

Smith Chiropractic Center, P.A.

1400 S Avenue D, Suite A ♦ Portales, NM 88130 ♦ (575) 356-4440
124 W 22nd, Hilltop Plaza ♦ Clovis, NM 88101 ♦ (575) 763-3333

Personal Information:

Date _____
Patient Name _____ Home Phone _____ Cell Phone _____ E-Mail _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____ Social Security # _____
Driver's License # _____ Sex M / F (Circle One) Single Married Widowed Separated Divorced
Employer _____ Occupation _____
Employer Address _____ Work Phone _____
Level of Education _____ Name and age of child (ren) _____
Emergency contact name & number _____ Relationship _____
Who can we thank for referring you? _____ Phone Number _____
Have you had previous chiropractic care? (Check one) Yes No If yes, please list who, where and when

Who is responsible for your bill? (Check one)

You and/or spouse Insurance Medicare Worker's Compensation Auto Insurance

Spouse information:

Spouse name _____ Date of Birth _____ Social Security # _____
Employer _____ Occupation _____
Employer Address _____ Work Phone _____

Current Health Conditions:

Please describe the principle health concern for which you came to this office

Is this condition related to an accident or injury? (Check one) Yes No Please explain

When did symptoms appear? _____ Is your condition getting worse? (Check one) Yes No

Have you been treated for this condition before today? (Check one) Yes No

Please explain. (List who treated you, their diagnosis and treatment you received)

Please list current medications: _____ Please list any allergies and the symptoms of a reaction (please include foods, latex and medications): _____

Please list all prior illnesses and injuries you have sustained _____

Have you received any surgeries? If so please describe the type of surgery, date, reason, result and current status:

Tobacco, Alcohol & Other Substance Use:

Have you used __ cigarettes __ cigars __ pipe __ chewing tobacco __ snuff (check all that apply)

Patients Name _____ Date _____

Score _____

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How much do / did you use per day? ____ Number of years? ____ Are you still using? Y / N If No When did you stop? ____ Have you been exposed to secondhand smoke at home or work? Y / N

Has alcohol ever interfered with your personal/ professional life? _____

Did you, or do you , use marijuana, cocaine, heroin or other illegal substances? _____

Family History:

Please include only blood relatives do not include adopted, foster or step family members. Please list current age or age at time of death. (Health condition examples cancer, cardiovascular disease, kidney failure, and diabetes)

Relative	Age	Alive		List of Health Conditions
		Y	N	
Mother		Y	N	
Father				
Brother				
Brother				
Sister				
Sister				
Grandparent				
Grandparent				
Grandparent				
Grandparent				

Systems Review:

Please check “Yes” or “No” box to indicate if you have any of the following symptoms.

Patients Name _____

Date _____

Score _____

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	Yes	No		Yes	No
<u>General</u>			<u>Musculoskeletal</u>		
Fevers			Joint Pain		
Night Sweats			Joint Swelling		
Chills			Injuries or Joint Fractures		
Recent Weight Change			Back Pain		
If yes, _____ lbs.			Neck Pain		
<u>Eyes</u>			<u>Skin</u>		
Eye disease or injury			Hives		
Do you wear glasses or contacts			Eczema		
Change in vision			Rash		
<u>Ears, Nose & Throat</u>			Abnormal pigmentation		
Change in hearing			<u>Neurological</u>		
Voice change			Fainting spells		
Sore throat			Convulsions		
Respiratory			Paralysis		
Shortness of breath			Headaches		
Cough			<u>Psychiatric</u>		
Wheezing			Depression		
<u>Cardiovascular</u>			Anxiety		
Chest Pain			Memory Loss or Confusion		
Shortness of breath while walking or lying down			Insomnia		
Difficulty walking two blocks			Endocrine		
Swelling of hands, feet or ankles			Excessive thirst		
Heart Murmur			Intolerance to heat / cold		
Irregular heart beat			<u>Hematologic</u>		
<u>Gastrointestinal</u>			Anemia		
Bleeding with bowel movements			Have you had abnormal bruising or bleeding		
Black stool			Swollen glands		
Recent change in bowel habits			Immunology / Allergy		
Frequent diarrhea			Allergies to animals or plants		
Heartburn or indigestion			Runny nose		
Constipation			Itchy Eyes		
<u>Genitourinary</u>					
Frequent urination					
Night time urination					
Burning or painful urination					
Blood in urine					
Sexual Difficulty					
Incontinence					

Insurance disclaimer – Verification of benefits is not a guarantee of payment. Benefits and payments are not determined until claim is received.

I, the undersigned (or my dependent) has insurance with _____ and assign directly to Dr. William J. Smith all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Smith to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Smith or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's signature _____ Date _____

Patients Name _____ Date _____

Score _____

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(This section intentionally left blank)

Patients Name _____

Date _____

Score _____

Oswestry Index Questionnaire

This questionnaire is designed to help us better understand how your pain affects your ability to manage everyday – life activities. Please mark each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present – day situation.

Section 1 – Pain Intensity

- | | |
|---|---|
| <input type="checkbox"/> My pain is mild to moderate. I do not need pain killers. | <input type="checkbox"/> I can stand as long as I want without extra pain. |
| <input type="checkbox"/> The pain is bad, but I manage without taking pain killers. | <input type="checkbox"/> I can stand as long as I want, but it gives me extra pain. |
| <input type="checkbox"/> Pain killers give complete relief from pain. | <input type="checkbox"/> Pain prevents me from standing for more than 1 hour. |
| <input type="checkbox"/> Pain killers give moderate relief from pain. | <input type="checkbox"/> Pain prevents me from standing more than ½ hour. |
| <input type="checkbox"/> Pain killers have no effect on the pain. | <input type="checkbox"/> Pain prevents me from standing more than 10 minutes. |
| | <input type="checkbox"/> Pain prevents me from standing at all. |

Section 2 – Personal Care

- 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 most days 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 causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking

- I can walk as far as I wish.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can walk only if I use a cane or crutches.
- I am in bed or in a chair for most of every day.

Section 5 – Sitting

- I can sit in any chair for as long as I like.
- I can sit in my favorite chair only, but for as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 – Standing

Patients Name _____

Date _____

Score _____

Section 7 – Sleeping

- Pain does not prevent me from sleeping well.
- I sleep well but only when taking medications.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

Section 8 - Social Life

- Social life is normal and causes me no extra pain.
- Social life is normal, but increases the degree of pain.
- Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, ect.
- 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 – 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 present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.

Section 10 – 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 restricts me to journeys of less than 1 hour.
- Pain restricts me to necessary journeys under ½ hour.
- Pain prevents traveling except to the doctor / hospital.

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NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Notice of Privacy practices.

Uses and Disclosure of Health Information

We use health information about you for treatment, to obtain payment information for treatment, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you chose to sign an authorization to disclose information, you can later revoke that authorization to stop any further uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights

Although your health record is the physical property of the healthcare practitioner of facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy upon request
- Inspect and obtain a copy of your health record as provided in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain and accounting of disclosures of your health as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Complaints

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact: Smith Chiropractic Center Office Administrator, 1400 S Ave. D, Suite A, Portales, NM 88130 or phone (505)356-4440.

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Signature of Patient or Legal Representative

Witness

Date

Date

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Authority to Release Medical Reports and Information

Re: _____ (patient’s name)

To: Medical and Benefit Providers

Date: _____

I, _____, hereby authorize you or any member or employee of your office or association, as well as any hospital in which I have been a patient, to release complete and legible copies of any and all information concerning my physical or psychiatric condition, both past and present to:

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or their duly authorized agents.

This authorization to release written or verbal information includes, but is not limited to medical reports, clinical notes, nurse’s notes, patient’s history of injury, subjective and objective complaints, x-rays, test results, interpretation of x-rays or other tests (including a copy of the report), diagnosis and prognosis: if applicable, any hospital operational logs, emergency logs, tissue committee reports, psychiatric reports and records, physical therapy records, all out-patient records, hospital bills, bills for services you have rendered, payments received, statements of earnings and benefits, and any other relevant and material information in your possession.

I hereby expressly waive any laws, regulations and rules of ethics which might prevent any hospital, doctor or other person who has treated or provided benefits in a professional capacity or otherwise from releasing said information.

A photostatic copy of this authorization, which contains my signature, shall be considered as effective as the original and shall be honored by those to whom it is sent or provided.

Signature

Date of Birth

Social Security #

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Financial Agreement

I, _____, understand that I am ultimately responsible for *full* payment of my or my dependent’s accounts at Smith Chiropractic Center, P.A.

I understand and agree that I am responsible and will be required to make full payment at the time of service for any future services rendered to me or my dependent(s) from Smith Chiropractic Center, P.A.

I also understand that I may be responsible for interest, up to 18%, on my account(s) on my balances that are outstanding over 30 days. In the event this account is turned over for collection, 35% of total charge will be applied to this account in addition to the 18% interest.

If Applicable:	
Interest begins _____ 20__	Interest Rate _____ %

Patient’s signature _____
Witness _____

Date _____
Date _____

*For your convenience,
We accept Visa, MasterCard, American Express and Discover*