Spine Care Associates of Alexandria, Inc.
6285 Franconia Rd. 703-719-7302
Alexandria, VA 22310
www.SpineCareOfAlexandria.com

Date_____

NEW PATIENT DEMOGRAPHICS:

Name:_____ DOB:_____Age_____
Address:_____SS#_____
City:_____State:_____Zip:_____Single/Married
Hm. #_____ Wk.#_____ Cell.#_____
Employer:_____Occupation:_____
Emergency Contact: Name and Phone # _____
Ins.Name_____ Policy/Subscriber#_____Grp#_____

Referred By: Internet/ Phonebook/ Insurance/ Coupon/ Other/ Patient_____
Primary Care Phy._____ ph.#_____
Would you like a letter sent to your Primary Care Physician? Y / N
Email:_____
Previous Chiropractic Care?Y/N If so how long ago?_____

MAIN COMPLAINT:

Why are you here today?(Please be specific)_____
_____
1.When did it start?_____ 2. How did it start?_____
3.Work related? **Y/N** , Auto Accident? **Y/N** ,Other Accident? **Y/N**
4.Does the pain radiate to any other part of your body , if so where?_____
5.Did your pain begin **Gradually**, or **Suddenly**?(Circle one)
6.Is your pain **Mild**, **Moderate**, or **Severe**? (Circle one)
7.Is your pain? Circle all that apply: **Dull, Sharp, Burning, Numbness, Soreness, Stiffness**.
8.Has your problem been getting **Better**, **Worse** or the **Same**?
9.Is your pain **Intermittent**, or **Constant**?
10.What makes your symptom **Better**?_____**Worse**?_____
11.Have you tried home remedies?_____
12.Have you seen any other doctors for this?_____
13.Have you had this before? **Y/N** If so when?_____
14.Any changes in body function? **Explain**_____
15.Have you lost any work as a result of your current problem? **Y/N** How Long?_____
16.Do you have any other problem you would like the Dr. To evaluate?_____

PAST MEDICAL HISTORY

1. Have you had any of the follow childhood diseases? **Measles, Rubella, Chicken Pox, Mumps, Scarlet Fever, Rheumatic Fever, Tuberculosis, Other:**_____
2. Have you been diagnosed with any other conditions?_____
3. Are you under a doctors care for any condition? **Y/N**_____
4. Have you ever broken any bones? **Y/N**_____
5. Have you had any past significant auto accidents? **Y/N** When?_____
6. Please list any current medications you are taking._____
7. Have you under gone any surgeries? **Y/N** Explain._____
8. Do you drink, smoke or use any recreational drugs? Explain._____
9. Do you have any allergies? **Y/N** Explain._____
10. History of family diseases?
Explain._____

Have you ever been diagnosed with any of the following? Please Circle Yes or No.

Y/N High Blood Pressure
Y/N Diabetes
Y/N Bone spurs on neck
Y/N Blurred or Double Vision
Y/N Currently Smoke
Y/N Hardening of the arteries
Y/N Heart or blood vessel diseases
Y/N Whiplash injury
Y/N Relatives who have suffered strokes
Y/N Smoked in the past

Have you had any of the symptoms in the past Year?

Y/N Slurred speech or speech Problems
Y/N Dizziness
Y/N Loss of consciousness, or Black out
Y/N Any other abnormal loss of sensation
Y/N Weakness, Clumsiness or strength loss Face, arms, hands, fingers, or legs
Y/N Difficulty swallowing
Y/N Temporary lack of understanding
Y/N Numbness in face, arms, hands fingers, or legs
Y/N Diminished or partial loss of vision
Y/N Hearing loss in one or both ears

PAIN DRAWING:

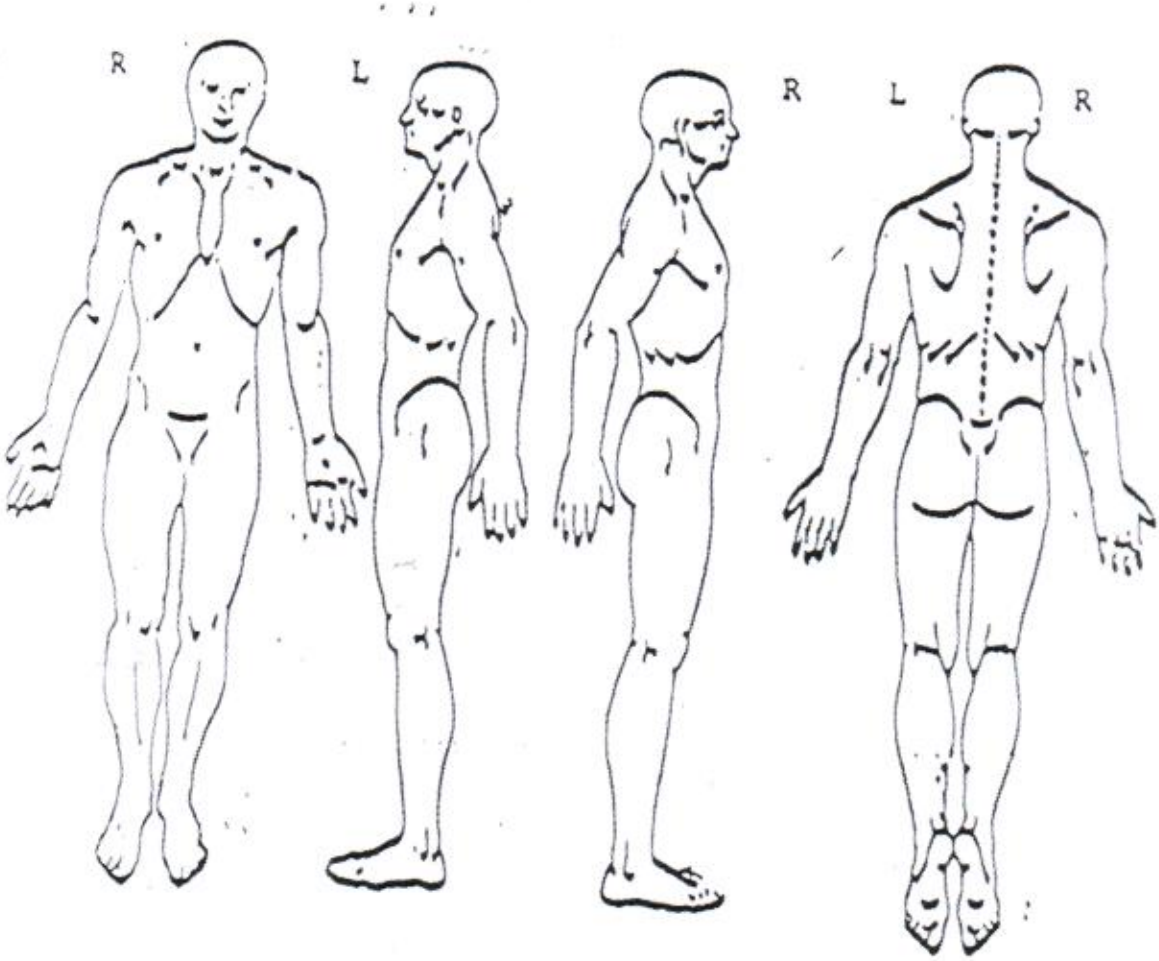
Circle the Severity of your pain on the line below:

0–1–2–3–4–5–6–7–8–9–10

(No pain) (Extreme pain)

Mark the location of your pain on the body outlines below using the following Letters:

A=Ache B=Burning N=Numbness P=Pins and Needles S=Stabbing X=Other(Specify)



Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which 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, 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 with moderate pain.
- ☐ 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 which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

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 only 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 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 my car 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 moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 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 pain in my neck.
- ☐ 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 a few of my usual 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.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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, 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 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra 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 as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree 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 improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.). Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

NOTICE OF MEDICARE COVERAGE FOR CHIROPRACTIC CARE

Your Medicare coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic adjustment (manipulative treatment) when it meets Medicare's specific rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or give counsel regarding your health.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or Treatments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

ALWAYS-COVERED SERVICES

A Medicare COVERED service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine, according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they will not pay. When we know or believe that your chiropractic adjustment is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the Advance Beneficiary Notice (ABN) which will show your financial obligation for continued care.

MY FINANCIAL RESPONSIBILITY

I have received the above Medicare information. I understand that I am personally **financially responsible** for all services not covered by Medicare. I am also responsible for applicable annual deductibles or copayments.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. If my account is turned over to collection I agreed to pay any additional collection fees. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

NOTICE OF "HIPPA" PRIVACY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those we feel are in need of your health care information. We strive to provide the best health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our compliance officer and it will be documented in your chart. You will be asked to authorize release of PHI to any party that is directly connected to your treatment, payment, or health care operations. If you have any questions, comments, or objections to the privacy policy on this form, please ask to speak with our compliance officer.

☐ I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Signature_____ Date_____