

Name _____ Date _____

Confidential Patient Case History

Please complete this questionnaire making sure your name and the date is at the top of each page. This confidential patient case history will become part of your permanent records. Thank you.

Your demographic information

Last Name _____	First Name _____	M.I. _____
Street _____		
City _____ State _____		
Zipcode _____		
Email _____		
Home _____	Work _____	
Cell _____	Fax _____	
Date of Birth _____		
Sex: F M		
Social Security Number _____		
Emergency Contact _____		
Home Phone _____		
Cell Phone _____		
Occupation _____		
Employer _____		
Marital Status: M S D W		
Children (Ages) _____		
Spouses name _____		

Information about your journey to our office

Who referred you to us? _____
How else did you hear about us? _____
Were you given accurate directions to find UHI? Yes No
How did you travel here? car, bus, train, cab, bicycle, walk
Did you find parking? Yes No
Where? Circle: Street Meter Parking Garage (location) _____

Information about your experience with natural health care

Have you seen a chiropractor before? Yes No
If yes, who is the doctor? _____
Where is the doctor's office? _____
If yes, what was your experience; if no, what have you heard about chiropractic?

Have you used natural health care before? Yes No If yes, what kind of natural health care?

Name _____

Date _____

In this box, describe your main problem only

If we could help you with **one** health **problem**, what would it be? Write you main problem/complaint here: _____

Answer the 10 most important questions about your problem here:

1. How many days out of the week or month do you find yourself suffering from this problem? Be specific, please. Circle one, if it applies to your problem:
Every day. Every other day. Several (2,3,4,5,6) days per week/month.
2. How long will it last on a bad day? _____
3. How long have you been suffering with this problem/complaint? (Since what year/month)
Be specific, please. _____
4. Have you had this or a similar condition in the past? Yes No
If Yes, describe it here _____
5. Has the problem been getting worse over time? Yes No
6. When the problem is at its worst, exactly what does it feel like?

7. On a scale of 1-10, with 10 being the worst, how do you rate this pain right now?
Rate the pain right now: 1 2 3 4 5 6 7 8 9 10
8. On a scale of 1-10, with 10 being the worst, how do you rate this pain in the last week?
Rate the pain in the last week: 1 2 3 4 5 6 7 8 9 10
9. What do you do that makes this problem worse?

10. Many people tell us that their condition makes them feel older than they are. Have you experienced this? Yes No How does it make you feel? _____

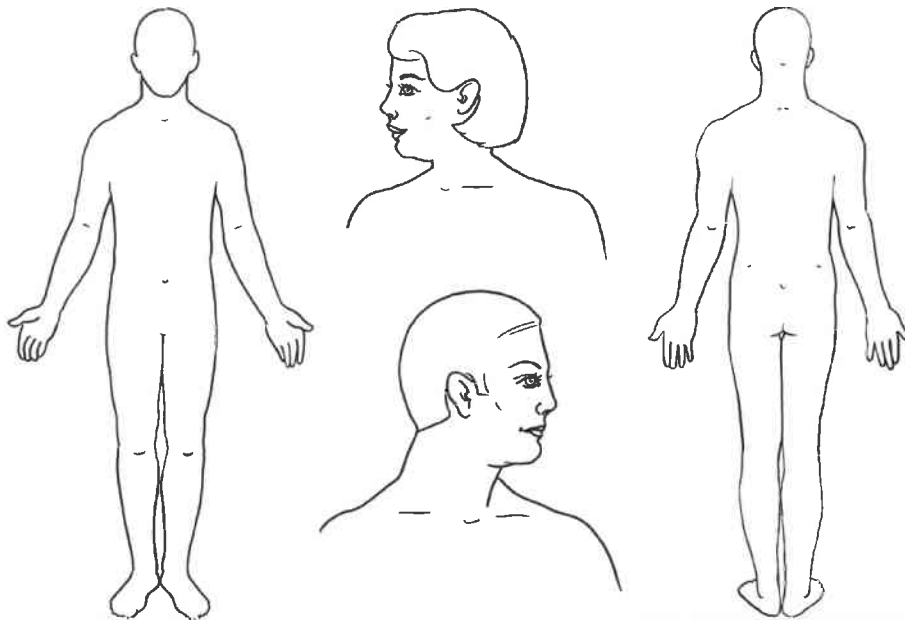
Mark the areas of your symptoms on the figures to the right. Use the following symbols to describe them:

Aches + + + + +

Numbness * * * *

Pins/Needles - - - - -

Stabbing // // // //



Describe what caused your problem.

Do think that a specific accident/injury/trauma caused this problem? Yes No
If yes, what was the event? _____

Have you had any falls or accidents in the past that may have caused injury to your neck and spine, even as a child? Yes No _____

Name _____

Date _____

In this box, describe how you have tried to manage this problem

Since the time you began suffering from this problem, what, if anything, have you tried as a remedy or cure that did not work? Please circle all that apply to your main problem:

Ice, heat, rest, over-the-counter drugs, physical therapy, exercise, stretching, massage, prescription drugs, doctor advice, ignoring it, waiting, change in diet, change in habits, staying away from activities, prayer, meditation, wishing, concentrating, acupuncture, changing activities, limiting activities, sleep, nutrition.

Anything else that you have tried to do to help your problem? _____

Anything that has given you relief? Yes No If yes, what was it that gave you the most relief?

Even if you have experienced temporary relief, has anything you have tried thus far fixed your problem yet? Yes No What was it? _____

In this box, describe how this problem is affecting you

Answer the following 10 important questions about your problem:

1. What activity does this problem prevent you from doing either partially or totally, that you would really like to be doing again if you didn't have this condition? _____

2. How does this problem prevent you from doing that? _____

3. What areas of your life is it most affecting?
Circle any that apply: My Work. My Hobbies. My Social Activities. My Sports.
My Ability to Rest. My Family Life. My Attitude. My Financial Plan.
My Personal Life. My Productivity. My Appetite. My interest in Others.
My Personal Hygiene. My enthusiasm. My Ability to Concentrate. My mental state.
4. How else is it affecting you? _____
5. Has this problem affected your sleep patterns?
Trouble falling asleep because you are uncomfortable? Yes No
Not enough restful sleep? Yes No
Awakening in the middle of the night? Yes No
Waking you earlier than you would normally awake? Yes No
6. Have you become discouraged about this? Yes No
7. If you are not discouraged, does it concern you that your problem persists? Yes No
Why does it concern you? _____

8. Are you concerned that it will not go away or get worse in the future? Yes No
9. How often are you able to keep a positive attitude?
Circle: Most of the time Some of the time Not very often Hardly at all
10. If you don't get this problem taken care of where do you think you will be in 5 years?

Are you ready to take care of this problem?

Taking into consideration what you have described so far, so you feel you need to change the way you have been dealing with this problem? Yes No

On a scale of 1 – 10, ten being the highest, how would you rate your commitment to getting rid of this problem? 1 2 3 4 5 6 7 8 9 10

Is there anything preventing you from getting this problem taken care of? Please specify your concerns: _____

Name _____

Date _____

Women doctor visits

Do you have a gynecologist? Yes No
 What is the name of this doctor? _____
 Address of this doctor: _____
 Do you see this doctor each year? Yes No
 When is the last time you saw this doctor? _____
 Are you satisfied with the care you receive from this doctor? Yes No

Family History

List anything that you know about the sickness, disease or death of the following relatives:

	Age if living	State of health	Age at death	Cause of death
Father				
Mother				
Sister(s)				
Brother(s)				
Grandmothers				
Grandfathers				

Past Diagnoses

Have you ever been diagnosed as having a disease? Yes No
 What is it? _____
 Have you ever been diagnosed with Cancer? Yes No
 High or Low Blood Pressure? Yes No
 Stroke? Yes No
 Have you ever suffered from: Alcoholism? Yes No Drug Addiction? Yes No

Trauma History

Any trauma your body suffered in the past is important to helping us help you. A trauma may be obvious or non-obvious. A trauma to your body could have happened last week, ten years ago, when you were three years old or during the birth process. *Please note that body trauma is most often related to a physical event, but may also be related to a chemical event or a mental event.* This list may help you to remember (please check any that apply):

Obvious Body Trauma

- Car accident
- Bike accident
- Ski accident
- A bad sprain
- Sports injury or accident
- Roller-blading accident
- A fall
- Being struck with an object
- Something that made you bleed
- Recreational injury
- A violent birth process
- A childhood injury or accident
- A time when someone thought you were 'really hurt'
- Surgery, any type
- Injury while moving (home/work)

Non-Obvious Body Trauma

- Always sleeping in a strained position
- Sitting at a bad work-station
- Repetitive movements related to work such as mouse use, hanging head over a desk or shoulder-held phone
- Repetitive movements related to sports like tennis, golf, baseball
- Movements related to playing an instrument
- Years of small falls related to youth sports
- Repeated carrying of a heavy bag
- Long term period of being over-weight
- Pregnancy or pregnancies too close together
- Birth process with forceps or difficult birth process
- Use of a drug that caused a reaction
- Mental trauma due to death of a loved one, divorce, money, drug addiction, bankruptcy, miscarriage

Please list dates (years will suffice) of trauma to your body and include a brief description of each event.

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

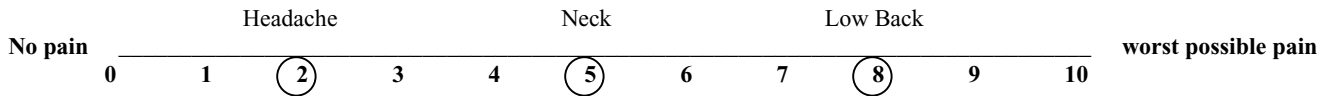
Date _____

Please read carefully:

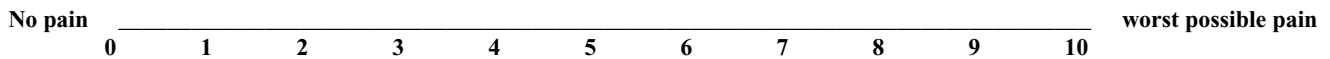
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

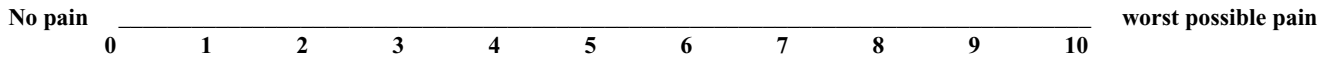
Example:



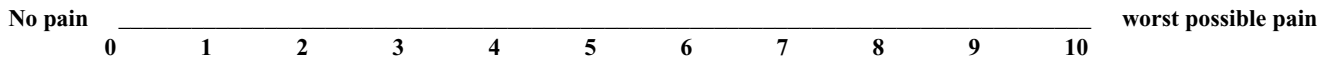
1 – What is your pain RIGHT NOW?



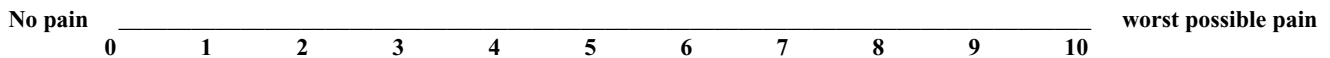
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____

Date _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ONE CHOICE which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box which most closely describes your problem right now.

SECTION 1 – Pain Intensity

- A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than 1/2 mile.
D. Pain prevents me from walking more than 1/4 mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than 1/2 hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

SECTION 6 – Standing

- A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than 1/2 hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

- A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

- A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

- A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Examiner _____

With Permission from:Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Universal Health Institute to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 312-266-9090. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and / or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

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. Date of last menstrual period _____.

X _____
Patient's Signature

X _____
Witness

Name _____

Date _____

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

SIGNATURE OF PARTICIPANT

DATE _____

SIGNATURE OF WITNESS

DATE _____

Universal Health Institute Financial Policy

We will verify your insurance benefits as a courtesy to you. Your insurance will provide a quote of benefits, not a guarantee of payment. Your insurance company retains the right to deny service payments and/or pay at a different percentage than quoted. Your insurance contract is between you, your employer, and your insurance company. We are not a party to that contract. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.____(initial).

Please note that the out-of-network benefits may apply if we are not contracted with your insurance company____(initial).

We do not accept or bill secondary insurance carriers.If you have Medicare and you have supplemental insurance, Medicare will send the claim to your secondary insurance on your behalf. ____ (initial).

If referrals or prescriptions are required by your insurance company, you are solely responsible for obtaining and keeping track of them.____(initial).

If your insurance company has not paid a claim within ninety (90) days of submission, you accept full responsibility for payment in full of any outstanding balance ____ (initial).

Your copayment, coinsurance and deductible must be paid at the time of service.____ (initial).

All services must be paid in full if you are satisfying a deductible set by your insurance copay. Any credits to your account will be applied to future visits____(initial).

If you discontinue care for any reason other than discharge by the doctor, all patient balances become immediately due and payable in full by you and you authorize us to use your credit card to collect full payment.____(initial).

In the case that an account becomes delinquent (90 days past due) and we are unable to charge your credit card for the balance due, your account will be turned over to a third-party collection agency. If this occurs, our staff will no longer handle the account and all correspondence and phone calls will be directed to our agency Keynote Consulting.____(initial).

All patients are required to maintain a valid credit card number on file with us. If you choose not to provide this information, we will not bill your insurance and you must pay cash for all service provided to you____(initial).

Cancellations:

Scheduled visits are available for all services at UHI. If you are unable to make your appointment, 24 hour notice must be given. If you make an appointment on another patient's behalf, you assume all financial responsibility for that appointment in the event of a cancellation or missed appointment. Any missed appointment carry a charge of \$50.00 (except for chiropractic adjustments). This fee are not covered by insurance and must be paid before scheduling another appointment.

This financial policy supercedes any and all previous financial policies, contracts, and agreements issued by Universal Health Institute.____(initial).

Card # _____ Expiration Date _____

CVV Code (3 digit number on the back of your card) _____

Printed Name as Appears on Card: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) _____ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.
<input type="checkbox"/> OPTION 1. I want the (D) _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. <input type="checkbox"/> OPTION 2. I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. <input type="checkbox"/> OPTION 3. I don't want the (D) _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

X-ray Assignment Agreement and Consent

I understand that my doctor is submitting my x-rays to Spinal Imaging, Inc. for second opinion radiological evaluation and analysis by a specialist. I also understand that the fee for such services will be submitted to my insurance company, healthcare carrier, attorney or worker's compensation carrier for payment. If I am paid directly by an insurance carrier or through legal a legal settlement, I will be responsible for the amount paid. If Spinal imaging, Inc. does not receive a lien, or if Spinal Imaging, Inc. does not receive a reply to a case status information request from my attorney, I will be billed for the amount of service. Once Spinal Imaging, Inc. receives a reply from the attorney, I will stop being billed.

I also give my consent to Spinal Imaging, Inc's use and disclosure of the Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has acted in reliance on this consent. I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy of Spinal Imaging, Inc, 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.

My signature authorizes the release of medical information and also authorizes the assignment of benefits to:

**Spinal Imaging, Inc.
5 Norfolk Avenue
P.O. Box 1200
South Easton, MA 02375**

In the event my insurance company or attorney sends payment of services to me, I agree to promptly remit such payment to Spinal Imaging, Inc.

Date

Patient Signature

Print Name