Pearson & Weary
CHIROPRACTIC ORTHOPEDICS AND REHABILITATION

Pain Relief Clinics

Please complete all sections.

Full Name: Nickname: Gender: ☐ M ☐ F ☐Other______________ Age:

Race: Date of Birth: / / Family Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep ☐ P No. Children:

Address: City: State: Zip:

Home Phone: ( ) Cell: ( ) Work Phone: ( )

I prefer to be contacted at: ☐ Home ☐ Cell ☐ Work SSN#: - -

Emergency Contact: Relationship: Phone: ( )

Can we contact you by email? ☐ Yes ☐ No Email:

Employer: Occupation: Years on the Job:

Who referred you to the clinic?

Do you have health insurance? ☐ Yes ☐ No Insurance company: ID#: Group#:

Are you the primary subscriber? ☐ Yes ☐ No Who is the primary subscriber? Date of birth of primary:

IS THIS RELATED TO A CAR ACCIDENT OR WORK INJURY? ☐ YES ☐NO

What is your chief complaint today?

When did your pain begin? (*a date is required for insurance policies*) Date of onset: / /

How did your pain begin?

What activities improve your condition?

What activities aggravate your condition?

Is your condition getting: ☐ Worse ☐ Better ☐ Staying the same Is your condition interfering with: ☐ work ☐sleep ☐daily routine

Is your condition worse during certain times of the day? ☐ Yes ☐ No If yes, when?

Do you have a primary care physician? ☐ Yes ☐No If yes, who?

Have you ever been to a chiropractor before? ☐ Yes ☐ No Date of last treatment: Name of chiropractor:

Did you have X-rays or MRI or any other imaging performed? ☐ Yes ☐ No What body part?

Which imaging center performed the testing? Estimated date of most recent imaging?

Have you seen any health care providers for this condition? ☐ Yes ☐ No

What have they recommended and what has been the outcome?

PLEASE COMPLETE THE FOLLOWING PAGES!

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PAST MEDICAL HISTORY

Have you been treated by a physician for any health condition in the past 6 months? ☐ Yes ☐ No

Please describe:

Have you ever had any of the following? ☐ Surgery ☐ Fractures ☐ Car Accidents ☐ On the job injuries ☐ Serious illness ☐ Trauma

☐ Cancer ☐ Stroke ☐ Heart attack ☐ TIA Describe:

Please list your medications/supplements:

Please list your allergies:

PAST FAMILY HISTORY

Do you have a family history of: ☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Arthritis ☐ Back or Disc Problems

☐ Other Describe:

SOCIAL HISTORY

Exercise ☐ None Number of times per week: Alcohol ☐ None Number of drinks per week:

Coffee ☐ None Number of cups per week: Vitamins ☐ None Number of times taken per week:

Smoking ☐ None Number of cigarettes per week: Water ☐ None Number of glasses per day:

Please answer the following questions so we can determine how to best support you.

Do you feel tired in the morning but still can't wind down at night? ☐ Yes ☐ No

Are you gaining weight even though you are exercising and eating right? ☐ Yes ☐ No

Do you suffer from bloating or constipation at least a few times a month? ☐ Yes ☐ No

Have you had a problem with memory and focus, also known as "brain fog?☐ Yes ☐ No

Are you moody or irritable more often than you used to be? ☐ Yes ☐ No

Do you have trouble falling asleep or staying asleep? ☐ Yes ☐ No

Have you had reactions to foods such as cheese, gluten, or soy? ☐ Yes ☐ No

Do you suffer from worsening allergies, eczema, or asthma? ☐ Yes ☐ No

Has a doctor ever told you that you were "Inflamed"? (Or have you ever had blood test results that showed elevated fasting glucose,

High-sensitivity C-reactive protein (HS-CRP), Sed rate, homocysteine, or ferritin?) ☐ Yes ☐ No

Do you get frequent colds or sinusitis? ☐ Yes ☐ No

Do you experience chronic joint pain? ☐ Yes ☐ No

Do you have difficulty recovering from injuries? ☐ Yes ☐ No

Do you have a history of repetitive injuries? ☐ Yes ☐ No

If injured, has your pain lingered for more than 3 months?☐ Yes ☐ No

Are there certain activities that you have not been able to do that you would like to be able to perform? Please list:

Patients Signature: ______________________________ Date:______________________

Pearson & Weary Agreements

HIPAA Privacy

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Pearson & Weary Pain Relief Clinic Notice of Privacy Practices (NPP). I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Financial Policies

I agree to pay for services rendered as the charge is incurred. I understand that health care and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments, co-insurances, deductible, and non-covered services. I also agree to pay for all copays and non-covered services after seeing the doctor. I authorize the doctor and his/her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjustor, case nurse, claims reviewer, employer, health care provider, or attorney in order to process any claim for reimbursement or charges incurred by me as a result of the professional services rendered and hereby release him/her of any consequences thereof. I hereby authorize and direct payment of any and all medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for the professional services rendered.

If required by my health insurance policy it is my responsibility to obtain a referral for my primary care physician prior to treatment at Pearson & Weary Pain Relief Clinic. I also understand that if I do not have prior authorization and it is denied, I am responsible to any charges not covered by my insurance company. Benefits are sometimes misquoted by the insurance company, and I understand that I am responsible for all services rendered, regardless of how I was quoted.

Time of Service Discount

Certain services provided may not be covered by your health plan. Those services however are deemed important to your recovery. Because you are responsible for paying for those services on the date the service is rendered, we offer a time of service discount of $25.00 for the total non-billed charges. This will not include supplements or supplies.

Cancellation Policy

We realize that emergencies come up, but if you need to cancel an appointment for any reason we do require 24 hours notice. We do have a waiting list of other patients who are in pain and would like to be seen as soon as possible. By giving us adequate notice of your cancellation, we are able to help others more quickly.

If you do not contact our office prior to your scheduled appointment on more than (2) occasions, you will be billed for a missed appointment fee of $25.00.
Please note that we have a reminder system in place as a courtesy to try to help our patients. However, if the reminder system fails, the appointment is still your responsibility.

______________________________	______________________________	__________________
Patient's or Guardian Printed Name	Patient's or Guardian Signature	Date

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Communication Preferences
I wish to be contacted in the following manner

☐ It is okay to leave a message with detailed information ☐ Leave call back number only

In order for my Doctor and scheduler to contact me, I prefer to be contacted in the following manner:

☐ Email ☐ Text ☐ Call ☐ None

PHI Use and Disclosure Authorization
If you wish to have your medical or billing information released to family members you must fill out the information and sign below.
I hereby authorize Pearson & Weary Pain Relief Clinic disclosure of my individually identifiable health information to the individuals listed:

1. Name_______________________________ Relationship_________________________
Authorization to:

☐ Past and future appointments

☐ Billing Information including statement balances

☐ Disclose treatment plans and test results

☐ Receive phone messages and/or email regarding appointments or test results

2. Name_______________________________ Relationship_________________________
Authorization to:

☐ Past and future appointments

☐ Billing Information including statement balances

☐ Disclose treatment plans and test results

☐ Receive phone messages and/or email regarding appointments or test results

This authorization is effective through (Check one):

☐ ______/______/_______

☐ No expiration unless revoked or terminated by the patient or the patients' personal representative.

____________________________ ____________________________
Patient Name (Print) Patient Signature

____________________________ ____________
Signature of parent/Guardian Date

Relationship to patient:______________

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Patient name: Date:

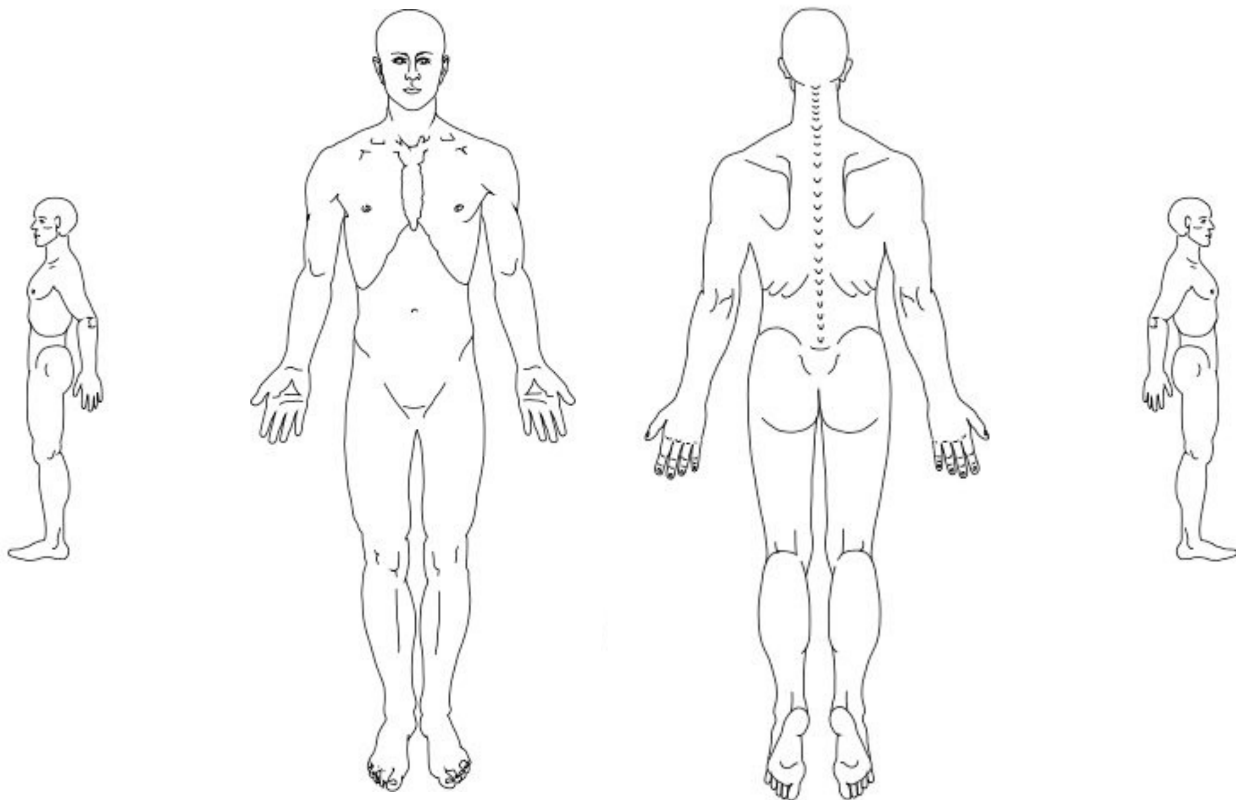
DESCRIBE YOUR CHIEF COMPLAINT TODAY: ☐ constant ☐ comes and goes ☐ sharp ☐ dull
☐ ache ☐ burning ☐ shooting ☐ Symptoms other than above: ________________________________

____

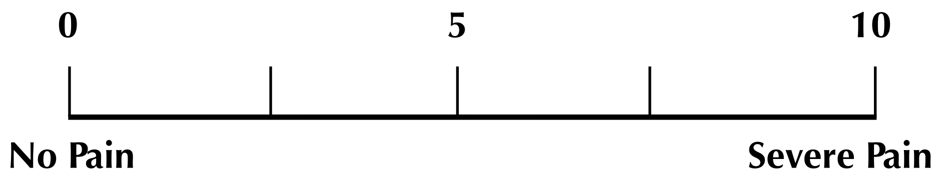
____

____

Mark or circle the area of your symptoms on the drawing and indicate if painful, numb, tingling or aggravated.



VISUAL ANALOGUE SCALE
Please rate your pain regarding your chief complaint.



2019 NON-Covered Therapy Explanation & Billing Consent

Certain services provided to you are not considered medically necessary by your health plan. While these services are extremely important to your recovery, the terms of your health care plan do not pay for them. The non-covered services and/or supplies are the responsibility of you, the patient.

You, as the patient do have the choice to pay our cash price versus billing your insurance. Otherwise known as TOS or Time of Service Discount. This discount is applied to the total of services not being billed to your insurance, when paid the same day out of pocket. One $25 discount will be applied to your services per visit. Prices are as shown below.

Service:	Charge:	TOS Discount:	TOS Price:
ART/AMIT	$45.00	$25.00	$20.00
Initial Exam	$108.00 - $176.00	$25.00	$83.00-$151.00
Re-Exam	$59.00-$108.00	$25.00	$34.00-$83.00
ART & Extremity	$75.00	$25.00	$50.00
Laser Treatment	$50.00	$25.00	$25.00

This discount is applied to the total of your services when paying at the Time of Service and not billing insurance. One Discount applied per visit total

Common insurance companies that will not cover these services are listed below:

- Kaiser Permanente/ Medicare/Medicare Replacement Plans/Supplemental Plans

I, ____, while under the care of Pearson and Weary Pain Relief Clinic, acknowledge and agree that if part of my care may not be a covered benefit of my healthcare plan; I acknowledge and understand that if this is true with my plan, I will be financially responsible for this part of my treatment. I also acknowledge and understand the information listed below.

By signing this document, I am agreeing to pay for these services and charges at the time the services are rendered. By paying for these services at the time of care, and only at the time of care, I will be offered a discount of $25.00 to my total balance due. I also acknowledge if I do not pay for these services at the time of my care, I do not receive a discount, and will be billed the usual and customary price. I also acknowledge that I do not receive a discount on any supplies and/or supplements purchased. There is a 60 day return policy on supplies, and a 7 day return policy for all UNOPENED supplements.

Patient Name: ____

Patient Signature: ____Date:_________________

Functional Rating Index

For use with Neck and/or Back Problems

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

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name: ______________________(Printed) ID#: ______________ Group #: ______________

Signature: ______________________ Date: ______________ Total Score: ______________

Pearson & Weary

CHIROPRACTIC ORTHOPEDICS & REHABILITATION

KELLI PEARSON, DC, DABCO • DANA WEARY, DC, DABCO
JAMIE GORE, DC • CHANCE O'LOONEY, DC

IN ORDER TO UPDATE THE INFORMATION IN OUR NEW ELECTRONIC HEALTH RECORD, PLEASE CHECK THOSE HEALTH CONCERNS THAT APPLY TO YOU WITH THE PERTINENT MONTH AND YEAR IF POSSIBLE.

	Condition	Now	Past	Date		Condition	Now	Past	Date
	Headaches					Indigestion / Heart Burn			
	Stroke					Leg fracture			
	TIA					Arm fracture			
	Vertigo					Spine Fracture			
	Dizziness					Cancer			
	Loss of consciousness					Crohn's Disease			
	Heart Condition					Fibromyalgia			
	High Blood Pressure					Nerve disorder			
	Double Vision					Anxiety			
	Lumbar Surgery					Depression			
	Cervical Surgery					Osteoarthritis			
	Herniated cervical disc					Rheumatoid Arthritis			
	Herniated lumbar disc					TMJ / Jaw Pain			
	Memory Loss					Knee pain			
	Diabetes					Shoulder pain			
	Bleeding Disorders					Elbow pain			
	Irritable Bowel					Carpal Tunnel			
	Plantar fascia					Osteoporosis			
	Motor Vehicle Accident					Joint Replacement			
	Head Trauma					Other:			
	Taking blood thinners								
	Loss of Bowel Control								

Data entered by: __________________ Audited by: _______________ Date Entered: ________________