mother									
Father									
Sister									
Brother									
Spouse									
Child									

SOCIAL HISTORY Check the boxes and fill in

Smoking ☐ Never been a smoker ☐ Former Smoker ☐ Current everyday smoker ☐ Current sometimes smoker

What is your level of interest in quitting smoking? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No interest *Very Interested*

Alcohol ☐ None ☐ Casual ☐ Moderate ☐ Heavy

Caffeine *(Coffee, Tea, Cola)* ☐ None ☐ <3 Drinks/day ☐ 3-6 Drinks/day ☐ >6 Drink/day

Drugs Use ☐ None ☐ Recreational ☐ Addicted **Exercise** ☐ None ☐ Daily ☐ Weekly

Employment Status ☐ Employed ☐ FT Student ☐ PT Student ☐ Retired ☐ Disabled ☐ Other

Employer _____Occupation _____

What is your main complaint? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

Does any position make it feel **worse** (please list)? _____

Does any position make it feel **better** (please list)? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Daily Routine Other: _____

Other Doctors Seen for **THIS** condition _____

Review of Systems

Have you experience any of the following: (*Mark all that apply*)

General	**Eyes**	**Gastrointestinal**	**Endo/HEME/Allerg**
☐ Fever	☐ Blurred Vision	☐ Heartburn	☐ Easily bruise/bleed
☐ Chills	☐ Double Vision	☐ Nausea	☐ Environmental Allergies
☐ Weight Loss	☐ Pain with bright light	☐ Vomiting	☐ Excessive Thirst
☐ Fatigue	☐ Eye Pain	☐ Abdominal Pain	**Neurological**
☐ Excessive Sweating	☐ Eye Discharge	☐ Diarrhea	☐ Dizziness
☐ Weakness	☐ Eye Redness	☐ Constipation	☐ Tingling
Skin	**Cardiovascular**	☐ Blood in Stool	☐ Tremor
☐ Rash	☐ Chest pain	☐ Black, tarry stool	☐ Sensory change
☐ Itching	☐ Palpitations	**Genitourinary**	☐ Speech change
HENT	☐ Shortness of Breath	☐ Painful urination	☐ Focal Weakness
☐ Headaches	☐ Pain in legs with walking	☐ Urgency	☐ Seizures
☐ Hearing Loss	☐ Leg swelling	☐ Frequency	☐ Loss of Consciousness
☐ Ringing in ear	☐ Peripheral nerve Disease	☐ Blood in urine	**Psychiatric**
☐ Ear pain	**Respiratory**	☐ Flank Pain	☐ Depression
☐ Ear Discharge	☐ Cough	**Musculoskeletal**	☐ Suicidal ideas
☐ Nosebleeds	☐ Blood when cough	☐ General muscle pain	☐ Substance Abuse
☐ Congestion	☐ Sputum production	☐ Neck pain	☐ Hallucinations
☐ Stridor	☐ Shortness of Breath	☐ Back pain	☐ Nervous/Anxious
☐ Sore Throat	☐ Wheezing	☐ Joint pain	☐ Insomnia
		☐ Falls	☐ Memory Loss

1. Have you had any spinal surgeries? (please circle) **Yes or No**

   What part of your spine was operated on? (please circle) **Neck, mid back or lower back.**
   How many spinal surgeries have you had? _____
   What YEAR did you have the surgery or surgeries _____

2. Have you had injections or medical procedures done to your Neck or Back? (please circle) **Yes or No**

   What part of your spine? (please circle) **Neck, mid back or lower back**
   What procedures or injections did you have completed to your spine? _____
   When did you have the injections or procedures? _____
   How many times did you have the injections or procedures _____
   Did the injections or procedures help with your pain _____
   Who did the injections or procedures? _____

3. Have you ever done physical therapy? (please circle) **Yes or No**

   When was the last time you did physical therapy? _____
   What area of your body did you do physical therapy for? _____
   How many sessions or how many weeks did you go to physical therapy? _____
   Did physical therapy help reduce your pain? _____

4. Do you see a chiropractor? (please circle) **Yes or No**

   When was the last time you were seen by the chiropractor? _____
   What area of your body did you see the chiropractor for? _____
   How many sessions or how many weeks did you go to the chiropractor? _____
   Did the chiropractor help reduce your pain? _____

5. Have you ever had a spinal cord stimulator or a pain pump? (please circle) **Yes or No**

Comments _____
_____

_____

Patient Signature _____**Date** _____

Parent/Guardian (*Print)* _____ Signature _____ Date _____

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (We) hereby consent to the performance of examination and treatment on me or on _____ _____, by the licensed Doctor of Chiropractic, medical, and or licensed physical therapist who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy and chiropractic treatment. I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgement to attempt anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose and recommend the best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic, physical therapy, and medical procedures which rarely includes, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed by my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am **NOT** pregnant, nor is pregnancy suspected or confirmed at this particular time.

_____ _____

Patients Name (PRINT) **Patients Signature**

_____

Relationship or authority if not signed by patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____(PATIENTS NAME) acknowledge that I have been given an opportunity to receive and or review the Notice of Privacy Practices for Advanced Pain Management of Elwood, which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received, or maintained by the practice.

_____ _____

Date **Signature**

_____

Print Name

Responsible Prescribing for Chronic Pain

Indiana is currently experiencing an epidemic of prescription-controlled substance overdoses. According to the Nation Institute on Drug Abuse, 7 million Americans currently abuse prescription drugs-more than the number using cocaine, heroin, hallucinogens, and inhalants combined. Every 25 minutes someone dies from a prescription drug overdose. A 2011 Youth Risk Behavior survey of a group of high school students found more than 20 percent reported they had taken prescription drugs one or more times without a doctor's prescription. Indiana ranked second highest out of the 35 states where students were surveyed.

This is a public health crisis that affects everyone in our community. In order to respond to this epidemic our clinic is instituting the following controlled substance policies for all patients and providers:

- We **DO NOT** prescribe controlled substances at your **FIRST VISIT.** If you are going to run out of your medication at the time of this visit you need to discuss this with your current medication provider.
- We have absolutely No legal or medical obligation to "take over" prescribing a medication regimen started by another provider. At your first visit we will perform a chart review and a thorough history and physical and give our recommendations that may or may not include controlled substances.
- Multiple medical studies of controlled substances have shown that they can reduce chronic pain by most at 30%. Consequently, you should expect no more than 30% pain relief with controlled substances for chronic non-cancer pain.
- In our clinic the maximum prescribed dose for patients with non-cancer pain is 30mg morphine equivalent per day. Doses in excess of this can lead to a 9-fold increase in overdose death and therefore are not provided.
- Methadone deaths exceed all other controlled substance deaths combined. As a result, we DO NOT provide prescriptions for methadone at this clinic.
- Monthly urine toxicology screenings will be performed on all patients receiving prescribed controlled substances. If you refuse to provide a urine sample, no controlled substances will be provided.
- Anyone receiving controlled substances from our clinic will be asked to sign a controlled substance contract. If you refuse to sign the contract or violate the contract in any way you will not be provided any controlled substances from our clinic.

Thank you for your understanding. Our goal to continue to provide responsible and compassionate care to you while ensuring the safety of our entire community.

My signature represents that I have read and understand the above controlled substance prescribing policy.

Name: _____ Date: _____

Signature: _____

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. If You Do **Not** Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated.

2. If You Have Insurance: All deductibles and co-payments are expected at the time of service only.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers but will be happy to provide a claim form for your secondary carrier.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If you carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

No Show Policy:

We understand that circumstance arise that do not allow you to keep your appointment. Please remember to be courteous to us by calling prior to your appointment time to cancel if you cannot make it. You may also leave a voicemail to cancel your appointment. If you do not call at least **24 hours prior** to your appointment a **$50 charge** will be assessed for each missed appointment. If you do not call at least **24 hours prior** to your scheduled pain management procedure such as injections, then a **$100 charge** will be assessed to your account. Insurance does **NOT** cover this fee. This fee will be due prior to scheduling your next appointment with any of the providers in this office. ***REMINDER CALLS ARE A COURTESY AND NOT REQUIRED.***

If you discontinue care or are discharged by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

_____

Print Name

_____ _____

Signature **Date**

Date _____

Patient Name _____

OPIOID RISK TOOL

Mark each box that applies

1. **Family History of Substance Abuse**		
	Alcohol	☐
	Illegal Drugs	☐
	Prescription Drugs	☐
2. **Personal History of Substance Abuse**		
	Alcohol	☐
	Illegal Drugs	☐
	Prescription Drugs	☐
3. **Age (Mark box if 16 – 45)**		☐
4. **History of Preadolescent Sexual Abuse**		☐
5. **Psychological Disease** (LISTED BELOW)		☐

- Attention Deficit Disorder
- Obsessive Compulsive Disorder
- Bipolar
- Schizophrenia
- Depression

OFFICE USE ONLY BELOW

TOTAL [ ]

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Signature _____ **Date** _____