

PATIENT INFORMATION FORM

Date: _____

Name: _____ Phone: () _____

Address: _____
Street City State Zip

Age: _____ Sex: M / F Birth date: _____ Marital Status: S / M / D / W

Social Security #: _____ Who referred you to our office? _____

Employer: _____ Occupation: _____

E-Mail Address: _____

If you have insurance, which covers chiropractic care, please provide us with the following information and present your insurance ID card:

Insurance Co.: _____ Insurance ID #: _____

Policyholder: _____ Relationship to patient: _____

What is your major complaint today? _____

When did you first notice your symptoms? _____

Is this condition due to an:

A. Auto Accident B. Work Injury C. Other Accident D. Unknown

Are the symptoms:

A. Improving B. Getting Worse C. About the Same D. Intermittent (comes & goes)

What activities aggravates the condition:

A. Standing B. Walking C. Sitting D. Lying Down E. Bending F. Lifting G. Twisting H. Coughing

Have you ever had these symptoms before? _____ If so, when: _____

Did you see another doctor for this condition:

A. Medical Doctor B. Chiropractor C. Orthopedic D. Acupuncturist E. Podiatrist F. Other

Doctors Name: _____ Date consulted: _____ Diagnosis: _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to my carrier and I may be personally responsible for payment if services are not covered.

Patients Signature _____ Date: _____

Patient Summary Form

PSF-750 (Rev. 2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Female
 Male

Patient name: Last [] First [] MI [] Patient date of birth: [] [] []

Patient address: [] [] [] City: [] [] State: [] Zip code: [] []

Patient insurance ID#: [] Health plan: [] Group number: []

Referring physician (if applicable): [] Date referral issued (if applicable): [] Referral number (if applicable): []

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form): [] 2. Federal tax ID(TIN) of entity in box #1: []

3. Name and credentials of the individual performing the service(s): []

4. Alternate name (if any) of entity in box #1: [] 5. NPI of entity in box #1: [] 6. Phone number: []

7. Address of the billing provider or facility indicated in box #1: [] 8. City: [] 9. State: [] 10. Zip code: []

Provider Completes This Section:

Date you want THIS submission to begin:

[] [] []

Patient Type

- 1 New to your office
- 2 Est'd, new injury
- 3 Est'd, new episode
- 4 Est'd, continuing care

Cause of Current Episode

- 1 Traumatic
- 2 Unspecified
- 3 Repetitive
- 4 Post-surgical
- 5 Work related
- 6 Motor vehicle

Date of Surgery

[] [] []

Type of Surgery

- 1 ACL Reconstruction
- 2 Rotator Cuff/Labral Repair
- 3 Tendon Repair
- 4 Spinal Fusion
- 5 Joint Replacement
- 6 Other

Diagnosis (ICD code)

Please ensure all digits are entered accurately

1° [] [] [] [] [] []

2° [] [] [] [] [] []

3° [] [] [] [] [] []

4° [] [] [] [] [] []

Nature of Condition

- 1 Initial onset (within last 3 months)
- 2 Recurrent (multiple episodes of < 3 months)
- 3 Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

- 98940 98942
- 98941 98943

Current Functional Measure Score

Neck Index [] [] DASH [] [] [] [] (other)

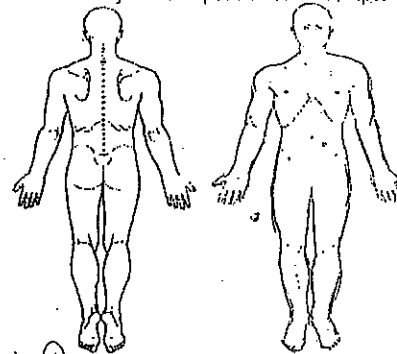
Back Index [] [] LEFS [] [] [] []

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on: [] [] []

Indicate where you have pain or other symptoms



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

- 1 Constantly (76%-100% of the time)
- 2 Frequently (51%-75% of the time)
- 3 Occasionally (26% - 50% of the time)
- 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

6. How is your condition changing, since care began at this facility?

- 0 N/A — This is the initial visit
- 1 Much worse
- 2 Worse
- 3 A little worse
- 4 No change
- 5 A little better
- 6 Better
- 7 Much better

7. In general, would you say your overall health right now is...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

Patient Signature: X

Date: [] [] []

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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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

- Ⓐ 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.

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Score

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.

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Score

South Shore Chiropractic, P.C.

465 Blue Point Road
Farmingville, NY 11738
(631) 732-1386
Fax: (631) 732-1544

I, _____ fully understand that my
Insurance Company, _____, requires a referral
from my primary care physician. I agree that I will cooperate in
this matter and get the referral within the designated time period; If
I do not get the referral for South Shore Chiropractic, P.C. on time
I do understand that I will be held responsible for the services
rendered to me at the time the referral should have been received.

Signature of Patient: _____

Date of Signature: _____

South Shore Chiropractic, P.C.

465 Blue Point Road
Farmingville, NY 11738
Tel: (631) 732-1386
Fax: (631) 732-1544

1245 Montauk Highway
Mastic, NY 11950
Tel: (631) 395-8520
Fax: (631) 395-8521

Date:

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

South Shore Chiropractic, P.C.
465 Blue Point Road
Farmingville, NY 11738

Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

South Shore Chiropractic, P.C.
465 Blue Point Road
Farmingville, NY 11738

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20_____

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder