CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name_____ Social Security #_____

Address_____ City_____ State_____ Zip_____

Home Telephone_____ Work Telephone_____

Email Address_____ Fax#_____ Pager_____

Age_____Birthdate_____ # Children_____

Marital Status: M S W D Occupation:_____

Spouse's Name_____ Spouse' Office Telephone_____

Referred by_____ Nearest Relative & Telephone_____

HEALTH INFORMATION: Have you had previous chiropractic care?_____

What is your major complaint?_____

_____

Other Complaints:_____

How long have you had this condition?_____ Have you had this or similar conditions in the past?_____

What activities aggravate your condition?_____

Is this condition getting progressively worse? Yes No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with you: Work ☐ Sleep ☐ Daily routine ☐ Other _____

How long has it been since you really felt good?_____

Other doctors who treated this condition_____

☐

_____

List surgical operations and years:_____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers

☐ Insulin ☐ Birth control pills ☐ Others_____

Age of mattress____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe:_____

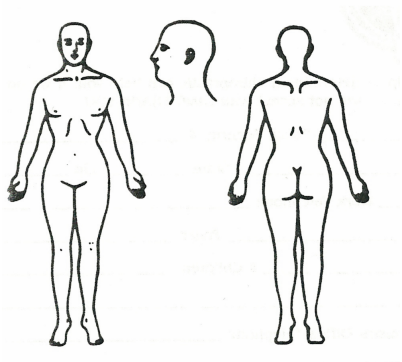
Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe:_____

CONFIDENTIAL PATIENT CASE HISTORY

Date of Last Physical Examination_____

Please mark your areas of pain on the figures below



Have you Ever Suffered From:

1. Dizziness_____
2. Backaches_____
3. Heart Trouble_____
4. Diabetes_____
5. Arthritis_____
6. Headaches_____
7. Asthma_____
8. Neuritis_____
9. Digestive Disorders_____
10. Nervousness_____
11. Sinus Trouble_____
12. Neck Pain_____

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐ No

If yes: Name of Company_____ Policy #_____

Are you covered by Medicare? ☐ Yes ☐ No

If yes: Health Insurance# _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

☐ MasterCard ☐ Visa ☐ American Express Card #_____ Exp. Date_____

All accounts not paid within 90 days will *automatically* be put through on your credit card.

Patient's Signature:_____ Date_____

Guardian or Spouse's Signature_____

Doctor's Signature_____

FAMILY HEALTH INFORMATION. (Many health problems are the result of heredity spinal weaknesses: thus information about your family members give us a better picture of your total health picture.)

NAME	RELATION	PAST & PRESENT HEALTH PROBLEMS

NECK PAIN AND DISABILITY INDEX

Patient Name:_____ Date:_____/_____/_____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ❑ 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 worse than imaginable at the moment.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

- ❑ 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.

SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can lift very light objects.
- ❑ I cannot lift or carry anything at all.

SECTION 4 - READING

- ❑ 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 light pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can't read as much as I want to because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

SECTION 5 - HEADACHES

- ❑ I have no headache 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.

SECTION 6 - CONCENTRATION

- ❑ 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.

SECTION 7 - WORK

- ❑ I can do as much work as I want.
- ❑ I can do only 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 work at all.
- ❑ I can't do any work at all.

SECTION 8 - DRIVING

- ❑ I can drive without any neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive at all.

SECTION 9 - SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❑ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ❑ My sleep is moderately disturbed (3-5 hrs. sleepless).
- ❑ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

- ❑ I am able to engage in all my recreational activities with no neck pain.
- ❑ I am able to engage in all my recreational activities with some neck pain.
- ❑ I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- ❑ I am able to engage in a few of my usual recreational activities because of neck pain.
- ❑ I can hardly do any recreational activities because of neck pain.
- ❑ I can't do any recreational activities at all.

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absence I----------I Extreme

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - 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 severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ❑ I do not have to change my way of washing or dressing 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 or dressing without help.

SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain but it does not increase with distance.
- ❑ I cannot walk more than one 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.

SECTION 5 - 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 one hour.
- ❑ Pain prevents me from sitting more than half an hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain.

SECTION 6 - STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than 1/2 hour without increasing pain.
- ❑ I cannot stand longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Pain reduces my normal sleep by 1/4 each night.
- ❑ Pain reduces my normal sleep by 1/2 each night.
- ❑ Pain reduces my normal sleep by 3/4 each night.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ My social life is unaffected by pain apart form limiting more energetic interests.
- ❑ 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.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I----------I Extreme

Craig A. Newman, D.C., P.A.

OFFICE POLICY

Welcome to Our Office
Please read this policy carefully and feel free to ask questions regarding any part of this form. We believe that a clear definition of our office and financial policies will allow us to concentrate on the primary goal of restoring or maintaining your health. If we do not believe your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate. Our practice will strive to provide you with the finest quality chiropractic care. If you have any questions regarding your treatment, please do not hesitate to ask. We welcome referrals and look forward to establishing a satisfactory doctor-patient relationship. **We ask that all cell phones be turned off before you are brought back for your treatment**.

Informed Consent to Chiropractic Care
You hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays. You understand and are informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. You consent to rely on the doctor's judgment and course of action in which he feels is necessary at the time of treatment.

Transferring Records
If you want to have copies of your records, you must authorize us to include all relevant information, including your payment history **upon request**. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information including your payment history. **There will be a $10 copying fee per film for x-rays and 48 hour notice will be required.**

Payment Options
You may choose to pay cash, check or credit/ debit card on the day that the treatment is rendered.

Returned Checks
There is a fee ($25.00) for any checks returned by the bank.

Insurance
Insurance is a contract between you and your insurance company. We will provide you with the service of billing your insurance company for you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by your insurance.**

Verification of Benefits
We may assist you, at our discretion, in verifying your insurance coverage in an effort to verify exactly what chiropractic coverage is available on your policy. **You as the policy holder are primarily responsible to verify benefits**. We cannot guarantee payment of the benefits and subsequently you may be responsible for any coinsurance, deductibles, or fees for non-covered services that may result.

Workers Compensation
We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury
If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your insurance. In the absence of insurance other financial arrangements may be discussed. We do accept letters of protection, but you will be responsible for paying any fees at the time of your visit until we receive the letter of protection signed by all parties. Payment of any outstanding bill remains the responsibility of the patient.

Required Payments
Any co-payment, deductibles or coinsurance, fees for non-covered services, or outstanding balances must be paid at the time of service.

Payments
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Craig A. Newman, D.C., P.A.

Past Due Accounts
If your account becomes past due, we will take steps to collect this debt. Should your account be more than thirty (30) days delinquent, your balance may be subject to interest charges at a rate of 1.5% per month. Any parent or legal guardian who brings a minor in for treatment is, and hereby agrees to be, responsible for paying the minor's account in full. If we have to refer your account to a collection agency you agree to pay all of the collection of the balance to a lawyer, you agree to pay all the lawyer's fees which we incur, plus all court costs. In case of suit, you agree the venue shall be in Hillsborough County, Florida.

Waiver of Confidentiality
You understand of this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date
Once you have signed this document you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____
Patient's Signature

_____
Date

Craig A. Newman, D.C., P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the **Notice of Privacy Practices** by the office of Dr. Craig Newman, D.C., P.A. and that I have read (or had the opportunity to read if I so choose) and understood the notice.

_____ _____

Patient's Signature Date

Medical Information Release

I authorize the release of medical information to my insurance company necessary to process my claim. I also authorize the payment of medical benefits directly to my physician. I understand I am financially responsible for charges not covered by this authorization.

_____ _____

Patient's Signature Date

Pregnancy Authorization (For Women Only)

I hereby certify that to the best of my knowledge I am not pregnant and hereby give permission to Dr. Newman or his staff to perform any x-rays he deems necessary. I will not hold Dr. Newman or his staff legally responsible should I find myself to be pregnant.

_____ _____

Patient's Signature Date