



WALDRON

Chiropractic Health Center, P.A.

D. Keatley Waldron, D.C. • Carl E. Lavin, D.C.
WEST SHORE PLAZA • 13 Ryant Blvd. • Sebring, FL 33870
863-382-4445 • Fax 863-382-4447

FOR OFFICE USE ONLY

NP: _____ Pt. Update _____

PATIENT INFORMATION

Date: _____

Name: _____ Age: _____ Gender: M / F

DOB: _____ SSN: _____ - _____ - _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ How Did You Hear About Us? _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone Number: _____

Medications: _____

FOR OFFICE USE ONLY

Vitals: BP: _____ P: _____ Temp: _____ Wt: _____ Ht: _____ SPO2: _____

DOCTOR'S NOTATION:

"We Specialize In Caring"



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PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

Waldron Chiropractic Health Center, P.A. now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. We believe strongly in protecting the privacy of our patients. When you provide this information to us, it is only used to communicate with you. To protect your privacy, no confidential or personal information will be sent from SolutionReach via email or text messaging. Waldron Chiropractic Health Center, P.A. does not share the names, e-mail addresses, or telephone numbers of patients with any other company, or with any other patient.

Please print all information neatly and legibly.

Name: _____

Email Address: _____

Cell Phone: _____

*******DATA FEES AND TEXT MESSAGING RATES MAY APPLY*******

I hereby give Waldron Chiropractic Health Center, P.A. permission to send messages to me via e-mail and/or text messaging as a means of communication.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

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Consent to Care/Financial Policy

I do hereby authorize Waldron Chiropractic Health Center to administer such care that is necessary for my particular case. This care may include consultation, examination, diagnostic x-rays and other health care procedures that is advisable and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future to treat me while employed by, working or associated with or serving as back up for the doctor of chiropractic named above, including those working at this clinic or office or any other office or clinic to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of the postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with the office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the medical conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. *I authorize the assignment of all insurance benefits to be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the clinic.*

I, _____, have read or have had read to me, the above consent. I also had the opportunity to ask questions about this consent, and by signing below, I agree to the above named procedures. I authorize this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature: _____ Date: _____
(If under age 18, Parent's Signature)

Insurance Information

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The nurse practitioner's office will provide any necessary report or required information to aid in insurance reimbursement of services, but understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Signature: _____ Date: _____
(If under age 18, Parent's Signature)

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

Date

Printed Name

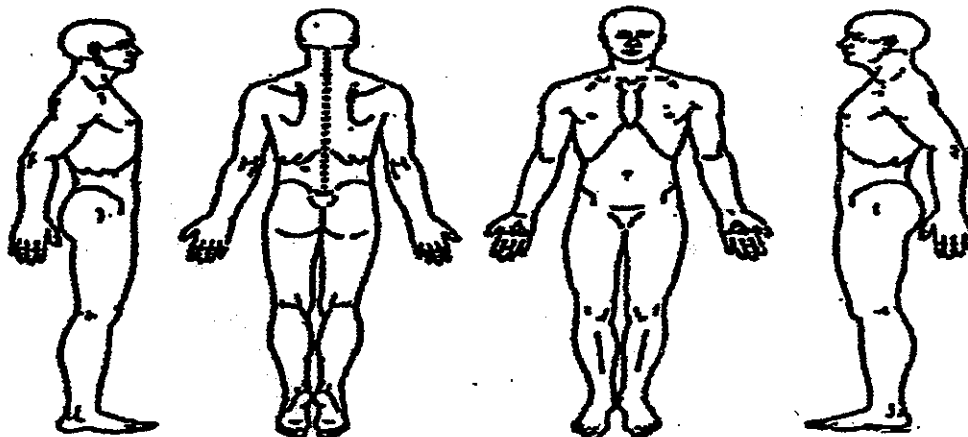
PATIENT INTAKE FORM

Patient Name: _____

Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

Constantly (76-100% of the time)

Frequently (51-75% of the time)

Occasionally (26-50% of the time)

Intermittently (1-25% of the time)

4. How would you describe the type of pain?

Sharp

Dull

Diffuse

Achy

Burning

Shooting

Stiff

Numb

Tingly

Sharp with motion

Shooting with motion

Stabbing with motion

Electric like with motion

Other: _____

5. How are your symptoms changing with time?

Getting Worse

Staying the Same

Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

Not at all

A little bit

Moderately

Quite a bit

Extremely

8. How much has the problem interfered with your social activities?

Not at all

A little bit

Moderately

Quite a bit

Extremely

9. Who else have you seen for your problem?

Chiropractor

Neurologist

Primary Care Physician

ER physician

Orthopedist

Other: _____

Massage Therapist

Physical Therapist

No one

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe?

Yes

Yes, at times

No

13. What aggravates your problem? _____

14. What alleviates the discomfort?

15. What concerns you the most about your problem; what does it prevent you from doing?

16. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

17. How would you rate your overall Health?

Excellent Very Good Good Fair Poor

18. What type of exercise do you do?

Strenuous Moderate Light None

19. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

For Females Only

Birth Control Pills
 Hormonal Replacement
 Pregnancy

21. List all prescription medications you are currently taking:

22. List all of the over-the-counter medications you are currently taking:

23. List all surgical procedures you have had:

24. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

25. What activities do you do outside of work?

26. Have you ever been hospitalized? No Yes
if yes, why _____

27. Have you been to a chiropractor in the past? No Yes

28. How long ago? _____

29. Have you had significant past trauma? No Yes

30. Anything else pertinent to your visit today? _____

31. Have you had a non-fasting cholesterol test in the past five years?

_____ It is good but can't remember the date it was taken
_____ Yes and knows the findings
_____ Will schedule a test

32. Have you had influenza vaccination this year?

_____ Yes but forgot the date
_____ Yes and knows the date
_____ No and refuses to get one

33. Have you been screened for colon cancer?

_____ Has had a negative fecal occult blood test in the past 5 years
_____ Yes and knows the date
_____ Has had a flexible sigmoidoscopy in the past 5 years
_____ Has had a double contrast barium enema in the past 5 years
_____ Will not be tested

34. Is up to date with papsmeears?

_____ Up to date and fine but doesn't know the exact date
_____ She knows the exact date and findings.
_____ She refuses to discuss this

Patient Signature _____ Date: _____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may apply to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity

1. I have no pain at the moment.
2. The pain is very mild at the moment.
3. The pain is moderate at the moment.
4. The pain is fairly severe at the moment.
5. The pain is very severe at the moment.
6. The pain is the worst imaginable at the moment.

Section 2 – Personal Care

1. I can look after myself normally without causing extra pain.
2. I can look after myself normally, but it causes extra pain.
3. It is painful to look after myself and I am slow and careful.
4. I need some help, but manage most of my personal care.
5. I need help every day in most aspects of self-care.
6. I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes extra pain.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can lift very light weights.
6. I cannot lift or carry anything at all.

Section 4 – Reading

1. I can read as much as I want to with no pain in my neck.
2. I can read as much as I want to with slight pain in my neck.
3. I can read as much as I want to with moderate pain in my neck.
4. I cannot read as much as I want because of moderate pain in my neck.
5. I cannot read as much as I want because of severe pain in my neck.
6. I cannot read at all.

Section 5 – Headaches

1. I have no headaches at all.
2. I have slight headaches, which come infrequently.
3. I have moderate headaches, which come infrequently.
4. I have moderate headaches, which come frequently.
5. I have severe headaches, which come frequently.
6. I have headaches almost all of the time.

Section 6 – Concentration

1. I can concentrate fully when I want to with no difficulty.
2. I can concentrate fully when I want to with slight difficulty.
3. I have a fair degree of difficulty in concentrating when I want to.
4. I have a lot of difficulty in concentrating when I want to.
5. I have a great deal of difficulty in concentrating when I want to.
6. I cannot concentrate at all.

Section 7 – Work

1. I can do as much work as I want to.
2. I can do only my usual work, but no more.
3. I can do most of my usual work, but no more.
4. I cannot do my usual work.
5. I can hardly do any work at all.
6. I cannot do any work at all.

Section 8 – Driving

1. I can drive my car without any neck pain.
2. I can drive my car as long as I want with slight pain in my neck.
3. I can drive my car as long as I want with moderate pain in my neck.
4. I cannot drive my car as long as I want because of moderate pain in my neck.
5. I can hardly drive at all because of severe pain in my neck.
6. I cannot drive my car at all.

Section 9 – Sleeping

1. I have no trouble sleeping.
2. My sleep is slightly disturbed (less than 1 hour sleepless).
3. My sleep is mildly disturbed (1-2 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless).
5. My sleep is greatly disturbed (3-5 hours sleepless).
6. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

1. I am able to engage in all of my recreational activities, with no neck pain at all.
2. I am able to engage in all of my recreational activities, with some pain in my neck.
3. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
4. I am able to engage in a few of my usual recreational activities because of pain in my neck.
5. I can hardly do any recreational activities because of pain in my neck.
6. I cannot do any recreational activities at all.

Comments: _____

Patient's Signature: _____ Date: _____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may apply to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLEARLY DESCRIBES YOUR PROBLEM RIGHT NOW.

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

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 increases the pain, but I manage not to change my way of doing it.
4. Washing and dressing increases 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 or dressing without help.

Section 3 – Lifting

1. I can lift heavy weights without extra pain.
2. I can lift heavy weights, but it causes 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. Pain does not prevent me from walking any distance.
2. Pain prevents me from walking more than one mile.
3. Pain prevents me from walking more than ½ mile.
4. Pain prevents me from walking more than ¼ mile.
5. I can only walk while using a cane or on crutches.
6. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

1. I can sit in any chair as long as I like without pain.
2. I can only sit in my favorite chair as long as I like.
3. Pain prevents me from sitting more than one hour.
4. Pain prevents me from sitting more than ½ hour.
5. Pain prevents me from sitting more than ten minutes.
6. Pain prevents me from sitting at all.

Section 6 – Standing

1. I can stand as long as I want without pain.
2. I have some pain while standing, but it does not increase with time.
3. I can not stand for longer than one hour without increasing pain.
4. I can not stand for longer than ½ hour, without increasing pain.
5. I can not stand for longer than ten minutes, without increasing pain.
6. I avoid standing, because it increases the pain straight away.

Section 7 – Sleeping

1. I get no pain in bed.
2. I get pain in bed, but it doesn't prevent me from sleeping well.
3. Because of my pain, my normal night's sleep is reduced by less than one-quarter.
4. Because of my pain, my normal night's sleep is reduced by less than one-half.
5. Because of my pain, my normal night's sleep is reduced by less than three-quarters.
6. Pain prevents me from sleeping at all.

Section 8 – Social Life

1. My social life is normal and gives me no pain.
2. My social life is normal, but increases the degree of my 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 get no pain while traveling.
2. I get some pain while traveling, but none of my usual forms of travel make it any worse.
3. I get extra pain while traveling, but it does not compel me to seek alternate forms of travel.
4. I get 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 at present.
4. My pain is neither getting better or worse.
5. My pain is gradually getting worse.
6. My pain is rapidly worsening.

Comments: _____

Patient's Signature: _____ Date: _____