Affordable Chiropractic.biz, LLC

1524 University Avenue, Green Bay, WI 54302

APPLICATION FOR CARE

Today's Date:_____

Name:_____ Age:_____ Birth Date:_____

Address:_____City:_____State:_____Zip:_____

Home Phone No._____ Work Phone No ._____Cell Phone _____

e-mail address:_____

Occupation:_____ Employer:_____

___Single ___Married ___ Divorced ___ Widowed ___Other Spouse's name & date of birth:_____

Smoking: __never __ former __ year quit: ____ __ current smoker: __ light (up to 10/day) __Heavy (10+/day)

Who may we thank for referring you to our office? _____

Name of Primary Care Doctor & Clinic location: _____

May we send a report of your care to his/her office? YES no

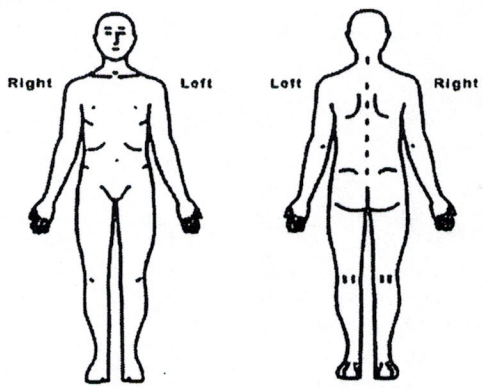
Describe your **Major Complaint today:**_____

How long have you had this condition?_____ When did it start?_____

Have you lost work days? YES / NO If yes, how many?_____

Have you had this similar condition before? YES NO If yes, when?_____

PLEASE "X" WHERE YOUR SYMPTOMS ARE:



GENERAL HEALTH HISTORY

Have you been treated for any health condition by a physician in the last year? __Yes __No

If yes, explain:_____

Have you previously received Chiropractic treatment? YES NO If yes, list dates consulted and for what problems:_____

When was your last visit? give approximate date)_____

Were you given any exercises to help stabilize or strengthen your spine? YES NO

Can you demonstrate these exercises? YES NO Are you currently pregnant? YES NO

Check off the drugs you are now taking: __Nerve Medication __ Pain Killers __ Muscle Relaxers __Insulin

__Blood Pressure medication __Birth Control Pills __Tranquilizers __Diet Pills __Sleeping Pills __Antidepressants

Other(please list)_____

Have you ever been in an automobile accident? __Past year __Past 5 years __Over 5years

List the approximate dates of any **operations**, serious accidents, or unusual diseases, you have had (include any broken bones):

_____

_____

_____

FINANCIAL RESPONSIBILITY

Fees are payable at the time services (examinations, x-rays, and adjustments) are received**, unless other arrangements have been made *in advance.***

Will this case be paid by ____ Cash / Check / credit /debit card /Mastercard/Visa

If this was related to an accident: __Workers' Compensation ___ Auto Insurance

If yes, when did the accident occur? : _____

If this is a work related incident, was your supervisor notified? Yes No

Please provide the name and work phone # for your supervisor and/or the Human Resources department of your employer: _____

_____

X-rays are part of your permanent record here and remain the property of this office.

I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Affordable Chiropractic.biz, LLC will prepare any necessary reports and forms to assist me in making collection from the insurance company. ***These will be submitted only once.*** Any amount authorized to be paid directly to Affordable Chiropractic.biz, LLC will be credited to my account upon receipt. However, I clearly understand & agree that all services rendered 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 and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby give permission for chiropractic care.

Patient's Name: _____

Patient's Signature_____ Social Security # : _____

Guardian or spouse's signature: _____ _____

OFFICE FINANCIAL POLICY

To our patients:

Thank you for selecting our office to provide chiropractic care for you and your family members. Before services can be initiated; it's it is essential that you are aware of the billing and payment policies of our office.

1. **Payment is expected at the time of service.** Our office accepts cash, checks, Visa, MasterCard, Discover and American Express.

2. Unfortunately, most healthcare insurance plans are too restrictive and require providers to agree to contracts that are insufficient to address the needs of most patients. For this reason, our doctor is not a provider in any insurance networks. You may want to call your insurance company to find out if "out of network" benefits are available.

3. As a courtesy to our patients, we will assist you in filing your insurance claims. Your policy is a legal, binding contract between you and your carrier. Thus, we will not act as a mediator, enter into any dispute, **or attempt to know what your coverage is.** We do not accept assignment of payments from insurance companies. **We cannot assume any responsibility for their performance.** Again, our office policy is : payment is expected at the time of service.

4. This office may make payment plan arrangements on an individual basis. Therefore, any unpaid balance after the last day of each month will be subject to a 3% interest charge.

5. Patients involved in a Worker's Comp. or other accident are required to make a 20% co-pay maximum of $40 per visit at the time of service. Patients are ultimately responsible for payment in the event that insurance does not pay.

MEDICARE PATIENTS

Medicare will not pay for x-rays or exams. Spinal adjustments may be denied as not medically necessary by the program standards.

I have read and understand the policies stated above.

_____ _____

Patient's or guardian's signature Date

Neck Disability Index (NDI) calculator

This Neck Disability Index (NDI) calculator assesses the degree of perceived pain neck and the disability status based on daily activities and underlying cervical spine pain.

1. **Pain Intensity**
A. I have no pain at the moment.
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

2. **Personal Care (Washing, Dressing etc.)**
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care. E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

3. **Lifting**
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

4. **Reading**
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

5. **Headache**
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

6. **Concentration**
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

7. **Work**
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

8. **Driving**
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

9. **Sleeping**
A. I have no trouble sleeping 0
B. My sleep is slightly disturbed (less than 1 hour sleepless). 1
C. My sleep is mildly disturbed (1-2 hours sleepless). 2
D. My sleep is moderately disturbed (2-3 hours sleepless). 3
E. My sleep is greatly disturbed (3-5 hours sleepless). 4
F. My sleep is completely disturbed (5-7 hours sleepless). 5

10. **Recreation**
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

____ / 50 = _____
Total / 50 = % disability

Oswestry Low Back Pain Disability Questionnaire

Instructions This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **ONE** box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but **please just check the one spot that indicates the statement which most clearly describes your problem.**

Section 1 – Pain intensity

__ I have no pain at the moment
__ The pain is very mild at the moment
__ The pain is moderate at the moment
__ 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

Section 2 – Personal care (washing, dressing etc)

__ 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 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

Section 3 – Lifting

__ I can lift heavy weights without extra pain I can lift heavy weights but it gives extra pain
__ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
__ Pain prevents me from lifting heavy weights, butl I can manage light to medium weights if they are conveniently positioned
__ I can lift very light weights
__ I cannot lift or carry anything at all

Section 4 – Walking*

__ Pain does not prevent me walking any distance
__ Pain prevents me from walking more than 1 mi
__ Pain prevents me from walking more than ½ mi
__ Pain prevents me from walking more than 100 yds
__ I can only walk using a stick or crutches
__ I am in bed most of the time

Section 5 – Sitting

__ I can sit in any chair as long as I like
__ I can only sit in my favourite chair as long as I like
__ Pain prevents me sitting more than one hour
__ Pain prevents me from sitting more than 30 minutes
__ Pain prevents me from sitting more than 10 minutes
__ Pain prevents me from sitting at all

Section 6 – Standing

__ I can stand as long as I want without extra pain
__ I can stand as long as I want but it gives me extra pain
__ Pain prevents me from standing for more than 1 hr
__ Pain prevents me from standing for more than 30 min
__ Pain prevents me from standing for more than 10 min
__ Pain prevents me from standing at all

Section 7 – Sleeping

__ My sleep is never disturbed by pain
__ My sleep is occasionally disturbed by pain
__ Because of pain I have less than 6 hrs sleep
__ Because of pain I have less than 4 hrs sleep
__ Because of pain I have less than 2 hrs sleep
__ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

__ My sex life is normal and causes no extra pain
__ My sex life is normal but causes some extra pain
__ My sex life is nearly normal but is very painful
__ My sex life is severely restricted by pain
__ My sex life is nearly absent because of pain
__ Pain prevents any sex life at all

Section 9 – 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 effect on my social life apart from limiting my more energetic interests eg, sport
__ Pain has restricted my social life and I do not go out as often
__ Pain has restricted my social life to my home I have no social life because of pain

Section 10 – Traveling

__ I can travel anywhere without pain 0
__ I can travel anywhere but it gives me extra pain 1
__ Pain is bad but I manage journeys over two hours 2
__ Pain restricts me to journeys of less than one hour 3
__ Pain restricts me to necessary errands under 30 min 4
__ Pain stops me from traveling except to get treatment 5

_____ / 50 = _____

Total / 50 = % disability

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a detoxification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Stiffness or limited movement	0 1 2 3 4
c. Pain or aches in muscles	0 1 2 3 4
d. Recurrent back aches	0 1 2 3 4
e. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

g. How often do you consume nonorganic foods? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a detoxification program.