Confidential Patient Data

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail: _____
Social Security #: _____ Age: _____ ❑ Male ❑ Female
Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____
Name of Spouse or Nearest Relative: _____ Phone: _____
Your Occupation _____ Your Employer: _____

REFERRED TO THIS OFFICE BY: ❑ Friend/Family Member – Name? _____

❑ Clinic Location ❑Clinic Website ❑ Insurance website ❑ Google/Yahoo Search

❑ Angie's List ❑ Yellow Pages ❑ Other _____

➢ **Would you like us to notify your primary care physician of your treatments here? ❑ yes ❑ no**

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	Stroke
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	tuberculosis
❑	❑	❑	venereal disease	❑ Other _____				❑ Other _____			

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition _____ Date of Last Physical Exam _____

Please list any medications you may be taking: _____

SURGICAL HISTORY:
1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

ACCIDENT HISTORY :
❑Job ❑Auto ❑Other 1. _____ Date: _____
❑Job ❑Auto ❑Other 2. _____ Date: _____
❑Job ❑Auto ❑Other 3. _____ Date: _____

Are both of your parents still alive? ❑Yes ❑No (please explain cause(s) death below) example (heart attack):

_____

Your Kids ❑None ❑Boys; Ages ___ ___ ___ ___ ___ ❑Girls; Ages ___ ___ ___ ___ ___

Please Describe Your Present Conditions:

Body Area ________________________________ *(example: low back, neck, headache)*
Please Circle Best Responses From Each Line Below

Pain Level: 1 2 3 4 5 6 7 8 9 10 (*1 is least, 10 is worst*)
Mild - Mild to Moderate – Moderate - Moderately Severe - Severe
Constant – Occasional – Intermittent - Frequent

Body Area ________________________________ *(example: low back, neck, headache)*
Please Circle Best Responses From Each Line Below

Pain Level: 1 2 3 4 5 6 7 8 9 10 (*1 is least, 10 is worst*)
Mild - Mild to Moderate – Moderate - Moderately Severe - Severe
Constant – Occasional – Intermittent - Frequent

Body Area ________________________________ *(example: low back, neck, headache)*
Please Circle Best Responses From Each Line Below

Pain Level: 1 2 3 4 5 6 7 8 9 10 (*1 is least, 10 is worst*)
Mild - Mild to Moderate – Moderate - Moderately Severe - Severe
Constant – Occasional – Intermittent - Frequent

Body Area ________________________________ *(example: low back, neck, headache)*
Please Circle Best Responses From Each Line Below

Pain Level: 1 2 3 4 5 6 7 8 9 10 (*1 is least, 10 is worst*)
Mild - Mild to Moderate – Moderate - Moderately Severe - Severe
Constant – Occasional – Intermittent - Frequent

Please Check All Activities That Are Worsened By Your Present Condition

General

- ☐ Sitting
- ☐ Sleeping
- ☐ Sexual Intercourse
- ☐ Exercising
- ☐ Climbing Stairs
- ☐ Standing
- ☐ Running
- ☐ Sitting in Recliner
- ☐ Chewing
- ☐ Lifting Children
- ☐ Bending
- ☐ Getting In/Out of Vehicle
- ☐ Reading
- ☐ Lying in Bed
- ☐ Kneeling
- ☐ Swimming
- ☐ Using Computer

Housework

- ☐ Doing Laundry
- ☐ Carrying Groceries
- ☐ Making Beds
- ☐ Caring for Pets
- ☐ Vacuuming
- ☐ Cooking
- ☐ Washing Dishes
- ☐ Sweeping
- ☐ Ironing

Yard Work

- ☐ Mowing Lawn
- ☐ Raking Leaves
- ☐ Gardening

Personal Grooming

- ☐ Combing Hair
- ☐ Shaving
- ☐ In/Out of Bathtub

Travel

- ☐ Driving
- ☐ Riding as Passenger

PLEASE CHECK THE FOLLOWING THAT **AGGRAVATE** YOUR CONDITION:
☐ COUGHING ☐ SNEEZING ☐ STRAINING AT STOOL ☐ BENDING ☐ CARRYING ☐ CLIMBING ☐ DRIVING ☐ EXERCISING ☐ GETTING IN/OUT OF BED ☐ GETTING IN/OUT OF CAR ☐ LIFTING ☐ PULLING/PUSHING ☐ REPETITIOUS MOVEMENTS ☐ STANDING ☐ STOOPING ☐ WALKING ☐ HEAT ☐ COLD

PLEASE CHECK THE FOLLOWING THAT **RELIEVE** YOUR CONDITION:
☐ CHIROPRACTIC CARE ☐ADVIL ☐ TYLENOL ☐ ASPIRIN ☐ PAIN PILLS ☐ MUSCLE RELAXERS ☐ RECLINING ☐ WALKING ☐ MASSAGES BY HAND OR VIBRATOR ☐ COLD/ICE PACK ☐ HEAT/HOT PACK ☐ HOT SHOWERS/TUB SOAKING ☐ HEAT LINIMENT ☐ MINERAL ICE ☐ EXERCISING ☐ SLEEPING

Patient's Signature: X______________________________ Date:____________________

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.
REVIEW OF SYSTEMS- Please fill out all of the sections, even if "DENY"

Constitutional: I.... ☐ Deny Any Constitutional Issue (s)

☐ Chills ☐ Fatigue
☐ Weight Gain ☐ Fever
☐ Daytime Somnolence (Drowsiness) ☐ Night Sweats
☐ Weight Loss

Eyes/Vision: I.... ☐ Deny Any Eyes/Vision Issue (s)
☐ Blindness ☐ Blurred Vision
☐ Eye Pain ☐ Field Cuts (visual field defect)
☐ Tearing ☐ Wears Glasses/Contact Lenses
☐ Cataracts ☐ Glaucoma
Change in Vision ☐ Itching (around eyes)
☐ Double Vision ☐ Photophobia

Ears,Nose & Throat: I.... ☐ Deny Any Ears, Nose & Throat Issue (s)
☐ Bleeding ☐ Dizziness ☐ Sinus Infections
☐ Headaches ☐ Nasal Congestion ☐ TMJ Problems
☐ Snoring ☐ Dental Implants ☐ Fainting
☐ Ear Drainage ☐ Head Injury ☐ Loss of Smell
☐ Nose Bleeds (frequent) ☐ Sore Throats (frequent)
☐ Dentures ☐ Ear Infections ☐ Discharge
☐ Hearing Loss ☐ Post Nasal Drip ☐ Rhinorrhea (Runny Nose)
☐ Tinnitus (Ringing in Ears) ☐ Difficulty Swallowing
☐ Ear Pain ☐ Hoarseness

Respiration: I.... ☐ Deny Any Respiration Issue (s)
☐ Asthma ☐ Cough
☐ Coughing Up Blood ☐ Shortness of Breath
☐ Sputum Production ☐ Wheezing

Gastrointestinal: I.... ☐ Deny Any Gastrointestinal Issue (s)
☐ Abdominal Pain ☐ Difficulty Swallowing
☐ Nausea ☐ Abnormal Stool
Belching ☐ Heartburn
Rectal Bleeding ☐ Black, Tarry Stool
☐ Hemorrhoids ☐ Vomiting
☐ Constipation ☐ Indigestion
☐ Vomiting Blood ☐ Diarrhea
☐ Jaundice (Yellowing Skin) ☐ Abnormal Stool Color

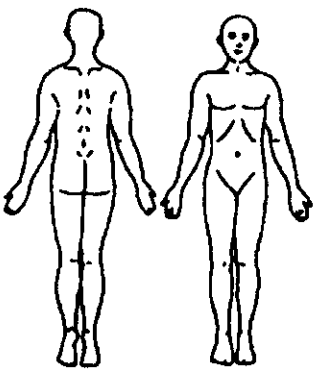
Endocrine: I.... ☐ Deny Any Endocrine Issue (s)
☐ Cold Intolerance ☐ Frequent Urination
☐ Voice Changes ☐ Diabetes
☐ Goiter ☐ Excessive Appetite
☐ Hair Loss ☐ Excessive Hunger
Heat Intolerance ☐ Excessive Thirst
☐ Unusual Hair Growth

Nervous System: I.... ☐ Deny Any Nervous System Issue (s)
☐ Dizziness ☐ Loss of Memory ☐ Stress
☐ Facial Weakness ☐ Numbness ☐ Strokes
☐ Headaches ☐ Seizures ☐ Tremors
☐ Limb Weakness ☐ Sleep Disturbances ☐ Unsteadiness of Gait
☐ Loss of Consciousness ☐ Slurred Speech

Allergy: I.... ☐ Deny Any Allergy System Issue (s)
☐ Anaphylaxis (history of) ☐ Food Intolerance
☐ Itching ☐ Nasal Congestion ☐ Sneezing

Please outline on the diagram the area of your discomfort

A= Aches B=Burning N=Numbness
P= Pins & Needles S= Stabbing O= Other



Cardiovascular: I.... ☐ Deny Any Cardiovascular Issue (s)

☐ Angina (Chest Pain) ☐ Heart Problems
☐ Claudication (Leg Pain) ☐ Heart Murmur
☐ Heart Problems ☐ Swelling of Legs
☐ Orthopnea (difficulty breathing while lying down)
☐ Palpitations (irregular or forceful beating of heart)
☐ Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath)
☐ Shortness of Breath with Exertion or Exercise
☐ Ulcers ☐ Varicose Veins

Female: I.... ☐ Deny Any Female Issue (s)
☐ Birth Control Therapy ☐ Breast Lumps/Pain
☐ Burning Urination ☐ Cramps
☐ Frequent Urination ☐ Hormone Therapy
☐ Irregular Menstruation ☐ Urine Retention
☐ Vaginal Bleeding ☐ Vaginal Discharge
Are you pregnant? Yes/No Date of Last Period:_____

Male: I.... ☐ Deny Any Male Issue (s)
☐ Burning Urination ☐ Erectile Dysfuncti
☐ Prostate Problems ☐ Urine Retention
☐ Frequent Urination ☐ Hesitancy/Dribbling

Skin: I.... ☐ Deny Any Skin Issue (s)
☐ Changes in Nail Texture ☐ Changes in Skin Color
☐ Hair Growth ☐ Hair Loss ☐ Hives
☐ Itching ☐ Paresthesia (numbness, prickling or tingling)
☐ Rash ☐ History of Skin Disorder
☐ Skin Lesions/Ulcers ☐ Varicositites

Psychologic: I.... ☐ Deny Any Psychologic Issue (s)
☐ Anhedonia ☐ Bipolar Disorder ☐ Mood Changes
☐ Confusion ☐ Convulsions ☐ Anxiety
☐ Depression ☐ Appetite Changes ☐ Insomnia
☐ Behavioral Changes ☐ Memory Loss

Hematology: I.... ☐ Deny Any Hematology Issue (s)
☐ Anemia ☐ Bleeding ☐ Blood Clotting
☐ Blood Transfusion ☐ Bruises Easy ☐ Fatigue
☐ Lymph Node Swelling

DO NOT WRITE BELOW THIS LINE

ANAYLSIS:
DIAGNOSIS:
Patient Accepted: ☐ **YES** ☐ **NO** ☐ **Referred**

_____
Doctor's Signature

Meridian Chiropractic Clinic

OSWESTRY DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in every day life. Please circle in each section only one statement which most closely applies to you.

Section 1: Pain Intensity

1 The pain comes and goes and is very mild.
2 The pain is mild and does not vary much.
3 The pain comes and goes and is moderate.
4 The pain is moderate and does not vary much.
5 The pain comes and goes and is severe.
6 The pain is severe and does not vary much.

Section 2: Personal Care (Washing, Dressing, etc.)

1 I would not have to change my way of washing or dressing in order to avoid pain.
2 I do not normally change my way of washing or dressing even though it causes some pain.
3 Washing and dressing increase the pain, but I manage not to change my way of doing it.
4 Washing and dressing increase the pain and I find it necessary to change my way of doing it.
5 Because of the pain, I am unable to do some washing and dressing without help.
6 Because of the pain, I am unable to do any washing and dressing without help.

Section 3: Lifting

1 I can lift heavy weights without extra pain.
2 I can lift heavy weights but it gives extra pain.
3 Pain prevents me from lifting heavy weights off the floor.
4 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
5 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
6 I can only lift very light weights at the most.

Section 4: Walking

1 I have no pain walking.
2 I have some pain walking but it does not increase with distance.
3 I cannot walk more than one mile without increasing pain.
4 I cannot walk more than 1/2 mile without increasing pain.
5 I cannot walk more than 1/4 mile without increasing pain.
6 I cannot walk at all without increasing pain.

Section 5: Sitting

1 I can sit in any chair as long as I like without pain.
2 I can sit only in my favorite chair as long as I like.
3 Pain prevents me from sitting more than 1 hour.
4 Pain prevents me from sitting more than 1/2 hour.
5 Pain prevents me from sitting for more than 10 min.
6 I avoid sitting because it increases pain immediately.

Section 6: Standing

1 I can stand as long as I want without pain.
2 I have some pain on standing, but is does not, increase with time.
3 I cannot stand for longer than one hour without increasing pain.
4 I cannot stand for longer than 1/2 hour without increasing pain.
5 I cannot stand for longer than 10 min. without increasing pain.
6 I avoid standing, because it increases the pain immediately.

Section 7: Sleeping

1 I have no pain in bed.
2 I have pain in bed but it does not prevent me from sleeping well.
3 Because of pain, my normal night's sleep is reduced by less than 1/4.
4 Because of pain, my normal night's sleep is reduced by less than 1/2.
5 Because of pain, my normal night's sleep is reduced by less than 3/4.
6 Pain prevents me from sleeping at all.

Section 8: Social Life

1 My social life is normal and gives me no extra pain.
2 My social life is normal, but increases the degree of pain.
3 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
4 Pain has restricted my social life and I do not go out very often.
5 Pain has restricted my social life to my home.
6 I have hardly any social life because of the pain.

Section 9: Traveling

1 I have no pain while traveling.
2 I have some pain while traveling, but none of my usual forms of travel make it any worse.
3 I have extra pain while traveling, but it does not compel me to seek alternative forms of travel.
4 I have extra pain while traveling which compels me to seek alternative forms of travel.
5 Pain restricts all forms of travel.
6 Pain prevents all forms of travel except that done lying down.

Section 10: Changing Degree of Pain

1 My pain is rapidly getting better.
2 My pain fluctuates, but overall is definitely getting better.
3 My pain seems to be getting better, but improvement is slow.
4 My pain is neither getting better nor getting worse.
5 My pain is gradually getting worse.
6 My pain is rapidly worsening.

Patient Signature X _____ Date: _____

Doctor's Signature _____ Score: _____

MERIDIAN CHIROPRACTIC CLINIC

correct the cause, healing will follow

AUTHORIZATION TO TAKE X-RAYS

I, _____ do hereby give my consent to allow Meridian Chiropractic Clinic and its representatives to take x-rays as deemed appropriate by the examining doctor of chiropractic. I also hereby declare to the best of my knowledge that I am not pregnant.

X _____

Signature

2162 NORTH MERIDIAN STREET, SUITE C INDIANAPOLIS, INDIANA 46202
(317) 923-4894 Fax (317) 924-4029

MERIDIAN CHIROPRACTIC CLINIC FINANCIAL POLICY

Our office will verify your insurance coverage in an effort to help you understand the chiropractic coverage available to you. However, you will be responsible for:

1. Services not covered by your insurance
2. Co-pays (monies due at time of service)
3. Balance remaining after your insurance company has responded to claims such as deductibles and/or co-insurance.
4. Balance that remains unpaid 90 days after filing with your insurance company.

Statements will be sent advising you of your balance and payment is expected within 30 days. An additional 2% charge will be added for any subsequent statements.

Several attempts will be made to collect any unpaid balance. However, if any balance remains unsatisfied, your account will be turned over to our attorney for collection purposes. You will then be responsible for all attorney's fees, collection fees and interest charges that will be added to your balance.

Regardless of insurance status, it is important to remember that you are ultimately responsible for any charges. Verification of coverage is not a guarantee of payment. Your insurance policy is a contract between you and your insurance company and we ask that you act on your own behalf in dealing with your insurance company.

It is the goal of this office to provide the best chiropractic care available. If you have any questions or concerns regarding your health care or financial responsibilities, please do not hesitate to ask.

I have read, understand and agree to the above policies.

Signature X _____

PATIENT NAME _____

To the patient: Please read this document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment I use as a Doctor of Chiropractic is called spinal manipulative therapy. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may also feel a sense of movement.

ANALYSIS/EXAMINATION/TREATMENT

As part of the analysis, examination and possible treatment, you are consenting to the following procedures:

spinal manipulative therapy	palpation	vital signs
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	postural analysis	electric muscle stimulation
radiographic studies	hot/cold therapy	

THE MATERIAL RISKS IN CHIROPRACTIC ADJUSTMENTS

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. THE DOCTOR WILL MAKE EVERY REASONABLE EFFORT DURING THE EXAMINATION TO SCREEN FOR CONTRAINDICATIONS TO YOUR CARE. However, it is your responsibility to inform the doctor of any condition that would not otherwise come to his attention.

THE PROBABILITY OF THESE RISKS OCCURRING

Fractures are rare occurrences and generally result from some underlying weakness of the bone which the doctor will check during examination, x-ray, and your history. Stroke has been the topic of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as extremely rare.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS:

Other treatment options for your condition may include:

-self-administered, over the counter analgesics and rest
-medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
-hospitalization
-surgery

If you choose to use one of the above noted treatment options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

THE RISKS AND DANGERS OF REMAINING UNTREATED

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Patients Name _____

Patients Signature X_____

Signature of Parent or Guardian (if minor) _____

Date_____