

CONFIDENTIAL PATIENT INFORMATION

DATE _____

Is your visit today due to an accident? Yes No If yes, complete both sides of this form

Name _____ Date of Birth _____ Male ___ Female ___

Address _____ City _____ State ___ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Email _____

SSN: _____ Employer _____ Occupation _____

Employer Address _____ Work Phone(____) _____ Marital Status _____

Spouse's Name _____ Spouse Date of Birth _____ No. of Children _____

Emergency Contact _____ Phone Number (____) _____

How did you hear about our office? Yellow Pages Sign/Location Internet **Friend/Patient **Physician

**Who can we thank for referring you to our office? _____

Were you referred to a certain doctor at this office? _____ If so, who? _____

(If any of the following are relevant to your medical history, please check the accompanying box)

- Polio Diabetes Asthma Scarlet Fever Digestive Disorder Anemia
- Hepatitis Arthritis Rheumatic Fever Tuberculosis Multiple Sclerosis Cancer
- Epilepsy Headache Heart Problems Carpal Tunnel Dizziness Backache
- Numbness Sinus Anxiety/Nervous Blood Pressure other _____

Surgeries _____

Medication Allergies _____ Current Medication _____

Pregnant? Yes No Date of Last Menstrual Period? _____ Last Physical _____

Primary Care Doctor _____ Phone Number (____) _____

Please present your insurance card(s) and driver's license or photo I.D. to the receptionist

Primary Health Insurance Company _____ Contract/I.D # _____

Card Holder Name _____ Date of Birth _____ Relationship _____

Secondary Insurance Company _____ Contract/I.D # _____

Card Holder Name _____ Date of Birth _____ Relationship _____

Patient Financial Agreement:

I understand and agree my health and accident insurance policies are an arrangement between myself and the insurance carrier. I understand that as a courtesy to me, this office will prepare any necessary forms to assist me in making collection from my insurance company and that any amount payable will be paid directly to this office. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and 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.

PATIENT SIGNATURE _____ DATE _____

LEGAL GUARDIAN/PATIENT REPRESENTATIVE _____ DATE _____

ACCIDENTAL INJURY REPORT

If your visit is due to an accident, please describe all events associated with the occurrence

Date of Accident _____ Time of Accident _____ AM PM

Type of Accident Work Related Automobile Other _____

Address where accident occurred _____

Were you treated at a hospital or clinic due to injury Yes No What facility? _____

Number of days hospitalized _____ Number of days missed from work _____

Have you had similar accident or injury before? Yes No Explain _____

Work Related Accident

Employer _____ Type of business _____

Address _____ Phone Number (____) _____

Was any equipment and/or object related to accident? Yes No What type? _____

Have you reported this injury to a supervisor/employer? Yes No

Has a Workers Compensation claim been filed? Yes No Claim Number _____

Workers Compensation Insurance Company _____

Claim Adjuster _____ Phone Number (____) _____

Automobile Accident

What type of vehicle was involved in accident? Truck Car Motorcycle Other _____

Were you a Driver Passenger Pedestrian If passenger, please indicate your location in vehicle _____

Was your vehicle moving when the accident occurred? Yes No MPH? _____

Did your vehicle hit other vehicle(s)? Yes No Where? _____

Did other vehicle(s) hit your vehicle? Yes No Where? _____

Was accident reported to police department Yes No What city or township? _____

Were traffic citations issued? Yes No To Whom? _____

Describe accident including cause and surrounding circumstances _____

Automobile Insurance Company _____ Claim Number _____

Claim Adjuster _____ Phone Number (____) _____

Attorney Information

Has your attorney advised you in this case? Yes No

Attorney's Name _____ Phone Number (____) _____

Attorney's Address _____ City _____ State _____ Zip _____

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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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

- ⓪ 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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Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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

- Ⓐ 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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Consent for Purposes of Treatment, Payment and Healthcare Operations

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician. This protected information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Baetens Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Baetens Chiropractic Center. I understand that Dr. Baetens/Dr. Craig may refuse to diagnose or treatment me, if I do not consent to the use or disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent.)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Baetens Chiropractic Center is not required to agree to the restrictions that I may request. However, if Baetens Chiropractic Center agrees to a restriction that I request, the restriction is binding on Baetens Chiropractic Center and Dr. Baetens/Dr. Craig.

I understand I have a right to review Baetens Chiropractic Center's Notice of Privacy Practices prior to signing this document. Baetens Chiropractic Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Baetens Chiropractic Center. The Notice of Privacy Practices for Baetens Chiropractic Center is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Baetens Chiropractic Center's duties with respect to my protected health information.

Baetens Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, at any time, except to the extent that Baetens Chiropractic Center or Dr. Baetens/Dr. Craig has taken action in reliance on this consent.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority