CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards.

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PATIENT INFORMATION

Name _____ Date _____

Social Security # _____ Date of Birth _____ ○Male ○Female

Address_____City_____ State _____ Zip _____

Email Address_____

Phone _____ Mobile _____ Work _____

Primary Care Physician _____ Last Visit Date _____

○ Married ○Single ○Divorced ○Widowed Number of Children _____ Names and Ages _____

_____

Employer _____ City/State _____

Emergency Contact Name _____ Ph # _____

INSURANCE INFORMATION

Primary Insurance Co. Name _____ Policy # _____

Insured's name (if other than self) _____ relationship to insured _____

Secondary Ins. Co. Name _____ Policy # _____

Insured's name (if other than self) _____ relationship to insured _____

Whom may we thank for referring you to this office? _____

Signature _____ **Date** _____

NAME _____

1.The symptoms that have prompted you to seek care today: _____

_____

2.How did they start? ○Auto Accident ○ Work Injury ○Other _____

3.Onset (when did you first notice the symptoms?)_____

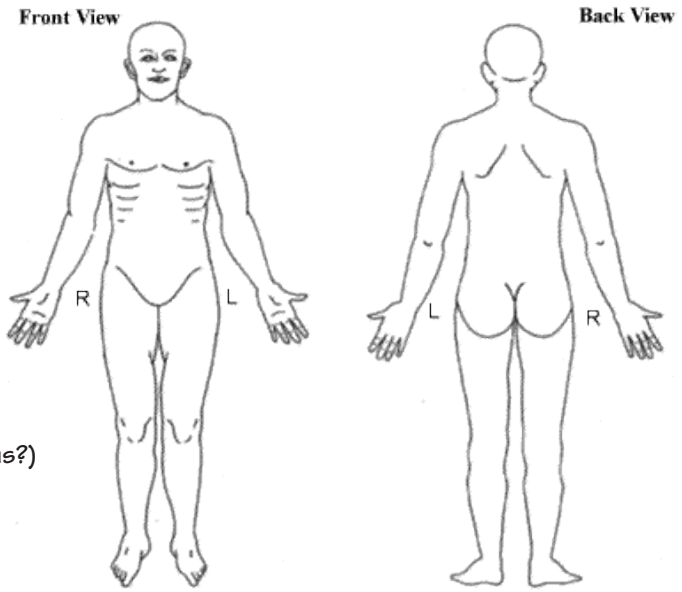
4. Intensity (How severe) at it's worst: 0 1 2 3 4 5 6 7 8 9 10 at it's best: 0 1 2 3 4 5 6 7 8 9 10

5. Duration & timing constant comes and goes How often?_____

6. Quality (what does it feel like?)

- ○ Pain
- ○ Numbness
- ○ Tingling
- ○ Stiff
- ○ Dull
- ○ Sharp
- ○ Cramping
- ○ Nagging
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Aching
- ○ Other _____

7. Location: Place an X on the illustration



8. Aggravating or Relieving (what makes it better and worse?)

Makes worse:_____

Makes better:_____

9. Radiation (Does the pain travel or shoot to other areas?)

Where? _____

10. Prior Interventions (What have you done to relieve the symptoms?)

- ○ Prescription Medication
- ○ Over the counter drugs
- ○ Massage
- ○ Physical Therapy
- ○ Surgery
- ○ Acupuncture
- ○ Chiropractic
- ○ Nothing

11. What else should Dr. Robben know about your condition? _____

12. How does your condition interfere with your:

Work _____

Recreational Activities_____

Household responsibilities _____

Personal Relationships _____

13. Activities of Daily Living (How does your condition interfere with your ability to function?)

	No Affect	Mild affect	Moderate affect	Severe affect
Sitting ————————	○	○	○	○
Rising from seated ————	○	○	○	○
Standing ————————	○	○	○	○
Walking————————	○	○	○	○
Lying Down————————	○	○	○	○
Bending over————————	○	○	○	○
Up/down stairs————————	○	○	○	○
Using a computer————————	○	○	○	○
Getting in/out of a car————	○	○	○	○
Driving a car————————	○	○	○	○
Looking over a shoulder————	○	○	○	○

	No affect	Mild affect	Moderate affect	Severe affect
Grocery Shopping————————	○	○	○	○
Household Chores————————	○	○	○	○
Lifting Objects———————-	○	○	○	○
Reaching Overhead———————--	○	○	○	○
Showering or bathing————————	○	○	○	○
Dressing myself————————	○	○	○	○
Love Life————————————	○	○	○	○
Getting to sleep————————	○	○	○	○
Staying asleep———————-	○	○	○	○
Concentrating———————--	○	○	○	○
Exercising———————————-	○	○	○	○

NAME_____

REVIEW OF SYSTEMS

Chiropractic care focuses on the interity of your nervous system which controls and regulates your entire body. Please darken the circles beside any condition that you have HAD or currently HAVE, and initial in the space provided. Thank you.

MUSCULOSKELETAL

○ NONE INITIALS_____

Had Have
- ○ ○ Osteoporosis
- ○ ○ Arthritis
- ○ ○ Scoliosis
- ○ ○ Neck Pain
- ○ ○ Back Pain
- ○ ○ Hip Disorders
- ○ ○ Knee Problems
- ○ ○ Foot/Ankle prob
- ○ ○ Shoulder Prob
- ○ ○ Elbow/Wrist Prob
- ○ ○ TMJ Prob
- ○ ○ Poor Posture

NEUROLOGICAL

○ NONE INITIALS_____

Had Have
- ○ ○ Anxiety
- ○ ○ Depression
- ○ ○ Headaches
- ○ ○ Dizziness
- ○ ○ Pins & Needles
- ○ ○ Numbness

CARDIOVASCULAR

○ NONE INITIALS_____

Had Have
- ○ ○ High Bld Pressre
- ○ ○ Low Bld Pressure
- ○ ○ High Cholesterol
- ○ ○ Poor Circulation
- ○ ○ Angina
- ○ ○ Excessive Bruising

RESPIRATORY

○ NONE INITIALS_____

Had Have
- ○ ○ Asthma
- ○ ○ Apnea
- ○ ○ Emphysema
- ○ ○ Hay Fever
- ○ ○ Shortness of breath
- ○ ○ Pneumonia

ENDOCRINE

○ NONE INITIALS_____

Had Have
- ○ ○ Thyroid problem
- ○ ○ Immune Disorder
- ○ ○ Hypoglycemia
- ○ ○ Frequent Urination
- ○ ○ Swollen glands
- ○ ○ Low Energy

DIGESTIVE

○ NONE INITIALS_____

Had Have
- ○ ○ Anorexia/Bulimia
- ○ ○ Ulcer
- ○ ○ Food Sensitivities
- ○ ○ Heartburn
- ○ ○ Constipation/diarrhea
- ○ ○ Digestive disorders

SENSORY

○ NONE INITIALS_____

Had Have
- ○ ○ Blurred Vision
- ○ ○ Ringing in ears
- ○ ○ Hearing loss
- ○ ○ Chronic ear infection
- ○ ○ Loss of smell
- ○ ○ Loss of taste

INTEGUMENTARY

○ NONE INITIALS_____

Had Have
- ○ ○ Skin Cancer
- ○ ○ Psoriasis
- ○ ○ Eczema
- ○ ○ Acne
- ○ ○ Hair Loss
- ○ ○ Rash

GENITOURINARY

○ NONE INITIALS_____

Had Have
- ○ ○ Kidney Stones
- ○ ○ Infertility
- ○ ○ Bedwetting
- ○ ○ Prostate Problem
- ○ ○ Erectile Dysfunction
- ○ ○ PMS symptoms

CONSTITUTIONAL

○ NONE INITIALS_____

Had Have
- ○ ○ Fainting
- ○ ○ Low Libido
- ○ ○ Poor appetite
- ○ ○ Fatigue
- ○ ○ Weight change
- ○ ○ Weakness

PERSONAL HISTORY

Please check any illnesses you have HAD in the past or currently HAVE now.

ILLNESSES

○ NONE INITIALS_____

Had Have
- ○ ○ AIDS
- ○ ○ Alcoholism
- ○ ○ Allergies
- ○ ○ Arteriosclerosis
- ○ ○ Arthritis
- ○ ○ Cancer
- ○ ○ Chicken Pox
- ○ ○ Diabetes
- ○ ○ Eczema
- ○ ○ Emphysema
- ○ ○ Glaucoma
- ○ ○ Goiter
- ○ ○ Gout

Had Have
- ○ ○ Heart Disease
- ○ ○ Hepatitis
- ○ ○ Malaria
- ○ ○ Measles
- ○ ○ Multiple Sclerosis
- ○ ○ Polio
- ○ ○ STD's
- ○ ○ Stroke
- ○ ○ Tuberculosis
- ○ ○ Thyphoid Fever
- ○ ○ Ulcer
- ○ ○ Other_____ _____

SURGERIES

○ NONE INITIALS_____

Had Have
- ○ ○ Appendectomy
- ○ ○ Bypass surgery
- ○ ○ Cancer
- ○ ○ Cosmetic
- ○ ○ Eye Surgery
- ○ ○ Hysterectomy
- ○ ○ Pacemaker
- ○ ○ Vasectomy
- ○ ○ Other

TREATMENTS

○ NONE INITIALS_____

Had Have
- ○ ○ Acupuncture
- ○ ○ Chiropractic
- ○ ○ Blood transfusion
- ○ ○ Dialysis
- ○ ○ Herbs
- ○ ○ Homeopathy
- ○ ○ Hormone Replacement
- ○ ○ Massage Therapy
- ○ ○ Physical Therapy
- ○ ○ Nutritional Supplements

FAMILY HISTORY

Some health issues are hereditary. Please tell us about your immediate family members.

Relative	Age (if living)	Illnesses	Age of Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
Grandparent1	_____	_____	_____	_____
Grandparent2	_____	_____	_____	_____
Grandparent3	_____	_____	_____	_____
Grandparent4	_____	_____	_____	_____

NAME_____

SOCIAL HISTORY

	Heavy	Moderate	Light	None
Alcohol use	O	O	O	O
Coffee	O	O	O	O
Tobacco	O	O	O	O
Excerise	O	O	O	O
Pain Relievers	O	O	O	O
Soft Drinks	O	O	O	O
Diet products	O	O	O	O
Water intake	O	O	O	O
Stress level	O	O	O	O

MEDICATIONS

Please list all medications and supplements that you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____

ACKNOWLEDGEMENTS

To set clear expectations, improve communications, and help you get the best results in the shortest time, please read each statement and initial your agreement.

Initials _____ I instruct Dr. Robben to deliver the care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a seperate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the privacy policy and understand how it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any third parties.

Initials _____ I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, or emails to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services that I may receive.

Initials _____ To the best of my knowledge, the information that I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Signature _____ **Date** _____

If patient is a MINOR child

Print child's full name_____

Relationship to child_____

Signature of Guardian _____

Documentation of Guardianship_____

AUTOMOBILE ACCIDENT QUESTIONNAIRE (Page 1 of 3)

Patient Name: _____ **Today's Date:** _____

Date of Accident : _____ **Location of Accident:** _____

The following questions pertain to YOU and the Vehicle you were in:

Vehicle type:
- ☐ Car
- ☐ Pickup
- ☐ Van
- ☐ Truck
- ☐ Station Wagon
- ☐ Bus
- ☐ Other _____

Vehicle size:
- ☐ Subcompact
- ☐ Full-size
- ☐ Compact
- ☐ Mini
- ☐ Mid-size
- ☐ Light
- ☐ Heavy
- ☐ Other _____

Your position in the vehicle:
- ☐ Driver
- ☐ Passenger -------Location-------☐ Left ☐ Middle ☐ Right
- ☐ Other _____ ☐ Front Passenger ☐ Rear Passenger ☐ Third Seat (rear)

Speed of your vehicle:
- ☐ Stopped
- ☐ Moving Moderately
- ☐ Parked
- ☐ Moving Fast
- ☐ Slowing
- ☐ Moving at approx ____ MPH
- ☐ Moving Slowly

If vehicle was slowed or stopped, WHY?:
- ☐ Traffic Signal
- ☐ Parking
- ☐ Pedestrian
- ☐ Traffic
- ☐ Stop Sign
- ☐ Busy Intersection

Collision Type:
- ☐ Driver side impact
- ☐ Head on Collision
- ☐ Passenger side impact
- ☐ Rear impact
- ☐ Front impact
- ☐ Pedestrian incident

The following questions concern the Other Vehicle involved in the accident:

Vehicle type:
- ☐ Car
- ☐ Pickup
- ☐ Van
- ☐ Truck
- ☐ Station Wagon
- ☐ Bus
- ☐ Other _____

Vehicle size:
- ☐ Subcompact
- ☐ Full-size
- ☐ Compact
- ☐ Mini
- ☐ Mid-size
- ☐ Light
- ☐ Heavy
- ☐ Other _____

Conditions at the time of the accident:

Time of day:
- ☐ Full daylight
- ☐ Dawn
- ☐ Dusk
- ☐ Night

Road Conditions
- ☐ Dry
- ☐ Damp
- ☐ Wet
- ☐ Snow covered
- ☐ Ice covered
- ☐ Patchy Ice/Snow

In the space below, list what is difficult or Impossible to do now, that you COULD DO BEFORE THE ACCIDENT:

The following questions concern the moment of impact of the accident:

Were you…
- ☐ Totally unaware that the accident was impending
- ☐ Aware that the accident was impending
- ☐ Aware that the accident was impending and braced for it

Restraints: (check all that apply)
- ☐ Seat belt
- ☐ Shoulder harness
- ☐ No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? ☐ Yes ☐ No ☐ Knocked off by impact

Was the air bag deployed?
- ☐ Car not equipped with air bag
- ☐ Air bag deployed
- ☐ Air bag not deployed

What position was your headrest in?
- ☐ High position
- ☐ Middle position
- ☐ Low position

What was the position of your head at the time of impact?
- ☐ Facing straight ahead
- ☐ Tilted forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Was your head thrown…?
- ☐ Backward and then forward
- ☐ Forward then backward
- ☐ To the left ☐ To the left then the right
- ☐ To the right ☐ To the right, then the left

Position of your body at the time of impact?
- ☐ Straight
- ☐ Leaning forward
- ☐ Rotated to the left
- ☐ Rotated to the right

Was your body thrown…?
- ☐ Backward and then forward
- ☐ Forward then backward
- ☐ To the left ☐ To the left then the right
- ☐ To the right ☐ To the right, then the left
- ☐ Across the vehicle
- ☐ Outside the vehicle
- ☐ Under the vehicle

Damage to the vehicle you were in:
- ☐ Incurred minimal damage
- ☐ Incurred moderate damage
- ☐ Incurred severe damage
- ☐ Not known

Citations:
- ☐ None issued
- ☐ Yourself
- ☐ Driver of other vehicle
- ☐ Not sure

Due to the force of the collision, which objects in the vehicle did your body strike?

Head
- ☐ Steering wheel ☐ Right door
- ☐ Dashboard ☐ Left window
- ☐ Windshield ☐ Right window
- ☐ Armrest ☐ Console
- ☐ Headrest ☐ Gear shift
- ☐ Rear view mirror ☐ Front seat
- ☐ Left door ☐ Back seat

Left Arm
- ☐ Steering wheel ☐ Right door
- ☐ Dashboard ☐ Left window
- ☐ Windshield ☐ Right window
- ☐ Armrest ☐ Console
- ☐ Headrest ☐ Gear shift
- ☐ Rear view mirror ☐ Front seat
- ☐ Left door ☐ Back seat

Right Arm
- ☐ Steering wheel ☐ Right door
- ☐ Dashboard ☐ Left window
- ☐ Windshield ☐ Right window
- ☐ Armrest ☐ Console
- ☐ Headrest ☐ Gear shift
- ☐ Rear view mirror ☐ Front seat
- ☐ Left door ☐ Back seat

Torso
- ☐ Steering wheel ☐ Right door
- ☐ Dashboard ☐ Left window
- ☐ Windshield ☐ Right window
- ☐ Armrest ☐ Console
- ☐ Headrest ☐ Gear shift
- ☐ Rear view mirror ☐ Front seat
- ☐ Left door ☐ Back seat

Left Leg
- ☐ Steering wheel ☐ Right door
- ☐ Dashboard ☐ Left window
- ☐ Windshield ☐ Right window
- ☐ Armrest ☐ Console
- ☐ Headrest ☐ Gear shift
- ☐ Rear view mirror ☐ Front seat
- ☐ Left door ☐ Back seat

Right Leg
- ☐ Steering wheel ☐ Right door
- ☐ Dashboard ☐ Left window
- ☐ Windshield ☐ Right window
- ☐ Armrest ☐ Console
- ☐ Headrest ☐ Gear shift
- ☐ Rear view mirror ☐ Front seat
- ☐ Left door ☐ Back seat

The following questions concern the time period immediately following the accident:

Did you lose consciousness?
☐ Yes
☐ No

Immediately following the accident, did you feel…?
☐ Dizzy ☐ Weak ☐ Headache
☐ Dazed ☐ Nervous
☐ Disoriented ☐ Nauseated

Were you able to walk unaided?
☐ Yes
☐ No

Where did you go…?
☐ Drove home ☐ Drove to work
☐ Was driven home ☐ Was driven to work
☐ Drove to hospital ☐ Drove to school
☐ Was driven to hospital ☐ Was driven to school
☐ Taken to hospital via ambulance ☐ Air Evac to Hospital

Next day discomfort..?
☐ Increased ☐ Decreased ☐ Same

Did your major complaints exist before the accident?
☐ Yes ☐ No

In what areas did you IMMEDIATELY feel pain?

☐ Head	Shoulder	☐ Left	☐ Right	Hip	☐ Left	☐ Right
☐ Neck	Arm	☐ Left	☐ Right	Thigh	☐ Left	☐ Right
☐ Upper back	Elbow	☐ Left	☐ Right	Knee	☐ Left	☐ Right
☐ Mid back	Wrist	☐ Left	☐ Right	Calf	☐ Left	☐ Right
☐ Ribs	Hand	☐ Left	☐ Right	Ankle	☐ Left	☐ Right
☐ Chest	Fingers	☐ Left	☐ Right	Foot	☐ Left	☐ Right
☐ Abdomen	Buttock	☐ Left	☐ Right	Toes	☐ Left	☐ Right
☐ Low back	☐ Pelvis					

In what areas did you experience lacerations (cuts)?

☐ Head	Shoulder	☐ Left	☐ Right	Hip	☐ Left	☐ Right
☐ Neck	Arm	☐ Left	☐ Right	Thigh	☐ Left	☐ Right
☐ Upper back	Elbow	☐ Left	☐ Right	Knee	☐ Left	☐ Right
☐ Mid back	Wrist	☐ Left	☐ Right	Calf	☐ Left	☐ Right
☐ Ribs	Hand	☐ Left	☐ Right	Ankle	☐ Left	☐ Right
☐ Chest	Fingers	☐ Left	☐ Right	Foot	☐ Left	☐ Right
☐ Abdomen	Buttock	☐ Left	☐ Right	Toes	☐ Left	☐ Right
☐ Low back	☐ Pelvis					

At the ☐ Hospital or ☐ Other Doctor's office, what areas were x-rayed?

☐ Head	Shoulder	☐ Left	☐ Right	Hip	☐ Left	☐ Right
☐ Neck	Arm	☐ Left	☐ Right	Thigh	☐ Left	☐ Right
☐ Upper back	Elbow	☐ Left	☐ Right	Knee	☐ Left	☐ Right
☐ Mid back	Wrist	☐ Left	☐ Right	Calf	☐ Left	☐ Right
☐ Ribs	Hand	☐ Left	☐ Right	Ankle	☐ Left	☐ Right
☐ Chest	Fingers	☐ Left	☐ Right	Foot	☐ Left	☐ Right
☐ Abdomen	Buttock	☐ Left	☐ Right	Toes	☐ Left	☐ Right
☐ Low back	☐ Pelvis					

Where did you experience pain on the day following the accident?

☐ Head	Shoulder	☐ Left	☐ Right	Hip	☐ Left	☐ Right
☐ Neck	Arm	☐ Left	☐ Right	Thigh	☐ Left	☐ Right
☐ Upper back	Elbow	☐ Left	☐ Right	Knee	☐ Left	☐ Right
☐ Mid back	Wrist	☐ Left	☐ Right	Calf	☐ Left	☐ Right
☐ Ribs	Hand	☐ Left	☐ Right	Ankle	☐ Left	☐ Right
☐ Chest	Fingers	☐ Left	☐ Right	Foot	☐ Left	☐ Right
☐ Abdomen	Buttock	☐ Left	☐ Right	Toes	☐ Left	☐ Right
☐ Low back	☐ Pelvis					

Neck Index

ACN Group, Inc. - Form N1-100

Patient #: _____

ACN Group, Inc. Use Only rev 11/13/2002

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.

Section 1 - Pain Intensity

⓪ 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

⓪ 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

⓪ 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

⓪ 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 in concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ 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

⓪ 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

⓪ 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

⓪ 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

⓪ 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 of 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

⓪ 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.

Neck Index Score _____

Oswestry Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only 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

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ 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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score

Beach Chiropractic
Christa Robben, D.C.

Patient Informed Consent and Responsibilities

The nature of the chiropractic adjustment: The doctor will use his/her hands or a mechanical device in order to move your spinal joints. This procedure is called a spinal adjustment and it is intended to reduce spinal subluxation.
You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as Electrical Stimulation, Ultrasound, Intersegmental Traction or hot packs may be used.

Possible Risks: I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment. While rare, these risks include but are not limited to fractures, disc injuries, strokes, and sprains. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same conditions, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can even be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

Patient Responsibilities: I understand my responsibilities as follows:
I am responsible for notifying Beach Chiropractic immediately of any changes in or loss of insurance coverage.

I am responsible for notifying Beach Chiropractic immediately of an address or telephone change, whether temporary or permanent.

I authorize all medical or other medical facility personnel to submit to Beach Chiropractic all required and/or necessary information to Beach Chiropractic or my insurer(s) and or any third party payor who provides me with coverage, concerning my medical history, as it may relate to my condition, and consent to the review of my records including medical records by Beach Chiropractic or it's agents, or by any Federal, State, or accrediting body or Agency as required by the Regulatory, Licensing, or Accrediting Body. I authorize Beach Chiropractic to release and obtain all information necessary including my medical information as it relates to my medical treatment and/or therapy to any person or for any purpose reasonable necessary for Beach Chiropractic to secure payment for any benefit being provided under this agreement.

I hereby irrevocably assign and transfer to Beach Chiropractic and/or Christa Robben, D.C., the benefits of any and all insurance policies covering myself for the medical services provided, and to be rendered by Beach Chiropractic and/or Christa Robben, D.C. for the medical condition being treated.

I authorize Beach Chiropractic to release to my attorney, insurance provider, worker's compensation carrier, or my referring physician any and all medical information pertinent to medical services provided by Beach Chiropractic.

I understand that if any legal action is necessary to enforce the terms and conditions of this agreement, the prevailing party shall be entitled to recover all costs including attorney's fees. This agreement shall be governed by the laws of the jurisdiction where Beach Chiropractic is located which is currently within the state of Florida.

IF YOU AND/OR THE INDIVIDUAL LISTED BELOW UNDERSTAND THE ABOVE INFORMATION, PLEASE SIGN BELOW.

I have read or have had read to me the explanation above of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the health plan recommended, and hereby give my full consent to treatment.

_____
Patient's Printed Name

_____ _____
Patient's Signature or Signature of Legal Guardian Date

Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that our sign-in form is visible to other patients as well as anyone within our office setting, and you have the right to request to sign in with an alternative form in order to verify your presence. You should also be aware that there may be multiple patients in the room while you receive certain forms of therapy, including but not limited to electrical stimulation, ultrasound, and Inter segmental Traction. You have the right to refuse these services or request a private room, though it may result in a longer wait-time.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal

representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain rights regarding your health record information, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to

CHRISTA ROBBEN, D.C., BEACH CHIROPRACTIC 3000 N. ATLANTIC AVE. STE. 105 COCOA BEACH, FL 32931 TEL: 321-868-2225 FAX: 321-868-2295