Midwest Chiropractic Center LLC
Welcome

ABOUT YOU	Today's Date:_____/_____/_____ File-Case No.:_____ _____ Name:_____ Email :_____ Street Address:_____ City:_____ State:____ Zip:_____ S.S.#:_____/____/_____ Birth date:___/___/___ Age:____ □ M □ F Referred By:_____ □ Single □ Married □ Divorced □ Separated □ Widow Home Phone:_____ Cellular:_____ Work Phone:_____ Employer:_____ Occupation:_____ Race: _____ Ethnicity: _____
SPOUSE	Spouse Name:_____ Birth date:____/____/____ S.S.# _____/_____/_____ Spouse Employer:_____ Phone:_____ Occupation:_____ Spouse Insurance Co.:_____ Phone:_____ Policy No:_____
PATIENT INSURANCE INFORMATION	Please check any and all insurance coverage you or your spouse have, that is applicable in this case. □ Major Medical □ PPO / HMO □ Auto Accident □ Work Injury □ Other_____ □ Medicare I.D.#_____ □ Medicaid I.D.#_____ Name of Insured:_____ Method of Payment: □ Cash □ Check □ Credit Card Relationship to Insured □ Self □ Spouse □ Child □ Other _____ Insurance Co. Name:_____ Adjuster:_____ DOA:_____ Address:_____ City:_____ State:____ Zip:_____ Phone:_____ Effective Date:____/___/____ Claim/Policy No:_____ **PLEASE BRING INSURANCE CARD AND DRIVERS LICENSE TO THE FRONT DESK TO COPY**
REASON FOR YOUR VISIT	Reason for Your Visit:_____ Other Doctors' Seen for This Condition:_____ Response:_____ Have You Had This in The Past? □ Yes □ No Explain:_____ When Did Symptoms Start:_____ Is It Getting Worse? □ Yes □ No Does It Interfere With □ Work □ Sleep □ Daily Routine □ Recreation Is It Painful To □ Sit □ Walk □ Bend □ Lie Down □ Lift Objects
HEALTH INFORMATION	Have You Ever Been Treated by A Chiropractor Before? □ Yes □ No For:_____ Please List, And Give Dates Of Any Serious Medical Conditions Or Surgeries You Have Had:_____ Pregnant? □ Yes □ No Do You Take? □ Muscle Relaxers □ Pain Killers □ OTC List Other Drugs That You Take:_____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with_____ Name of Insurance Company and assign directly to Dr. Manz/Midwest Chiropractic Center LLC all medical benefits, if any, otherwise payable to me for services rendered. This assignment will serve as notice to any and all attorneys & insurance companies either listed or not listed above. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _____ _____ Signature of Insured/Guardian Date

Midwest Chiropractic Center, LLC
6649 N. High St. Suite 101 Worthington, OH 43085
Phone: (614) 847-9667 Fax: (614) 847-9688

Patient Name: _____ Case #: _____ Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.
Please read the information below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Midwest Chiropractic Center, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

I _____, do hereby designate Peter Manz D.C., and Midwest Chiropractic Center to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and provided in 29CFR2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health expense(s) incurred as a result of the services I receive from the above named doctor/office. These rights include all rights to act on my behalf with respect to initial determinations of claims, to pursue appeal of the benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies

X-RAY CONSENT

To the best of my knowledge I **am pregnant / am NOT** pregnant /**I am male** and g**ive my permission / don't give permission** to x-ray me for diagnostic interpretation. *(Circle one above)* *(Circle one above)*

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event of emergency or that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____ Phone #: _____

Children: _____ Phone #: _____

Others: _____ Phone #: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device?
i.e. home answering machines or voicemails? Yes [ ] No [ ]

I understand that e-mail is often the best way to communicate about my condition and account. E-mails may be unencrypted by either the sender or the receiver and I acknowledge and understand the risks of unencrypted mails. I realize that information may be provided to me in another format such as print out or computer disk. I agree____ do not agree____ to emails regarding my account.

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided a copy of Midwest Chiropractic Center, LLC's HIPAA practices

Print Name: _____

Signature: _____ Date: _____

Patient Consent for Use and Disclosure of Protected Health Information

Midwest Chiropractic Center, LLC

I hereby give my consent for Midwest Chiropractic Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Midwest Chiropractic Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Midwest Chiropractic Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Midwest Chiropractic Center's Office Manager, Tracey Manz at 6104 Huntley Rd. Columbus OH 43229.

With this consent, Midwest Chiropractic Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Midwest Chiropractic Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Midwest Chiropractic Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Midwest Chiropractic Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Midwest Chiropractic Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Midwest Chiropractic Center may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Case # Date

MIDWEST CHIROPRACTIC CENTER LLC
6649 N. High St. Suite 101
Worthington, OH 43085
(614)847-9667

JOB DESCRIPTION/DAILY ACTIVITY

1. IN A TYPICAL EIGHT HOUR WORKDAY I: (CIRCLE ONE)

SIT	1	2	3	4	5	6	7	8	HOURS
STAND	1	2	3	4	5	6	7	8	HOURS
WALK	1	2	3	4	5	6	7	8	HOURS

2. ON THE JOB, I PERFORM THE FOLLOWING ACTIVITIES:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINOUSLY
BEND/STOOP				
SQUAT				
CRAWL				
CLIMB				
KNEEL				
BALANCE				
PUSHING				
PULLING				
REACH ABOVE- SHOULDER LEVEL				

3. ON THE JOB, I LIFT:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINOUSLY
UP TO 10 POUNDS				
11-24 POUNDS				
25-34 POUNDS				
35-50 POUNDS				
51-74 POUNDS				
75 TO 100 POUNDS				

4. DO YOU HAVE TO BEND OVER WHILE DOING ANY LIFTING? YES NO

5. ARE YOUR FEET OR HANDS USED FOR REPETITIVE MOVEMENT? YES NO

6. ARE YOU REQUIRED TO DRIVE ANY AUTOMOTIVE EQUIPMENT? YES NO

7. ARE YOU EXPOSED TO DUST, FUMES, AND/OR GREASE? YES NO

IF YES, PLEASE EXPLAIN: _____

ADDITIONAL COMMENTS: _____
_____
_____

_____ _____
SIGNATURE **DATE**

_____ _____
Print Name **Case #:**

Medication/Surgery Information
Midwest Chiropractic Center, LLC

Patient Name: _____ **Case No:** _____

Medication Updates (please be specific)

Name: _____

Dosage: _____

Name: _____

Dosage: _____

Name: _____

Dosage: _____

_____

Surgery Updates Please Be Specific (Month, Day and Year):

Name: _____

Date: _____

Name: _____

Date: _____

_____

Alcohol Consumption: Beer- __3 or more wk __3 or less wk; Wine- __3 or more wk __3 or less a wk; Liquor- __3 or more a wk __3 or less a wk ____ None

Smoking: ___ Yes ___ No
If yes: __Current everyday __Current some day __ Former smoker __ Never smoker
If yes: Amount per day/wk: _____

Drug Usage: _____

Allergies (meds/environmental): _____

_____

MIDWEST CHIROPRACTIC CENTER, LLC
6649 NORTH HIGH ST. SUITE 101 WORTHINGTON, OH 43085
614-847-9667(P) 614-847-9688 (F)

LOW BACK PAIN AND DISABILITY INDEX (ROLLAND-MORRIS DISABILITY QUESTIONAIRE)

Patient Name:_____ Case #: _____ Date:_____

Please Read: When your back hurts, you may find it difficult to do some of the things that you normally do. Circle the numbers that apply to you and your condition.

1. I stay at home most of the time because of the pain in my back.
2. I change position frequently to try and make my back comfortable.
3. I walk more slowly than usual because of the pain in my back.
4. Because of the pain in my back, I am not doing any of the jobs that I usually do around the house.
5. Because of the pain in my back, I use a handrail to get upstairs.
6. Because of the pain in my back, I lie down to rest more often.
7. Because of the pain in my back, I have to hold on to something to get out of a reclining chair.
8. Because of the pain in my back, I ask other people to do things for me.
9. I get dressed more slowly than usual because of the pain in my back.
10. I only stand up for short periods of time because of the pain in my back.
11. Because of the pain in my back, I try not to bend or kneel down.
12. I find it difficult to get out of a chair because of the pain in my back.
13. My back hurts most of the time.
14. I find it difficult to turn over in bed because of the pain in my back.
15. My appetite is not very good because of the pain in my back.
16. I have trouble putting on my socks (or stockings) because of the pain in my back.
17. I only walk short distances because of the pain in my back.
18. I sleep less because of the pain in my back.
19. Because of the pain in my back, I get dressed with help from someone else.
20. I sit down for most of the day because of the pain in my back.
21. I avoid heavy jobs around the house because of the pain in my back.
22. Because of the pain in my back, I am more irritable and bad tempered with people.
23. Because of the pain in my back, I go upstairs more slowly than usual.
24. I stay in bed most of the time because of the pain in my back.

Score_____ PJM/MMB

MIDWEST CHIROPRACTIC CENTER LLC
6649 N. High St. Suite 101
Worthington, OH 43085
(614)847-9667

NECK PAIN AND DISABILITY INDEX (VERNON-MIOR)

Patient Name:_____Case #_____ Date:_____/_____/_____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely 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 worse than 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 objects without any extra pain.

☐ I can lift heavy objects, but it gives extra pain.

☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.

☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.

☐ I can lift very light objects.

☐ I cannot lift or carry anything at all.

SECTION 4 - READING

☐ I can read as much as I want to with no pain in my neck.

☐ I can read as much as I want to with light pain in my neck.

☐ I can read as much as I want to with moderate pain in my neck.

☐ I can't read as much as I want to because of moderate pain in my neck.

☐ I can hardly read at all because of severe pain in my neck.

☐ I cannot read at all.

SECTION 5 - HEADACHES

☐ I have no headache at all.

☐ I have slight headaches which come infrequently.

☐ I have moderate headaches which come infrequently.

☐ I have moderate headaches which come frequently.

☐ I have severe headaches which come frequently.

☐ I have headaches almost all the time.

SECTION 6 - CONCENTRATION

☐ I can concentrate fully when I want to with no difficulty.

☐ I can concentrate fully when I want to with slight difficulty.

☐ I have a fair degree of difficulty in concentrating when I want to.

☐ I have a lot of difficulty in concentrating when I want to.

☐ I have a great deal of difficulty in concentrating when I want to.

☐ I cannot concentrate at all.

SECTION 7 - WORK

☐ I can do as much work as I want.

☐ I can do only my usual work, but no more.

☐ I can do most of my usual work, but no more.

☐ I cannot do my usual work.

☐ I can hardly work at all.

☐ I can't do any work at all.

SECTION 8 - DRIVING

☐ I can drive without any neck pain.

☐ I can drive as long as I want with slight neck pain.

☐ I can drive as long as I want with moderate neck pain.

☐ I can hardly drive at all because of severe neck pain.

☐ I can't drive at all.

SECTION 9 - SLEEPING

☐ I have no trouble sleeping.

☐ My sleep is slightly disturbed (less than 1 hr. sleepless).

☐ My sleep is mildly disturbed (1-2 hrs. sleepless).

☐ My sleep is moderately disturbed (3-5 hrs. sleepless).

☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

☐ I am able to engage in all my recreational activities with no neck pain.

☐ I am able to engage in all my recreational activities with some neck pain.

☐ I am able to engage in most, but not all of my usual recreational activities because of neck pain.

☐ I am able to engage in a few of my usual recreational activities because of neck pain.

☐ I can hardly do any recreational activities because of neck pain.

☐ I can't do any recreational activities at all.

Midwest Chiropractic Center LLC- Pain Assessment Record
6649 North High St. Worthington OH 43085

In order for us to best serve you, and so that we may determine the progress of your present condition, please provide us with the following information. **PLEASE PRINT**

Name: _____ Case No: _____ Date: _____

Current Pain Record

1. List present complaints: _____

   _____

2. Is your condition: ☐ Improved ☐ Staying the same ☐ Getting worse

3. How does your pain interfere with your work: _____

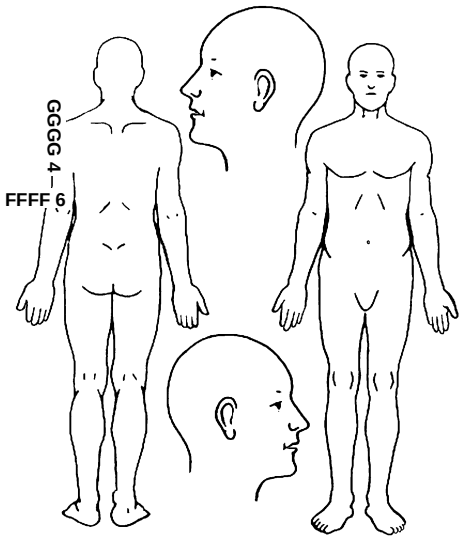
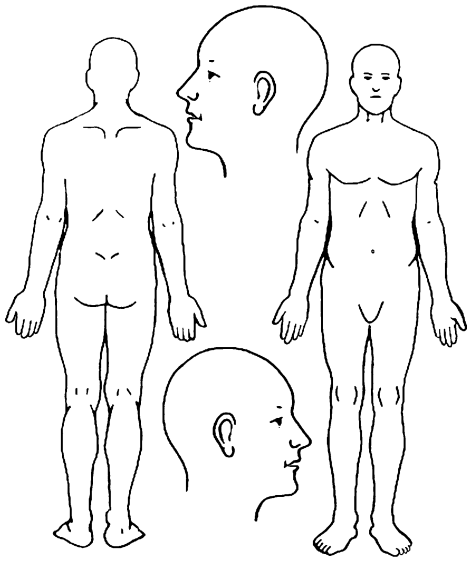
   home activity: _____ school activity: _____

4. Type of Pain:

   ☐ A: Sharp ☐ B: Tingling ☐ C: Throbbing ☐ D: Numbness ☐ E: Aching ☐ F: Shooting

   ☐ G: Dull ☐ H: Burning ☐ I: Cramping ☐ J: Stiffness ☐ K: Swelling ☐ L: _____

5. Please mark your area(s) of pain with the letter (A, B, C etc.) associated with the Type Of Pain you checked above. Indicate the degree of pain by using a scale from 1 (discomfort) to 10 (extreme pain) as seen in the example below:

Example	Show Us Where It Hurts
	

Doctor/Patient Comments:

Patient's Signature: _____ Date: _____