Confidential Patient Health Record **Date:** _____

PERSONAL HISTORY

Name:_____ Address:_____
Email Address:_____ City:_____ State:____ Zip:_____
Home Phone: (_____)_____ Birth date:_____ Age:_____ Sex: M F
Cell Phone: (_____)_____ Circle One: Single Married Divorced
Cell Phone Provider: _____ Widowed Partner
Social Security #:_____ Emergency Contact:_____
Business Employer:_____ Phone #: (_____)_____
Type of Work:_____ Relationship:_____
Business Phone:_____ Health Insurance Carrier:_____
How did you hear about us?_____ ID #:_____ Group#:_____

CURRENT HEALTH CONDITION

Chief Complaint:_____
When Did This Condition Begin?_____
Has This Condition Occurred Before? □ Yes □ No
Is This Condition: Job Related / Auto Accident / Home Injury / Fall / Other_____
Have You Made A Report Of Your Accident To Your Employer? □ Yes □ No □ N/A
Any Other Doctors Seen For This Condition? □ Yes □ No Who?_____
Type of Treatment:_____
Medications Currently Being Taken:_____
_____
Vitamins/Supplements Currently Being Taken:_____
Do You Wear Foot Orthotics? □ Yes □ No Do you have a pacemaker? □ Yes □ No
Any Other Conditions That You Wish to Discuss With the Doctor:_____
_____

PAST HEALTH HISTORY

Major Surgeries/Operations:_____
_____
Major Accidents/Falls:_____
Hospitalizations (other than above):_____
Have You Had Previous Chiropractic Care? □ Yes □ No Date of Last Visit:_____
Treating Doctor and/or Facility:_____
Results:_____
_____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES THAT YOU HAVE HAD:

□ Pneumonia	□ Pleurisy	□ Diabetes	□ Anemia
□ Mumps	□ Polio	□ Epilepsy	□ Heart Disease
□ Influenza	□ Chicken Pox	□ Whooping Cough	□ Measles
□ Rheumatic Fever	□ Arthritis	□ Cancer	□ Thyroid
□ Small Pox	□ Tuberculosis	□ Mental Disorders	□ Eczema

Have you tested HIV positive? □ Yes □ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD WITHIN THE PAST 6 MONTHS:

MUSCULO-SKELETAL
□ Low Back Pain
□ Pain Between Shoulders
□ Neck Pain
□ Arm Pain
□ Joint Pain/Stiffness
□ Walking Problems
□ Difficult Chewing/Clicking Jaw
□ General Stiffness

NERVOUS SYSTEM
□ Nervousness
□ Numbness
□ Paralysis
□ Dizziness
□ Forgetfulness
□ Confusion/Depression
□ Fainting
□ Convulsions
□ Cold/Tingling Extremities
□ Stress

EENT
□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Ear Aches
□ Hearing Difficulty
□ Stuffy Nose

GASTRO-INTESTINAL
□ Poor/Excessive Appetite
□ Frequent Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Hemorrhoids
□ Liver Problems
□ Gall Bladder Problems
□ Weight Issues
□ Abdominal Cramps
□ Gas/Bloating
□ Heartburn
□ Black/Bloody Stool
□ Colitis

GENERAL
□Fatigue
□ Allergies
□ Loss of Sleep
□ Fever
□ Headaches

MALE/FEMALE
□ Menstrual Irregularity
□ Menstrual Cramps
□ Vaginal Pain/Infection
□ Breast Pain/Lumps
□ Prostate/Sexual Dysfunction

FEMALES ONLY
When was our last period?
____/____/____

Are you Pregnant?
□ Yes □ No □ Not Sure

CONSUMPTION
□ Coffee
□ Tea
□ Alcohol
□ Caffeinated Beverages
□ Cigarettes
□ White Sugar
□ Water in ounces/day_____

FAMILY HISTORY
□ Mother
□ Father
□ Brother
□ Sister
□ Child
□ Spouse

REVISED OSWESTRY INDEX

Name:_____ **Date:**_____ **Disability %:**_____

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

Section 1-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 moderately increasing.
- □ The pain is moderate and does not vary much.
- □ The pain comes and goes and is severe.
- □ The pain is severe and does not vary much.

Section 2-Personal Care (Washing, Dressing, etc.)
- □ I would 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 increase 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.

Section 3-Lifting
- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives extra pain.
- □ Pain prevents me from lifting heavy things off the floor.
- □ Pain prevents me from lifting heavy things off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can only lift very light weights at the most.

Section 4-Walking
- □ I have no pain while walking.
- □ I have some pain on walking but it does not increase with distance.
- □ I cannot walk more than one mile without increasing pain.
- □ I cannot walk more than ½ mile without increasing pain.
- □ I cannot walk more than ¼ mile without increasing pain.
- □ I cannot walk at all without increasing pain.

Section 5-Sitting
- □ I can sit in any chair as long as I like without pain.
- □ I can sit only 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 ½ hour.
- □ Pain prevents me from sitting more than 10 minutes.
- □ I avoid sitting because it increases pain immediately.

Section 6-Standing
- □ I can stand as long as I want without pain.
- □ I have some pain standing, but it does not increase with time.
- □ I cannot stand longer than 1 hour without increasing pain.
- □ I cannot stand for longer than ½ hour without increasing pain.
- □ I cannot stand for longer than 10 minutes without increasing pain.
- □ I avoid standing because it increases the pain immediately.

Section 7-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 night's sleep is reduced by less than ¼.
- □ Because of pain, my normal night's sleep is reduced by less than ½.
- □ Because of pain, my normal night's sleep is reduced by less than ¾.
- □ Pain prevents me from sleeping at all.

Section 8-Social Life
- □ My social life is normal and gives me no pain.
- □ My social life is normal but increases the degree of pain.
- □ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.....
- □ Pain has restricted my social life and I do not go out much.
- □ Pain has restricted my social life to my home.
- □ I have hardly any social life because of my pain.

Section 9-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 compel me to seek alternative forms of travel.
- □ I get extra pain while traveling which compels me to seek alternative forms of travel.
- □ Pain prevents all forms of travel except one lying down.
- □ Pain restricts all forms of travel.

Section 10-Changing Degrees 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 slowly improves.
- □ My pain is neither getting better nor worse.
- □ My pain is gradually worsening.
- □ My pain is rapidly worsening.

From Vernon H. Minor S. JMPT 1991: 14(7):409-415

CONSENT FOR TREATMENT AND CONSULTATION/HIPAA POLICIES

I hereby request and consent to the performance of Chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic Radiographs, on myself (or on the patient named below, for whom I am legally responsible) by Dr. Jason W. Ingham and/or other licensed doctors of chiropractic who now or in the future treat the undersigned while employed by, working or associated with or serving as vacation relief for Dr. Jason W. Ingham whether signatories to this form or not.

Chiropractic only has one goal. It is important that each patient understand both the objective and the method used to obtain this goal. This will prevent any confusion or disappointment. We do not offer to diagnose or treat any condition other than vertebral subluxation. However, if during the course of your chiropractic spinal examination, we encounter any non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider that specializes in that area.

I understand and I am informed that, as in the practice of medicine, the practice of chiropractic involves 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 on the facts then known, is in my best interest. I also understand that the practice of chiropractic is limited in its diagnostic abilities and Dr. Jason W. Ingham cannot, will not, and is not expected to diagnose medical conditions.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician. This protected health 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 Advanced Spine & Sports Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Advanced Spine & Sports Care. I understand that Dr. Ingham may refuse to diagnose or treat me, if I don't consent to the use or disclosure of my protected health information for the above states of 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. Advanced Spine & Sports Care is not required to agree to the restrictions that I may request, the restriction is binding on Advanced Spine & Sports Care and Dr. Ingham.

I understand I have a right to review Advanced Spine & Sports Care's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of care operations of Advanced Spine & Sports Care. The Notice of Privacy Practices for Advanced Spine & Sports Care is also provided on request at the main administrative desk of this practice. Notice of Privacy Practices also describes my rights and Advanced Spine & Sports Care's duties with respect to my protected health information.

Advanced Spine & Sports Care 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 Advanced Spine & Sports Care's 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 that Advanced Spine & Sports Care or Dr. Ingham has taken action in reliance on this consent.

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

PATIENT SIGNATURE _____ **DATE** _____

GUARDIAN SIGNATURE_____ **DATE** _____

REFERRING PHYSICIAN: **ADVANCED SPINE & SPORTS CARE**

Type of Case: ____ Grp. Health ____ Medicare ____ Work Comp ____ PI
____ PI w/ MedPay ____ Bill Patient ____ Bill Doctor ____ Date of Accident: _____

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip : _____

Telephone: ( ) _____ DOB: _____/_____/_____ SS# _____ - _____ - _____

SEX: M or F Relation of Insured: SELF SPOUSE CHILD OTHER: _____

Employer: _____ Phone# : _____

Address: _____ CITY, ST, ZIP _____

INSURANCE INFORMATION:	PRIMARY	SECONDARY
INSURANCE NAME:	_____	_____
INS ADDRESS:	_____	_____
INS. CITY/STATE/ZIP:	_____	_____
POLICY OR CLAIM NUMBER:	_____	_____
GROUP:	_____ PH( ) - _____	_____ PH#( ) - _____
ADJUSTOR:	_____	_____
INSURED IF DIFF. FROM PT:	_____	_____
ADDRESS:	_____	_____
INSURED SOC. SEC. #	_____/_____/_____	_____/_____/_____

I, _____ consent to specialized radiology consultants ("SRC") use and disclosure my Protected Health information for the purpose of providing radiology readings for me, and for the SRC's general health care operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management, and other general operation activities, I understand that the SRC's diagnosis of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this consent, "protected Health Information" means any information, including demographic information, created or received by SRC, that relates to my past, present, or future physical or mental health or condition: the provision of health care to me; or the past, present, or future payment for the provision of health care services to me: and that either identifies me of from which there is reasonable basis to believe the information can be used to identify me.

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

I understand I have a right to review the SRC's Privacy practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice duties regarding the types of uses and disclosures of my Protected Health Information. I understand if I desire a copy, I may call the above number and one will be copied and mailed to me.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or SRC has acted in reliance to this consent.

I understand that there will be a separate bill for SRC's radiology interpretation and written report. I also authorize all claims to be sent directly to the insurance company and I authorize payment to be made directly to SRC and accept responsibility for any remaining balance billed.

_____ Date: _____

Signature of Patient or Personal Representative

Specialized Radiology Consultants
Wheaton, IL
Fax: 630.462.9778