Amelia Chiropractic Clinic, 2888 S. 8th St. , Fernandina Beach, FL 32034 (904 321-0002)

CONFIDENTIAL PATIENT INFORMATION

FEDERAL AND STATE LAWS REQUIRE ALL HEALTH CARE PROVIDERS TO COLLECT THE FOLLOWING INFORMATION AND KEEP IT ON FILE FOR FOUR (4) YEARS. PLEASE COMPLETE THE FOLLOWING FORMS. THANK YOU.

(PLEASE PRINT)

NAME_____ TODAY'S DATE_____

HOME PHONE_____CELLULAR/PAGER_____

ADDRESS_____ E-MAIL ADDRESS_____

CITY_____STATE_____ZIP_____

AGE_____BIRTH DATE_____ MARITAL STATUS M S W D # OF CHILDREN_____

OCCUPATION_____ PHONE_____

EMPLOYER_____

ADDRESS_____

NAME OF SPOUSE_____ OCCUPATION_____

EMPLOYER_____ PHONE_____

NEAREST RELATIVE_____ PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

NAME OF PERSON RESPONSIBLE FOR PAYMENT _____

NAME OF HEALTH PLAN _____

AUTHORIZATION TO PROVIDE TREATMENT AND BILL HEALTH PLAN:

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. WE UNDERSTAND THAT YOUR HEALTH INFORMATION IS PERSONAL AND WE ARE COMMITTED TO PROTECTING IT. WE CREATE A RECORD OF YOUR CARE AND SERVICES YOU RECEIVE AT OUR CLINIC. WE NEED THIS RECORD TO PROVIDE YOU WITH QUALITY CARE AND COMPLY WITH FEDERAL AND STATE LAWS. COPIES OF YOUR RECORDS ARE AVAILABLE FOR A NOMINAL FEE. WE WILL MAINTAIN YOUR RECORDS IN ACCORDANCE WITH STATE LAW FOR NO LESS THAN FOUR YEARS.

THE INFORMATION OBTAINED FROM YOU WILL ALWAYS BE HELD IN STRICT CONFIDENCE.
BY SIGNING BELOW, YOU ARE AGREEING TO ALLOW US TO PROVIDE YOU APPOINTMENT CONFIRMATIONS, BIRTHDAY CARDS, AND OTHER SUCH INFORMATION THAT WILL MAKE YOUR TREATMENT MORE ENJOYABLE AND PRODUCTIVE.

I AUTHORIZE THE DOCTORS OF AMELIA CHIROPRACTIC CLINIC TO PROVIDE TREATMENT TO ME. I UNDERSTAND THAT AMELIA CHIROPRACTIC CLINIC WILL VERIFY MY INSURANCE COVERAGE AND PREPARE NECESSARY REPORTS AND FORMS, AND ASSIST IN MAKING COLLECTION FROM MY HEALTH PLAN. BY SIGNING BELOW, I AM AUTHORIZING AMELIA CHIROPRACTIC CLINIC. TO RELEASE MY HEALTH INFORMATION INCLUDING MY MEDICAL HISTORY, X-RAY RESULTS, AND PHYSICAL EXAMINATION FINDINGS, DIAGNOSIS AND PROGNOSIS TO MY HEALTH PLAN.

UNFORTUNATELY, THERE IS NO GUARANTEE MY HEALTH PLAN WILL MAKE PAYMENT AND I UNDERSTAND THAT CHARGES FOR TREATMENT ARE ULTIMATELY MY RESPONSIBILITY. ANY AMOUNT PAID BY THE HEALTH PLAN WILL BE PAID DIRECTLY TO AMELIA CHIROPRACTIC CLINIC AND WILL BE CREDITED TO MY ACCOUNT. A SERVICE CHARGE OF 5% PER MONTH WILL BE ASSESSED ON ALL ACCOUNTS OLDER THAN 60 DAYS. ANY FEES NECESSARY FOR THE COLLECTION OF THIS ACCOUNT WILL ALSO BE MY RESPONSIBILITY. IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEE FOR PROFESSIONAL SERVICES RENDERED WILL BE IMMEDIATELY DUE AND PAYABLE.

MY HEALTH PLAN (S) IS HEREBY DIRECTED AND AUTHORIZED TO MAKE PAYMENTS DIRECTLY TO AMELIA CHIROPRACTIC CLINIC.

PATIENT'S SIGNATURE_____SS #_____

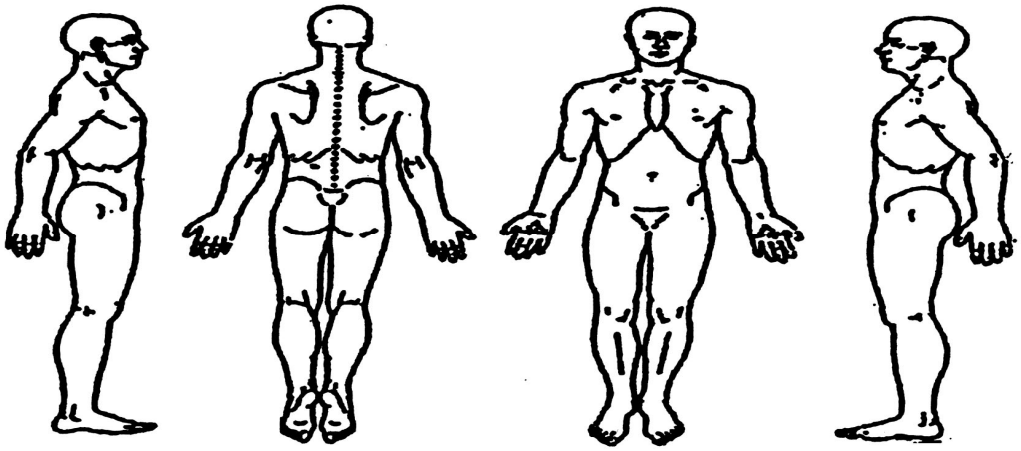
PARENT/ GUARDIAN
SIGNATURE AUTHORIZING CARE_____ DATE_____

Amelia Chiropractic Clinic, 2888 South 8th Street, Fernandina Beach, FL 32034 (904)321-0002

Confidential Patient Information

Patient Name: _____ **Date** _____

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



2. How often do you experience your symptoms?
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time) □ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

□ Sharp	□ Numb	□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion	□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion	□ Shooting	□ Electric like with motion
□ Stiff	□ Other _____		

4. How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

5. Using a scale of 0-10 (10 being the worst), how would you rate your problem?
(please circle) 0 1 2 3 4 5 6 7 8 9 10

6. How much has the problem interfered with your work?
__ Not at all __ A little bit __ Moderately __ Quite a bit __ Extremely

7. How much has the problem interfered with your social activities?
__ Not at all __ A little bit __ Moderately __ Quite a bit __ Extremely

8. Who else have you seen for your condition?

□ Chiropractor	□ Neurologist	□ Primary Care Physician	□ ER physician
□ Orthopedist	□ Massage Therapist	□ Physical Therapist	□ Other _____

9. How long have you had this problem? (i.e. date of onset?)_____

10. How do you think your problem began? (i.e. accident or injury) _____

_____

11. What aggravates your problem?_____

12. What alleviates your problem?

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

_____

14. What is your: Height_____ Weight _____

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

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

16. List all medications you are currently taking:_____

_____

___Any Medical Allergies?_____

Do you smoke? _____Yes ____No

17. Please check any of the conditions below that may apply to you.

□ Headaches	□ High Blood Pressure	□ Neck Pain	□ Heart Attack
□ Chest Pains	□ Frequent Urination	□ Stroke	□ Smoking/Tobacco Use
□ Excessive Thirst	□ Angina	□ Drug/Alcohol Dependence	□ Kidney Stones
□ Allergies	□ Kidney Disorders	□ Depression	□ Bladder Infection
□ Systemic Lupus	□ Painful Urination	□ Epilepsy	□ Loss of Bladder Control
□ Dermatitis/Eczema/Rash	□ Prostate Problems	□ HIV/AIDS	□ Abnormal Weight Gain/Loss
□ Diabetes	□ Loss of Appetite	□ Ulcer	□ Arthritis
□ Hepatitis	□ Rheumatoid Arthritis	□ Liver/Gall Bladder Disorder	□ Cancer
□ General Fatigue	□ Tumor	□ Loss of muscle coordination	□ Asthma
□ Visual Disturbances	□ Chronic Sinusitis	□ Abdominal Pain	
□ Dizziness	□ Other _____		

18. List all surgical procedures you have had: _____

_____

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

_____

20. What activities do you do at work?

___ Sit: __ most of the day __ Half of the day __ A little of the day

___Stand: __ most of the day __ Half of the day __ A little of the day

___ Computer Work: __ most of the day __ Half of the day __ A little of the day

___ On the Phone: __ most of the day __ Half of the day __ A little of the day

21. What activities do you do outside of work? _____

_____

22. Have you had significant past trauma? ___ No ___ Yes

23. Anything else pertinent to your visit today?

_____

Patient Signature_____ Date: _____

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | ***Unbearable pain***

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

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

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

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

The Neck Disability Index

Patient name: _____ File#_____ Date:_____

Please read instructions:

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 answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just 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 the worst 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 weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, 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 lift very light weights.
- ☐ 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 slight 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, 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 headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that 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 to.
- ☐ I can do 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 do any work at all.
- ☐ I can't do any work at all.

SECTION 8-DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want, with slight pain in my neck.
- ☐ I can drive my car as long as I want, with moderate pain in my neck.
- ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car 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 (2-3 hrs sleepless).
- ☐ My sleep is greatly 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 recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck pain at all.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.

2. Using this system, a score of 10-28% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-48% is moderate; 50-68% is severe; 72% or more is complete.

Amelia Chiropractic Clinic
2888 S. 8th Street, Fernandina Beach, FL 32034 * Tel (904) 321-0002

INSURANCE AUTHORIZATION

I AUTHORIZE THE DOCTORS OF RD RICE CHIROPRACTIC, P.A. **DBA - AMELIA CHIROPRACTIC CLINIC** TO PROVIDE TREATMENT TO ME. I UNDERSTAND THAT RD RICE CHIROPRACTIC, P.A. **DBA - AMELIA CHIROPRACTIC CLINIC** WILL VERIFY MY INSURANCE COVERAGE AND PREPARE NECESSARY REPORTS AND FORMS, AND ASSIST IN MAKING COLLECTION FROM MY HEALTH PLAN. BY SIGNING BELOW, I AM AUTHORIZING RD RICE CHIROPRACTIC, P.A. **DBA - AMELIA CHIROPRACTIC CLINIC** TO RELEASE MY HEALTH INFORMATION INCLUDING MY MEDICAL HISTORY, X-RAY RESULTS, AND PHYSICAL EXAMINATION FINDINGS, DIAGNOSIS AND PROGNOSIS TO MY HEALTH PLAN.

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PATIENT'S SIGNATURE_____

PARENT/ GUARDIAN
SIGNATURE AUTHORIZING CARE_____

DATE_____

Amelia Chiropractic Clinic

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: **The doctor will use his/her hands or a mechanical device in order to adjust your spine. Various therapeutic procedures, such as hot or cold packs, electric muscle stimulation, or therapeutic ultrasound may also be used.**

Possible Risks: **As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The therapeutic procedures could produce skin irritation, burns or minor complications. Should you have questions you will be given the opportunity to discuss them with the doctor before you receive treatment.**

Probability of risks occurring: **The risk of complications due to chiropractic treatment have been described as "rare", about as often as complications from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be further reduced by screening procedures. The probability of adverse reaction due to therapeutic procedures is also considered "rare."**

Other treatment options which could be considered **may include the following:**

- ***Over-the-counter analgesics.*** **The risk of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.**
- ***Medical care,*** **typically anti-inflammatory drugs, tranquilizers and analgesics. Risk of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.**
- ***Hospitalization*** **in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.**
- ***Surgery*** **in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.**

Risks of remaining untreated: **Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.**

I have read the explanation above of chiropractic treatment. I have fully evaluated the risks and benefits of undergoing treatment. I have decided to undergo chiropractic treatment, and herby give my full consent to treatment. I intend this agreement to be in effect for all treatments from the date signed until I curtail treatment at this facility.

_____	_____	_____
Patient Printed Name	Patient Signature	Date

Witness:

_____	_____	_____
Printed Name	Signature	Date

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) **Date**

_____
Parent, Guardian or Patient's Legal Representative

_____
Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Please list below person(s) that we may discuss your medical information with.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Amelia Chiropractic Clinic

2888 South 8th Street
Fernandina Beach, FL 32034
(904) 321-0002 (voice & fax)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: _____

_____

_____

Please release my x-rays and medical records to:

The Amelia Chiropractic Clinic
2888 S. 8th Street
Fernandina Beach, FL. 32034
(904) 321-0002

_____
Signature

Name of Patient (Please Print)_____

Date of Birth _____

Amelia Chiropractic Clinic

2888 S. 8th Street, Fernandina Beach, FL 32034 * Tel (904) 321-0002

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your Chiropractic Health Provider. In order to provide you and our other patients with the best optimal spine care, we request that you follow our guidelines regarding broken or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least **24 hour notice** in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Therefore, all broken or cancelled appointments within 24 hours of the scheduled time will be charged a **missed appointment fee of $25.00 for an office visit**. Thank you for your consideration of our policies, and for the opportunity to be your Chiropractic office of choice.

_____ _____

Signature Date

EHR Certification – Patient Information 4

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Name: (Print clearly) _____ **Today's Date:** _____

Date of Birth: _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Circle all that apply)

White	American Indian/ Alaskan Native	Black/African American
Asian	Native Hawaiian/ Pacific Islander	

Please list health history, the condition and the relative (i.e., Mother, Father, Sister, Brother, Son Daughter, etc.)

Health Condition	Relative

If there is an emergency, in which language would you like to receive the message?

_____

What is your preferred method of contact?

Home	Work	Cell

Phone Number: _____

Phone Call: ☐ Text: ☐ E-Mail: ☐

Email Address:_____

For confidential correspondence, please create a Secret Question, i.e., What was my first pet's name? (Answer must have at least six characters):

Secret Question**:**_____

Secret Answer:_____

OFFICE USE ONLY

Vitals: In EZnotes, complete by 1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: _____/_____ **Height:** _____ Weight: _____

Smoking Status:

Smokes everyday	Smokes some days	Former Smoker	Never Smoked

If you smoke, how many cigarettes do you smoke per day?_____

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	**# of MD refills issued:**	**Quantity of Pills:**	**Strength:** i.e. 10 mg	**MD's instruction:** i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:

Check here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	**Symptom:** i.e. headache	**Severity:** i.e. Mild, Moderate, Severe, Fatal

Even though the Federal Government suggests that I apply for a Microsoft Health Vault account, I would prefer not to: (Please check box to opt out) ☐

OFFICE USE ONLY

Entered into EZnotes by (name): Date & Time: Completed?