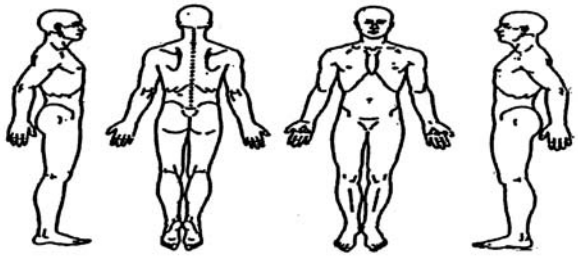
PATIENT INTAKE FORM

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) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. 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:_____

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

_____

15. What is your: Height_____ Weight _____ Age _____
Occupation _____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

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

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

19. 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
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:

_____

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

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

_____

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

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

SHIELDS CHIROPRACTIC CLINIC, INC

CASE HISTORY

(PLEASE PRINT CLEARLY)

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ SOCIAL SECURITY # _____ DRIVER LIC # _____

CELL PHONE .# _____

AGE _____ BIRTHDATE _____ SEX _____ STATUS M S W D NO. OF CHILDREN _____

EMAIL ADDRESS _____

SERVICE PROVIDER FOR CELL PHONE _____

WOULD YOU LIKE TO BE SENT EMAIL OR TEXT APPT REMINDER YES OR NO

OCCUPATION _____ EMPLOYER _____ YEARS EMPLOYED _____
EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ PHONE _____

SPOUSE'S NAME _____ BIRTHDATE _____ SOCIAL SECURITY # _____
OCCUPATION _____ EMPLOYER _____ YEARS EMPLOYED _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ REFERRED BY _____

ACCIDENT INFORMATION:

WHERE DID THE ACCIDNET HAPPEN? WORK? AUTO? HOME? OTHER _____
DATE _____ TIME _____
INJURY REPORTED TO EMPLOYER? YES NO NAME OF SUPERVIOR _____
DESCRIPTION OF THE
ACCIDENT _____
_____
WERE YOU TAKEN TO THE HOSPITAL? YES NO FOR HOW LONG? _____
NAME OF HOSPITAL _____ NAME OF DOCTOR(S) _____
HAVE YOU HAD ANY OTHER PERSONAL INJURY OR ACCIDENT? PAST YEAR? PAST 5 YEARS? OVER 5 YEARS? NONE?
DESCRIBE _____
DO YOU HAVE AN ATTORNEY? YES NO
NAME AND ADDRESS _____

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S
SIGNATURE _____ DATE _____

David P. Shields, D.C.
1952 STATE ROUTE 66, GRG, PA 15601
724-834-7882 FAX: 724-834-7886

Shields Chiropractic Clinic, Inc

ASSIGNMENT OF BENEFITS AND INTENT TO PAY DOCTOR

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL SERVICES PERFORMEI AT SHIELDS CHIROPRACTIC CLINIC, INC. I HEREBY ASSIGN ALL MY MEDICAL BENEFITS AVAILABLE FOR THE SERVICES RENDERED BELOW TO THE UNDERSIGNED DOCTOR. I DO DIRECT PAYMENT OF THESE SERVICES TO HIS OFFICE ADDRESS.

I ALSO AUTHORIZE THE INFORMATION NECESSARY TO PROCESS THIS CLAIM TO BE RELEASED TO THE COMPANY PROCESSING THIS CLAIM. THIS SAME INFORMATION CAN NOT BE RELEASED TO AN OUTSIDE CONSULTANT WORKING TO EVALUATE MY CLAIM WITHOUT MY EXPRESSED WRITTEN CONSENT.

I ALSO ACKNOWLEDGE THAT I AM FULLY RESPONSIBLE FOR ANY DIFFERENCE IN PAYMENT BETWEEN THE INSURANCE BENEFITS AND THE TOTAL HEALTH CARE BILL FOR THE SERVICES BEING RENDERED. I HAVE AGREED WITH THIS PROVIDER OF HEALTH CARE TO MAKE FULL PAYMENT TO HIM ON THIS BALANCE OF AFOREMENTIONED SERVICES.

PHOTOCOPIES OF THIS AGREEMENT OF BENEFITS AND INTENT TO PAY THE DOCTOR ARE CONSIDERED TO BE TRUE AND CORRECT AS THE ORGINIAL AGREEMENT DRAFTED.

Signature of the Patient_____ **Date**_____

David P. Shields, D.C.
1952 STATE ROUTE 66
GREENSBURG, PA 15601

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

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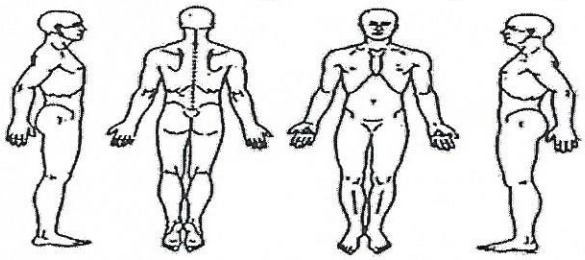
2. Indicate on the drawings below where you have pain/symptoms



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_____

15. What is your: Height_____ Weight _____ Age _____ Occupation

_____

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□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

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□ **On the phone:** □ Most of the day □ Half of the day □ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes if yes, why

_____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

David P. Shields, D.C.
1952 Business Route 66
Greensburg, PA 15601

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients' signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Informed Consent To Chiropractic Treatment

An early and accurate diagnosis with timely intervention by an experienced chiropractic physician will help reduce the development of chronic pain and permanent physical impairment. Abnormal movement of the spine and compromising loads placed upon the spine increase the risk for injury and the potential for neurological compromise. Severe or longstanding nerve injury can lead to permanent muscle weakness, chronic pain, and in some cases, impairment of bowel and bladder function.

The nature of chiropractic treatment: Dr. Shields will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. 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 ancillary procedures could produce skin irritation, burns or other minor complications.

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

Other treatment options that could be considered may include the following:

- *Over-the-counter analgesics.* The risks 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. Risks of these drugs include a multitude of undesirable side effects and patient dependency in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable diseases in a significant number of cases.
- *Surgery* in conjunction with medical care adds 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 had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name	Signature	Date

SHIELDS CHIROPRACTIC CLINIC

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected information. (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

___ Home Telephone_____
- ___ OK to leave message with detailed information
- ___Leave message with call back number only

___ Work Telephone_____
- ___OK to leave message with detailed information
- ___Leave message with call back number only

___ Written Communication
- ___OK to mail to my home address
- ___OK to mail to my work/ office
- ___OK to fax to _____

___ Cell Phone_____
- ___OK to leave message with detailed information
- ___Leave message with call back number only

IS THERE ANOTHER PERSON(S) YOU WISH US TO SPEAK WITH ABOUT YOUR CASE

Spouse_____

Family Member_____

Patient Signature_____ Date_____

Print Name_____ Date of Birth_____

****

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ Date of Birth_____

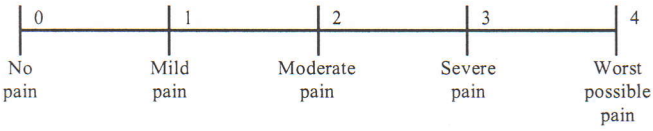
Signature_____ Date_____

Functional Rating Index

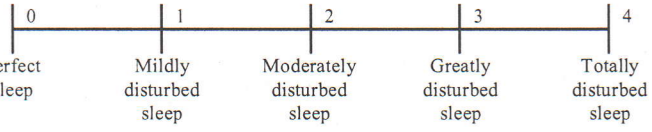
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

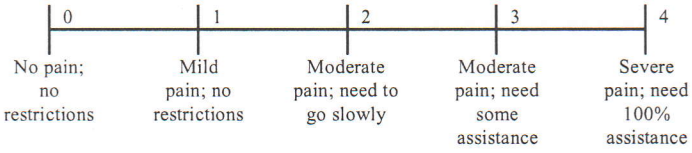
1. Pain Intensity



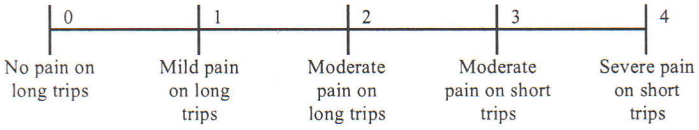
2. Sleeping



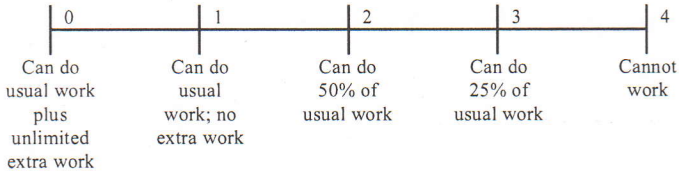
3. Personal Care (washing, dressing, etc.)



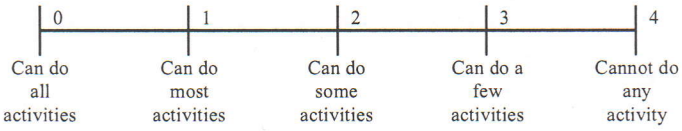
4. Travelling (driving, etc.)



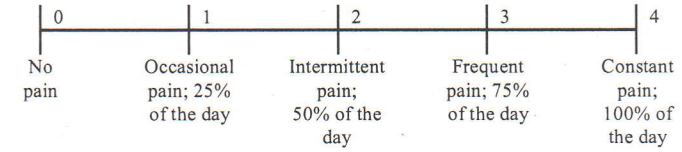
5. Work



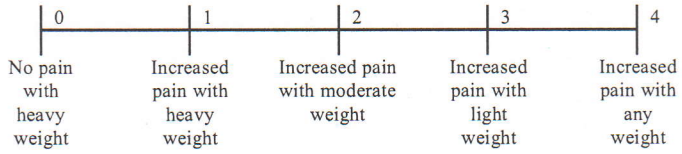
6. Recreation



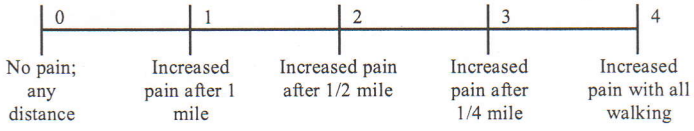
7. Frequency of Pain



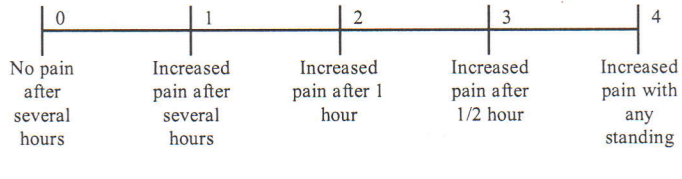
8. Lifting



9. Walking



10. Standing



Patient's Signature _____

Date _____

For Office Use Only:

Practitioner ID#: _____

Total Score _____ / 40

Clinical Diagnosis Codes:

Patient ID#: _____