

Date of Birth _____ Age _____ Social Security # _____
 Last _____ First _____ Middle Initial _____
 Address _____ City _____ ST _____ Zip _____
 Phone (H) _____ (W) _____ (C) _____
 Email _____ May we send you our online newsletter? Yes no
 Your Occupation _____ Employer _____
 Spouse's Name _____ Spouse DOB _____ Spouse SSN: _____
 Have you been to another doctor for this problem? Yes No Who/Where? _____
 Who may we thank for referring you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____
 Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time
 What makes the symptoms increase? _____ What relieves the symptoms? _____
 Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate
 Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%
 Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____
 Please list all previous treatments for this condition (give doctor's name and dates if possible) _____
 Do you have any family members who suffer from the same complaint? If so, who? _____

SECONDARY COMPLAINT: _____
 Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time
 What makes the symptoms increase? _____ What relieves the symptoms? _____
 Type of Pain: Sharp Dull Ache Burn Throb Does the Pain Radiate into your: Arm Leg Does not radiate
 Do you have Numbness or Tingling? yes no How often do you experience these symptoms? 100% 75% 50% 25% 10%
 Please rate the intensity of your symptoms on a scale of 1-10 (1 being no symptoms, 10 being extreme) _____
 Please list all previous treatments for this condition (give doctor's name and dates if possible) _____
 Do you have any family members who suffer from the same complaint? If so, who? _____

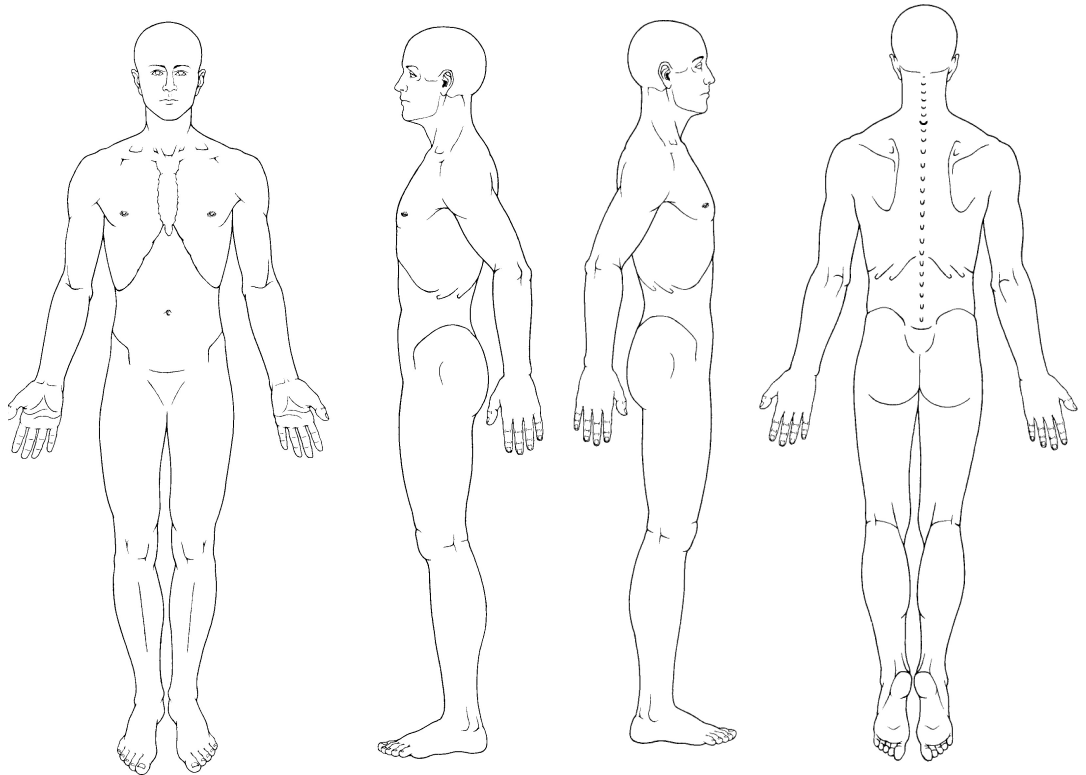
Do you smoke? yes no If yes, how many packs per week? _____
 Have you ever smoked in the past? yes no If yes, when did you quit? _____
 Do you take birth control? yes no Have you ever taken birth control in the past? yes no
 Do you consume alcohol? yes no If yes, how many drinks per week? _____
 Do you consume caffeine? yes no If yes, how many drinks per day? _____
 Do you exercise? yes no If yes, how many times per week and what type? _____
 Do you have a high stress level? yes no If yes, list reasons: _____

Please list any medications or vitamins you are currently taking:

PATIENT SIGNATURE _____ **DATE** _____

Please mark off the areas of your complaint on the diagram above with the following indicators:

- PPP = pain
- NNN = numbness
- TTT= tingling
- BBB= burning
- CCC= cramping
- XXX = other



Please list all surgeries, injuries, accidents, falls, etc: _____

Please check if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herpes
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> MS	<input type="checkbox"/> Mumps
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Stroke
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Suicide Attempt	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Vaginal Infections	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Other:				

PATIENT SIGNATURE _____ DATE _____

NECK PAIN QUESTIONNAIRE

Patient Name: _____

Date: _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your neck pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice that most closely describes your problem right now.

<p><i>Pain Intensity</i></p> <ul style="list-style-type: none"> € I have no pain at the moment. € The pain is very mild at the moment. € The pain is moderate at the moment. € The pain is fairly severe at the moment. € The pain is very severe at the moment. € The pain is the worst imaginable at the moment. 	<p><i>Concentration</i></p> <ul style="list-style-type: none"> € I can concentrate fully when I want to with no difficulty. € I can concentrate fully when I want to with slight difficulty. € I have a fair degree of difficulty in concentrating when I want to. € I have a lot of difficulty in concentrating when I want to. € I have a great deal of difficulty in concentrating when I want to. € I cannot concentrate at all.
<p><i>Personal Care (Washing, Dressing, etc.)</i></p> <ul style="list-style-type: none"> € 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 every day in most aspects of self care. € I do not get dressed, I wash with difficulty and stay in bed. 	<p><i>Work</i></p> <ul style="list-style-type: none"> € I can do as much work as I want to. € I can only do my usual work, but no more. € I can do most of my usual work, but no more. € I cannot do my usual work. € I can hardly do any work at all. € I cannot do any work at all.
<p><i>Lifting</i></p> <ul style="list-style-type: none"> € I can lift heavy weights without extra pain. € I can lift heavy weights, but it gives extra pain. € Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table. € Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. € I can lift very light weights. € I cannot lift or carry anything at all. 	<p><i>Driving</i></p> <ul style="list-style-type: none"> € I can drive my car without any neck pain. € I can drive my car as long as I want with slight pain in my neck. € I can drive my car as long as I want with moderate pain in my neck. € I cannot drive my car as long as I want because of moderate pain in my neck. € I can hardly drive at all because of severe pain in my neck. € I cannot drive my car at all.
<p><i>Reading</i></p> <ul style="list-style-type: none"> € I can read as much as I want to with no pain in my neck. € I can read as much as I want to with slight pain in my neck. € I can read as much as I want to with moderate pain in my neck. € I cannot read as much as I want because of moderate pain in my neck. € I cannot read as much as I want because of severe pain in my neck. € I cannot read at all. 	<p><i>Sleeping</i></p> <ul style="list-style-type: none"> € I have no trouble sleeping. € My sleep is slightly disturbed (less than 1 hour sleepless). € My sleep is mildly disturbed (1-2 hours sleepless). € My sleep is moderately disturbed (2-3 hours sleepless). € My sleep is greatly disturbed (3-5 hours sleepless). € My sleep is completely disturbed (5-7 hours)
<p><i>Headaches</i></p> <ul style="list-style-type: none"> € I have no headaches at all. € I have slight headaches which come infrequently. € I have moderate headaches which come infrequently. € I have moderate headaches which come frequently. € I have severe headaches which come frequently. € I have headaches almost all the time. 	<p><i>Recreation</i></p> <ul style="list-style-type: none"> € I am able to engage in all of my recreational activities with no neck pain at all. € I am able to engage in all of my recreational activities with some pain in my neck. € I am able to engage in most, but not all of my recreational activities because of pain in my neck. € I am able to engage in a few of my recreational activities because of pain in my neck. € I can hardly do any recreational activities because of pain in my neck. € I cannot do any recreational activities at all.

LOW BACK PAIN QUESTIONNAIRE

Patient Name: _____

Date: _____

Patient Signature: _____

This questionnaire is designed to enable us to understand how much your low back pain had affected your ability to manage your everyday activities. Please answer each section by checking the ONE CHOICE that most applies to you. Please select the one choice that most closely describes your problem right now

<p>Pain Intensity</p> <ul style="list-style-type: none"> <input type="radio"/> The pain comes and goes and is very mild. <input type="radio"/> The pain is mild and does not vary much. <input type="radio"/> The pain comes and goes and is moderate. <input type="radio"/> The pain is moderate and does not vary much. <input type="radio"/> The pain comes and goes and is severe. <input type="radio"/> The pain is severe and does not vary much. 	<p>Standing</p> <ul style="list-style-type: none"> <input type="radio"/> I can stand as long as I want without pain. <input type="radio"/> I have some pain while standing, but it does not increase with time. <input type="radio"/> I cannot stand for longer than one hour without increasing pain. <input type="radio"/> I cannot stand for longer than 1/2 hour without increasing pain. <input type="radio"/> I cannot stand for longer than ten minute without increasing pain. <input type="radio"/> I avoid standing, because it increases the pain straight away.
<p>Personal Care</p> <ul style="list-style-type: none"> <input type="radio"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="radio"/> I do not normally change my way of washing or dressing even though it causes some pain. <input type="radio"/> Washing and dressing increases the pain, but I manage not to change my way of doing it. <input type="radio"/> Washing and dressing increases the pain and I find it necessary to change my way of doing it. <input type="radio"/> Because of the pain, I am unable to do some washing and dressing without help. <input type="radio"/> Because of the pain, I am unable to do any washing or dressing without help. 	<p>Sleeping</p> <ul style="list-style-type: none"> <input type="radio"/> I get no pain in bed. <input type="radio"/> I get pain in bed, but it does not prevent me from sleeping well. <input type="radio"/> Because of pain, my normal night's sleep is reduced by less than one than one quarter. <input type="radio"/> Because of pain, my normal night's sleep is reduced by less than one-half. <input type="radio"/> Because of pain, my normal night's sleep is reduced by less than three-quarters. <input type="radio"/> Pain prevents me from sleeping at all.
<p>Lifting</p> <ul style="list-style-type: none"> <input type="radio"/> I can lift heavy weights without extra pain. <input type="radio"/> I can lift heavy weights, but it causes extra pain. <input type="radio"/> Pain prevents me from lifting heavy weights off the floor. <input type="radio"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table. <input type="radio"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="radio"/> I can only lift very light weights, at the most. 	<p>Social Life</p> <ul style="list-style-type: none"> <input type="radio"/> My social life is normal and gives me no pain. <input type="radio"/> My social life is normal, but increases the degree of my pain. <input type="radio"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc. <input type="radio"/> Pain has restricted my social life and I do not go out very often. <input type="radio"/> Pain has restricted my social life to my home. <input type="radio"/> I have hardly any social life because of the pain.
<p>Walking</p> <ul style="list-style-type: none"> <input type="radio"/> Pain does not prevent me from walking any distance. <input type="radio"/> Pain prevents me from walking more than one mile. <input type="radio"/> Pain prevents me from walking more than 1/2 mile. <input type="radio"/> Pain prevents me from walking more than 1/4 mile. <input type="radio"/> I can only walk while using a cane or on crutches. <input type="radio"/> I am in bed most of the time and have to crawl to the toilet. 	<p>Traveling</p> <ul style="list-style-type: none"> <input type="radio"/> I get no pain while traveling. <input type="radio"/> I get some pain while traveling, but none of my usual forms of travel make it any worse. <input type="radio"/> I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. <input type="radio"/> I get extra pain while traveling which compels me to seek alternative forms of travel. <input type="radio"/> Pain restricts all forms of travel. <input type="radio"/> Pain prevents all forms of travel except that done lying down.
<p>Sitting</p> <ul style="list-style-type: none"> <input type="radio"/> I can sit in any chair as long as I like without pain. <input type="radio"/> I can only sit in my favorite chair as long as I like. <input type="radio"/> Pain prevents me from sitting more than one hour. <input type="radio"/> Pain prevents me from sitting more than 1/2 hour. <input type="radio"/> Pain prevents me from sitting more than ten minutes. <input type="radio"/> Pain prevents me from sitting at all. 	<p>Changing Degree of Pain</p> <ul style="list-style-type: none"> <input type="radio"/> My pain is rapidly getting better. <input type="radio"/> My pain fluctuates, but overall is definitely getting better. <input type="radio"/> My pain seems to be getting better, but improvement is slow at present. <input type="radio"/> My pain is neither getting better nor worse. <input type="radio"/> My pain is gradually worsening. <input type="radio"/> My pain is rapidly worsening.

OFFICE FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your chiropractic treatment being successful. Our goal is to help you live a much healthier and happier life.

Please understand that payment of your bill is considered part of your treatment. The following is a statement of our FINANCIAL POLICY. We require that you read, agree to and sign prior to any treatment.

The patient is responsible for the entire bill. If an insurance company is involved, we do not promise that they will pay. ANY SERVICES NOT COVERED BY YOUR INSURANCE COMPANY WILL BE THE RESPONSIBILITY OF THE PATIENT.

The portion of the fee the patient is responsible for must be paid at the time of treatment. This amount will depend on your insurance coverage. Your insurance company will be contacted and your coverage verified in order to calculate your portion of the bill. THE REQUIRED AMOUNT THE PATIENT OWES MUST BE PAID AT THE TIME OF TREATMENT AS A CONDITION TO RECEIVE TREATMENT.

We accept cash, check, Visa, Mastercard, American Express or Discover credit/debit cards.

POLICY ON INSURANCE

- We will fill out and submit all forms for your convenience.
- Our office will verify insurance coverage by phone in advance to determine your benefits.
- The insurance company is not responsible for the bill. This is the patient's responsibility.
- An insurance company's determination of what they consider to be usual, customary and reasonable may on occasion differ from our fees. The office will not enter into a dispute over their determination of the amount they reimburse. Any amount not paid by the insurance company is the patient's responsibility.

We require 2 hours notice for cancelled appointments. Everything will be done in order to arrange an appointment time that is convenient for the patient. If the patient cannot make his/her appointment, we ask that you please call to cancel your appointment 2 hours in advance. You will be charged for any broken appointments. This charge is the responsibility of the patient and will not be billed to the insurance company.

Thank you for trusting us with your care. Our entire office staff will do all we possibly can to help you with your health condition and your financial responsibilities. If you have any questions regarding our office financial policy, please contact Gloria, Susan or Wanda and they will do their best to answer any questions you may have.

I have read, understand and agree to provisions of this Financial Policy. Signed: _____

INSURANCE ASSIGNMENT OF PAYMENT

My insurance company and/or attorney are requested and authorized to pay direct to Geoffrey A. Sandels, D.C., any monies due to him on my account, the same to be deducted from any settlement made on my behalf.

Further, I agree to pay Geoffrey A. Sandels, D.C., the difference, if any, between the total amount of his charges and the total amount paid to him by the insurance company or attorney. It is further understood that I agree to pay Geoffrey A. Sandels, D.C., the full amount of his charges, should my condition be such that it is not covered by my policy or if for any reason, the insurance company refuses to pay my claim.

Patient Signature: _____ Date: _____

Patient Name: _____

AUTHORIZATION TO PERFORM X-RAYS AND CONSENT FOR TREATMENT

This is to acknowledge that Geoffrey Sandels, D.C., may recommend that x-rays be taken so that a complete study and analysis may be made of my present problem or illness. Therefore, Dr. Sandels is hereby authorized and directed to complete a radiographic examination in order to treat my present problem or illness.

I give consent to Dr. Geoffrey Sandels to administer whatever treatment is deemed necessary to treat my problem or illness.

To the best of my knowledge I am NOT pregnant. I give my permission for Dr. Geoffrey A. Sandels to x-ray me for diagnostic interpretation.

Signed: _____ Date: _____

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. Heritage Chiropractic Clinic’s (HCC) Privacy Notice has been made available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for HCC to provide treatment to me, and also necessary for HCC to obtain payment for that treatment and to carry out its health care operations. HCC explained to me that the Privacy Notice will be available to me in the future at my request. HCC has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. HCC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by HCC:
 - a) A postcard mailed to me at the address provided by me; and
 - b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. HCC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for HCC to treat me and obtain payment for that treatment, and as necessary for HCC to conduct its specific health care operations.
5. I understand that I have a right to request that HCC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, HCC is not required to agree to any restrictions that I have requested. If HCC agrees to a requested restriction, then the restriction is binding on HCC.
6. I understand that this Consent is valid for *seven years*. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that HCC has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, HCC has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then HCC will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual Date: _____

Signature of Legal Representative*

Relationship Witness: _____