Pearson & Weary
CHIROPRACTIC ORTHOPEDICS AND REHABILITATION

Pain Relief Clinics

Please complete all sections.

Full Name: Nickname: Gender: ☐ M ☐ F ☐ Other:

Date of Birth: / / Age: Race: (optional)

Family Status: ☐ Single ☐ Married ☐ Widow(ed) ☐ Divorce ☐ Separated ☐ Partner No. of Children:

Full Address: City: State: Zip:

Cell Phone: ( ) Home Phone: ( ) Email:

Emergency Contact: Relationship: Phone: ( )

Employer: Occupation: Who referred you to the clinic? Full Name:

Do you have a primary care provider? ☐ Yes ☐ No Name of Provider:

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

Are you the primary subscriber? ☐ Yes ☐ No Name of primary subscriber? Date of birth / primary:

What is your relationship to the primary subscriber?

Who is financially responsible for your care? Name:

CHIEF COMPLAINT INFORMATION:

Describe the location of your chief complaint:

How did your pain begin? (note the date in the next line)

NOTE: A date of onset is <u>required</u> for Medicare and all insurance policies . Date of onset: / /

What is the severity of your complaint: 0 - no pain / 10 - severe pain:

Is your complaint getting progressively worse?

Is your complaint better at certain times of the day or with certain activities?

Is your complaint worse at certain times of the day or with certain activities?

What makes your complaint better?

What makes your complaint worse?

Circle any of the associated symptoms you experience: Numbness Tingling Weakness Headaches Feeling a catch / locking up

How frequently do you experience the symptoms you circled above?

Previous treatment including current providers you are seeing:

PLEASE COMPLETE THE FOLLOWING TWO PAGES!

What have they recommended and what has been the outcome?

Please list other concerns you have in the order of their importance:

Have you had chiropractic care before? ☐ Yes ☐ No Date of last treatment: Name of DC:

Have you had 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?

PAST MEDICAL HISTORY

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

Please describe:

Please list your medications:

Please list your allergies:

Please list any supplements / vitamins you take on regular basis:

SOCIAL HISTORY

Smoking /Tobacco	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of times per week:
Alcohol	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of drinks per week:
Water	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of cups per week:
Coffee	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of cups per week:
Exercise	☐ None	☐ Light	☐ Moderate	☐ Heavy	Number of times per week:

Please describe your exercise:

PAST FAMILY HISTORY - Please list any incidence of the following in your family:

☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Diabetes ☐ Arthritis ☐ Back or Disc Problems

☐ Other Describe:

YOUR GOALS AND ASPIRATIONS

Are there certain activities that you have been unable to perform that you would like to return to or begin? *(Please list)*

Patients Signature: _____ Date: _____

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HIPAA Privacy

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI) The patient is also provided the right to request confidential communication and can be provided in the manner they choose.

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

I prefer to be contacted in the following manner: (please check all that apply). ☐ Email ☐ Text ☐ Call

I give permission for all staff of Pearson & Weary Clinic (PWC) to discuss my patient care and billing account with:

Name _____ Name _____

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 PWC. I also understand that if I do not have prior authorization and it is denied, I am responsible for any charges not covered by my insurance company. I understand benefits are sometimes misquoted by the insurance company.

Time of Service Discount

Certain services provided may not be covered by your health plan. Those services 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.) Examples of non- covered services may include (but are not limited to), soft tissue therapy techniques, treatment of extremities and laser treatment.

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.
Clinic Policy: If you do not contact our office 24 hours prior to your scheduled appointment on more than (2) two occasions, you will be billed for the 3rd missed appointment for a fee of $25.00, whether it be for chiropractic or movement. If you do not contact the office 24 hours prior to your scheduled massage appointment, you will be billed $35.00.

_____ _____ _____

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

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Patient name: Date:

DESCRIBE YOUR CHIEF COMPLAINT TODAY:

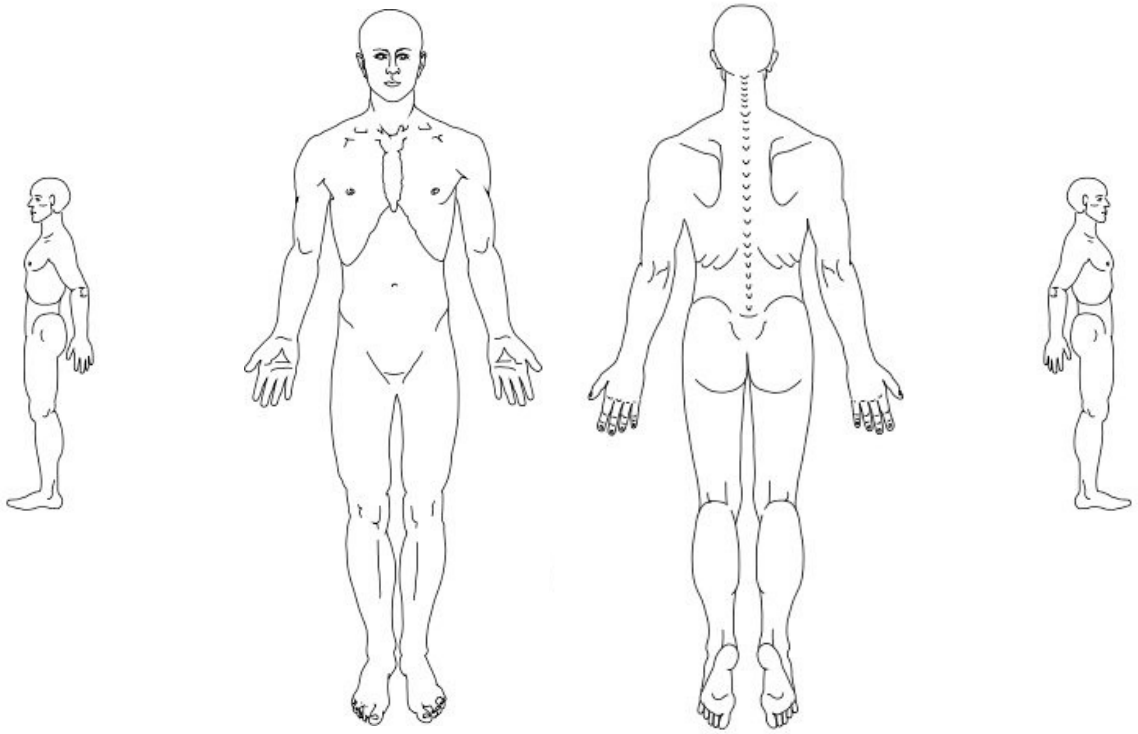
_____

_____

_____

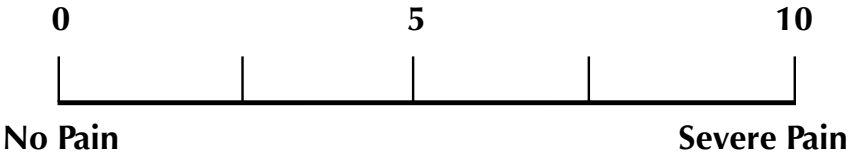
Mark or circle the area of your symptoms on the drawing and indicate if possible:

Pain (P) **Numbness (N)** **Tingling (T)** **Achey (A)** **Sharp (S)**



VISUAL ANALOGUE SCALE

Please rate your pain regarding your chief complaint.



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Functional Rating Index

For use with Neck and or Back Problems

In order to 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 below, please **CIRCLE the number** which most closely describes your condition right now.

PAIN INTENSITY

0	1	2	3	4
no pain	mild pain	mod pain	severe pain	worst pain

ABILITY TO DO RECREATION

0	1	2	3	4
all activity	most activity	some activity	a few activities	cannot do any

SLEEP DISTURBANCE

0	1	2	3	4
perfect	mildly	moderate	greatly	totally

FREQUENCY OF PAIN

0	1	2	3	4
no pain	25% of day	50% of day	75% of day	constant pain

PERSONAL CARE RESTRICTIONS

0	1	2	3	4
none	mild	moderate	severe	needs help

PAIN WITH LIFTING WEIGHT

0	1	2	3	4
no pain heavy wt	some w/ heavy wt	worse w/ mod wt	worse w/ light wt	worse w/ any wt

PAIN WITH TRAVEL (DRIVING)

0	1	2	3	4
no pain	mild long trip	mod long trip	mod short trip	severe short trip

WALKING

0	1	2	3	4
no pain 1 mile	pain 1/2 mile	pain 1/4 mile	pain asap	pain

ABILITY TO DO WORK

0	1	2	3	4
extra work	usual work	50% of usual	25% of usual	unable to work

ABILITY TO STAND

0	1	2	3	4
no pain 1 hour	pain at 1/2 hour	pain at asap	pain pain	increased

Please circle the average level of pain in the last week. (No pain 0 - Worst pain 10)

0 1 2 3 4 5 6 7 8 9 10

Name: _____ Date: _____ Score: (by staff) _____

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Full Name _____ Date: _____

Review of Systems: In order to provide the best care possible, please check those health concerns that apply to you. Please write **C** for Current and **P** for Past history in the box to the left of the condition.

P	C	
		CONSTITUTIONAL
		Weight change
		Fever
		Weakness
		Undue fatigue
		CARDIOVASCULARR
		High BP
		Faintness
		Vertigo
		Chest pains
		Heart palpitations
		GENITOURINARY
		Hernia
		Frequent urination
		Painful urination
		Rashes
		Skin lesions
		JOINT REPLACED (yr)
		HERNIATED DISC (yr)
		SURGERY (yr)

P	C	
		IMMUNOLOGIC
		Allergies to food
		Hepatitis
		Rheumatoid
		Lupus
		Psoriasis
		RHEUMATOLOGIC
		Chest pain
		Cough
		Asthma
		Bronchitis
		PSYCHIATRIC
		Anxiety
		Depression
		Insomnia
		Energy Loss
		CANCER (yr)
		FRACTURE (yr)
		TRAUMA (MVA / OTJ)

P	C	
		EAR / NOSE /
		Dizziness
		Tinnitus
		Hearing Loss
		Nose Bleeds
		Hoarseness
		Swallowing difficulty
		GASTROINTESTINAL
		Appetite change
		Nausea
		Diarrhea
		Constipation
		HEMATOLOGIC
		Anemia
		Bruise easily
		HEMATOLOGIC
		Hot /cold intolerance
		Excessive sweating
		Thyroid problems
		OTHER
		Loss of bowel control
		Osteporosis
		Stroke / TIA (yr)
		Heart attack (yr)

KEY: **MVA : Motor vehicle accident** **OTJ : On-the-job injury**