



Dr. Jennifer M. Wells, D.C.
and Associates

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

First Name: _____ MI: _____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: ____/____/____ Age: _____ Gender: Male Female Unspecified SSN: _____-_____-____

Primary Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Preferred Contact Method: (check one) Primary Phone Cell Phone Work Phone Email

Occupation: _____ Employer: _____

Status: (check one) Single Married Divorced Widowed Separated Children?: Yes No How Many: _____

Spouse's Name: (if applicable) _____

Emergency Contact: (Name, Relationship, Phone #) _____

How were you referred to Back Country Chiropractic?: _____

INSURANCE OR PRIVATE PAY INFORMATION

Type of Insurance: Private Insurance Medicare Auto Insurance Worker's Comp Other _____

Primary Insurance Carrier: _____ Phone: _____

Policy #: _____ Group #: _____ Claim #: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birthdate: ____/____/____ Policy Holder's SSN: _____-_____-____ Employer: _____

Is patient covered by another insurance? Yes No

Secondary Insurance Carrier: _____ Phone: _____

Policy #: _____ Group #: _____ Claim #: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birthdate: ____/____/____ Policy Holder's SSN: _____-_____-____ Employer: _____

ASSIGNMENT/AUTHORIZATION/RELEASE/ACKNOWLEDGEMENT: (check all applicable boxes and initial)

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Back Country Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services. Initial: _____

Some Insurance plans are not allowing any treatment other than a basic adjustment or manipulation 98940 paid code that is medically necessary only. Therefore, any "extraspinal" adjustments or treatments by the doctor, to include massage by the doctor 97124, flexion-distraction 97012, or electrical stimulation 97014 MAY be an additional \$10 to \$25 fee on top of your regular co-pay or insurance. Also, any care deemed not medically necessary by your insurance will be reduced to our out-of-pocket daily fee schedule. Initial: _____

Private Pay/Cash: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Person responsible for this account: _____ Initial: _____

Cancellation or No-Show Fees: Cancellations for adjustments or massages without a 24-hour notice may be subject to a \$25 fee for adjustments, \$30 for 1-hour massages, and \$15 for half-hour massages. Initial: _____

A Credit Card on File Requirement: By checking this box, I authorize my credit card on file to be charged if not paid for at the time of service for the following: deductibles, co-insurance, non-covered therapies as stated above, cancellations without a 24-hour notice, and no-show fees or any care deemed not medically necessary by my insurance company. Initial: _____

CC #: _____ Exp. Date: ____/____/____ CVV: _____ Signature: _____

Signature of Patient, Parent, or Legal Guardian: X _____ Date: _____

REASON FOR VISIT

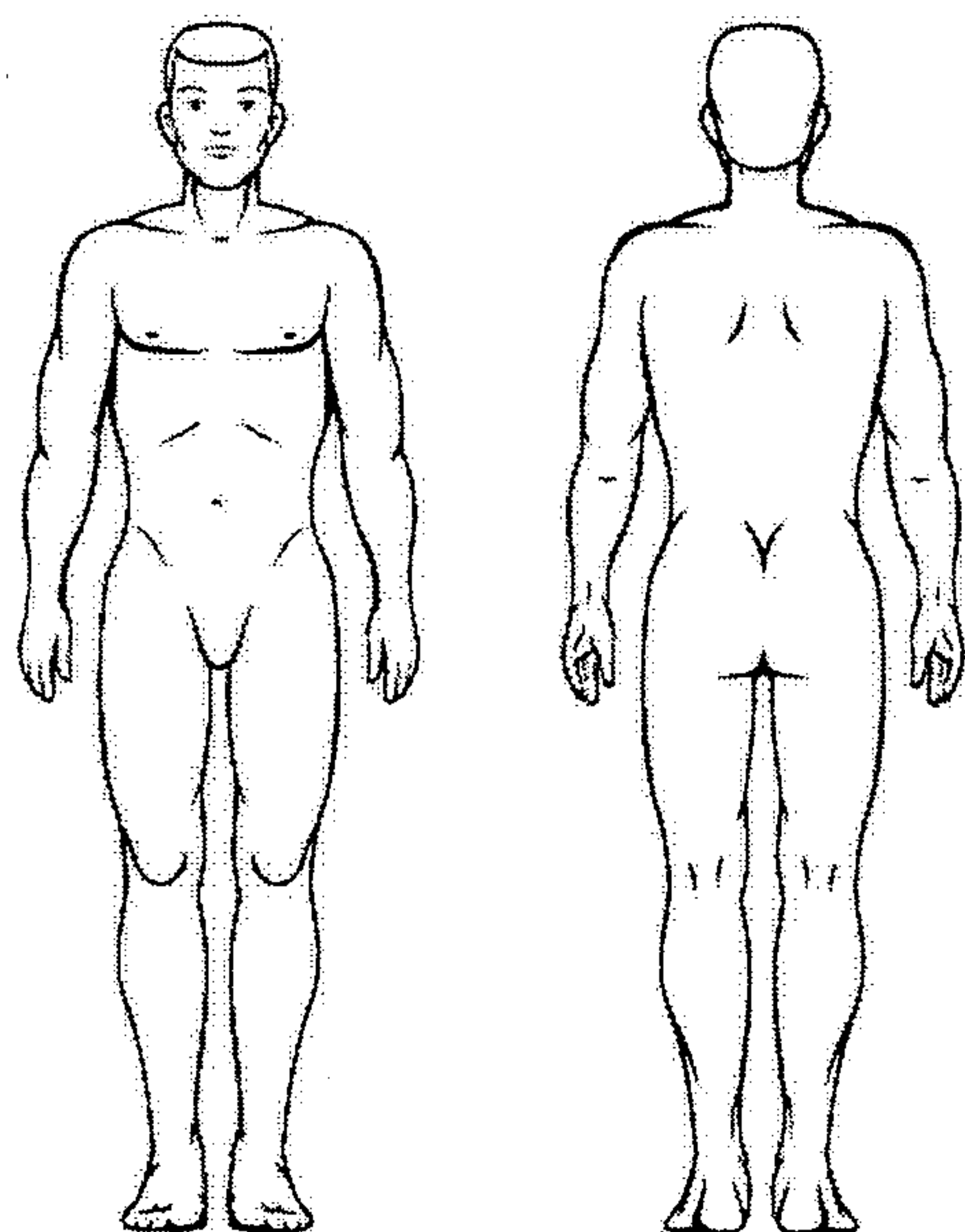
What is the reason for your visit today? Headache Neck Pain Mid-Back Pain Low Back Pain Other_____

What caused this complaint(s)? _____

When did this complaint begin? ____ / ____ / ____ Is it getting worse? Yes No Constant Comes and Goes

Have you had this or similar complaint in the past? Yes No If "Yes", when? _____

What does your complaint(s) feel like? **Circle all that apply:** Sharp / Dull / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Numbness / Other: _____



← Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain			Moderate Pain				Worst Possible Pain		
1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (if applicable) _____

What aggravates this complaint(s)? **Circle all that apply:** Sitting / Standing / Walking / Getting Up From Seat / Walking Stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending Forward / Bending Backward / Twisting / Reaching / Lifting / Desk Work / Coughing / Everything / Unknown / Other: _____

What relieves this complaint(s)? **Circle all that apply:** Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Lying Down / Medication / Acupuncture / Nothing / Other: _____

Are you interested in learning more about acupuncture: Yes No

How often do you experience your symptoms? 25% of the day 50% of the day 75% of the day 100% of the day

Time of complaint: **Check appropriate box:** Morning As day progresses Afternoon Evening While sleeping

During activities After activities Symptoms are constant and do not change Other: _____

With time, are your symptoms: Improving Worsening Not changing

Have you seen other doctors for this complaint? Yes No If "Yes", please provide the following information:

Doctor's Name: _____ Date Consulted: ____ / ____ / ____ Diagnosis: _____

Is this condition interfering with your: **Circle all that apply:** Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily routine / Social activities / Exercise / Other: _____

Is your complaint interfering with your daily activities? Not at all A little bit Moderately Quite a bit Extremely

NAME: _____ DATE: _____

HEALTH HISTORY

Please check ALL of the health conditions below that apply to you currently or in the past.		Family History	
		Relationship: (Father, Mother, Sister, Brother)	
<input type="checkbox"/> Osteoarthritis/Degenerative Joint Disease	<input type="checkbox"/> Whiplash Injury <i>Date of injury:</i>	<input type="checkbox"/> Cancer <i>Type:</i>	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Anemia	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Joint Pain (<u>circle</u> location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other: _____	<input type="checkbox"/> Diabetes (check one) <input type="checkbox"/> Type I <input type="checkbox"/> Type II	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Migraines	<input type="checkbox"/> Heart Problems / Stroke	
<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Osteoporosis /Osteopenia	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Genetic Disorders	
<input type="checkbox"/> Depression/ Anxiety	<input type="checkbox"/> Fibromyalgia / Chronic Fatigue	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Disc Herniation	<input type="checkbox"/> Genetic Disorders	<input type="checkbox"/> Other (List):	
<input type="checkbox"/> High Blood Pressure /Hypertension	<input type="checkbox"/> Please list any other medical conditions:		
<input type="checkbox"/> Heart Disease / Stroke			

WOMEN ONLY: Currently Pregnant? Yes No Painful /Abnormal Menstrual Cycle? Yes No Menopause? Yes No Miscarriage? Yes No Do you have children? Yes No If "Yes", type of birth? Circle Vaginal or C-Section

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

SURGERIES and/or HOSPITALIZATIONS (List and Date):

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

List current prescription medications, including frequency and dosage if known. If there are NO current medications, check here

Name of prescription medication	Dosage/Start date	4.	5.
1.			
2.			
3.			

List any known allergies you have had to prescription medications. If NO medication allergies are known, check here

1. _____ 2. _____

SOCIAL HISTORY

Do you exercise? Yes No Times per week? _____ Intensity? Light Moderate Strenuous Type?

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker
If "Yes", how often do you smoke: Current every day smoker Current sometimes smoker Circle level below ↓:
If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) 0 1 2 3 4 5 6 7 8 9 10

Do you drink alcohol? Yes No How many drinks per week? _____ For how many years?

Do you drink caffeine? Yes No How many drinks per day? _____ What type? Coffee Tea Soft Drinks Energy Drinks

Do you take pain killers? Yes No How often? Daily Weekly Monthly Rarely
What type? Aspirin Ibuprofen Tylenol Other _____

What do your work duties include? Sitting Standing Light Labor Heavy Labor Other: _____

Please describe your overall health right now? Excellent Very Good Good Fair Poor

What is your current stress level? Mild Moderate High

Have you seen a chiropractor in the past? Yes No If so, when was your last treatment?

What are your hobbies?

NAME: _____ DATE: _____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal Manipulative Therapy
- Orthopedic Testing
- EMS
- Other (please explain)_____
- Palpation
- Basic Neurological Testing
- Ultrasound
- Vital Signs
- Laser Treatment
- Hot/Cold Therapy
- Range of Motion Testing
- Postural Analysis
- Radiographic Studies

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1. Self-administered, over-the-counter analgesics and rest
2. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
3. Hospitalization
4. Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW:

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Back Country Chiropractic and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Back Country Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name: _____ Signature: X _____ Date: _____

Physician's Name: _____ Signature: X _____ Date: _____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as to back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgement for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here **X**_____. Effective as of the date of first professional services.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: X _____ Date: _____

Parent or Guardian: _____ Signature: X _____ Date: _____

Witness Name: _____ Signature: X _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

May we phone, email or send you a text to confirm appointments? Yes No

May we leave a message on phone numbers or with any family members? Yes No

May we discuss medical condition with any member of your family? Yes No

If so, list name(s) of member(s) allowed? _____

Patient Name (print): _____

Signature of Patient, Parent, or Legal Guardian: X _____ Date: _____

Patient Summary Form

PSF-750 (Rev. 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.
Please review the Plan Summary for more information.

Patient Information

Patient name Last			Patient name First			Patient name MI			<input type="radio"/> Female <input type="radio"/> Male			Patient date of birth					
Patient address						City			State			Zip code					
Patient insurance ID#						Health plan						Group number					
Referring physician (if applicable)						Date referral issued (if applicable)						Referral number (if applicable)					

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)						2. Federal tax ID(TIN) of entity in box #1											
3. Name and credentials of the individual performing the service(s) 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other																	
4. Alternate name (if any) of entity in box #1						5. NPI of entity in box #1						6. Phone number					
7. Address of the billing provider or facility indicated in box #1						8. City						9. State 10. Zip code					

Provider Completes This Section:

Date you want THIS submission to begin:

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Patient Type

- 1 New to your office
- 2 Est'd, new injury
- 3 Est'd, new episode
- 4 Est'd, continuing care

Cause of Current Episode

- 1 Traumatic
- 2 Unspecified
- 3 Repetitive
- 4 Post-surgical
- 5 Work related
- 6 Motor vehicle

Date of Surgery

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Type of Surgery

- 1 ACL Reconstruction
- 2 Rotator Cuff/Labral Repair
- 3 Tendon Repair
- 4 Spinal Fusion
- 5 Joint Replacement
- 6 Other

Diagnosis (ICD codes)

Please ensure all digits are entered accurately

1°					
2°					
3°					
4°					

Nature of Condition

- 1 Initial onset (within last 3 months)
- 2 Recurrent (multiple episodes of < 3 months)
- 3 Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

- 98940 98942
- 98941 98943

Current Functional Measure Score

Neck Index		DASH		
Back Index		LEFS		(other FOM)

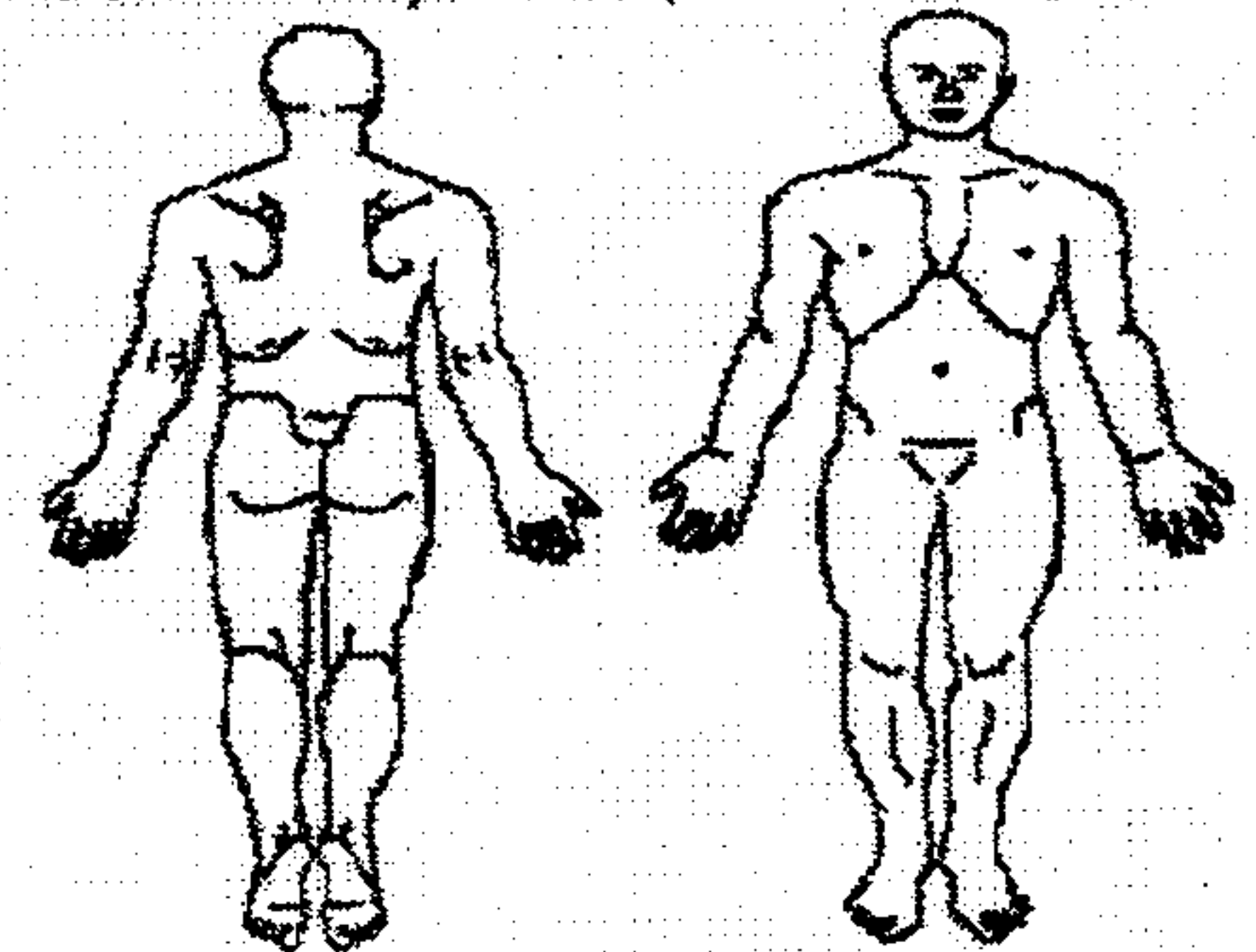
Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

--	--	--

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

- 1 Constantly (76%-100% of the time)
- 2 Frequently (51%-75% of the time)
- 3 Occasionally (26% - 50% of the time)
- 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

6. How is your condition changing, since care began at this facility?

- 0 N/A — This is the initial visit
- 1 Much worse
- 2 Worse
- 3 A little worse
- 4 No change
- 5 A little better
- 6 Better
- 7 Much better

7. In general, would you say your overall health right now is...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

Patient Signature: X

Date: _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⑥ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⑥ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⑥ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⑥ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⑥ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⑥ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⑥ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⑥ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⑥ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⑥ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____

Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓒ The pain comes and goes and is moderate.
- Ⓜ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓒ Because of pain my normal sleep is reduced by less than 25%.
- Ⓜ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

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 1 hour.
- Ⓜ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓒ I cannot stand for longer than 1 hour without increasing pain.
- Ⓜ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓒ I cannot walk more than 1 mile without increasing pain.
- Ⓜ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓒ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓜ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓒ Pain prevents me from lifting heavy weights off the floor.
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓔ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓒ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓜ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

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 affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓜ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

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.
- Ⓜ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

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Index
Score



Patient Billing Acknowledgement Form Non-Covered Services**

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

** Not for use in New Jersey

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Services to be provided:

Supply • supplements 10-80% DME • cervical decompression collar 30⁰⁰
• deluxe cervical pillow 50⁰⁰
• lumbar brace 45-55⁰⁰
• ice pack 10-30⁰⁰

Modalities/Procedures • massage by doctor or therapist 10⁰⁰ → 75⁰⁰ Other
• laser treatment 25⁰⁰ 30⁰⁰

Time frame from 6/1/19 through _____

Schedule/details (The doctor performs a 1-unit massage w/ every treatment @ 10⁰⁰
xtra + usual co-pay)

Provider Signature: [Signature]

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I _____, acknowledge that I have been told
Patient Name – Printed or Typed
in advance by my provider that the services/products listed above are not
covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature _____

Date _____

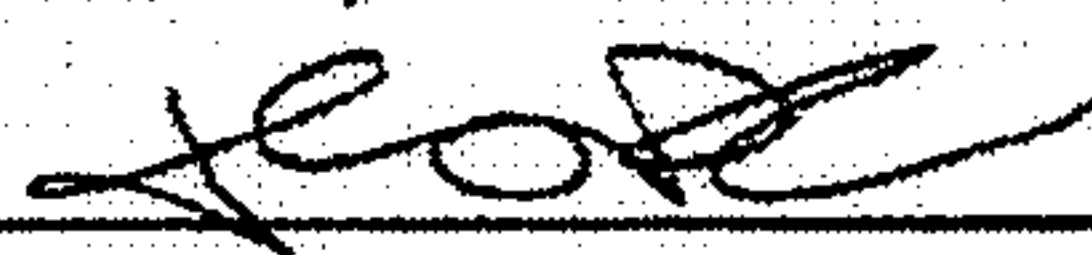
Patient Billing Acknowledgement Form Maintenance/Elective Care**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

Maintenance/Elective care is treatment that does not significantly improve a clinical condition. While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

If, during the course of Maintenance/Elective Care, you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered Maintenance/Elective and may then be covered by your health plan. Your provider must submit a request for insurance coverage.

**** Not for use in New Jersey**

P R O V I D E R	<p><u>Services to be provided are listed below:</u></p> <p><input checked="" type="checkbox"/> Chiropractic Manipulative Therapy <u>50⁰⁰</u> <input checked="" type="checkbox"/> In-Home Care _____ <i>* Supportive or maintenance care</i></p> <p><input type="checkbox"/> Modalities/Procedures <u>laser tx 25-30⁰⁰</u> <input type="checkbox"/> Other <u>massage by therapist</u> <i>* massage by doctor 10⁰⁰ 35⁰⁰ → 75⁰⁰</i></p> <p>Time frame from <u>6/1/19</u> through _____</p> <p>Schedule/details <u>The doctor performs a 1-unit massage one every</u> <u>visit @ 10⁰⁰ (included</u> <u>in maintenance care)</u></p> <p>Provider Signature: <u></u></p>
P A T I E N T	<p>I _____, acknowledge that I have been told Patient Name – Printed or Typed</p> <p>in advance by my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.</p> <p>Patient/Guardian Signature _____ Date _____</p>