MAIN STREET CHIROPRACTIC WELLNESS CENTER

PATIENT INFORMATION

NOTE: PLEASE COMPLETE THIS FORM WITH YOUR SIGNATURE AT THE BOTTOM OF THE PAGE

Patient's Name:_____ Nickname: _____

Social Security #:_____ E-mail Address:_____

Address:_____ Home Phone:(___)_____

City_____ State_____ Zip_____ Cell Phone: (___)_____

Birth Date:_____ Sex: M F Marital Status: M S W D Spouses Name:_____

Your Employer_____ Phone: (___)_____

Address: _____

Name & Address of your physician:_____

Would you like a report sent to him/her? ☐ Yes ☐ No

Name and address of Nearest Relative not living with you _____

_____City_____ State_____ Zip_____ Phone (___)_____

Who or What Referred you to the offices of _____

INSURANCE INFORMATION*

**Please complete this section in full if you are covered by insurance or are entitled to receive benefit payments.*

This information will assist us in helping you obtain the benefits to which you may be entitled.

Name of Insured: _____ Insured's Birth Date: _____

Insured's Employer: _____ Address: _____

Name of Insurance Company_____

Address_____

Type: ☐ Group ☐ Private ☐ Workman's Comp ☐ Automobile

Policy#_____ Group# _____ Membership#_____

PATIENT CERTIFICATION AND SIGNATURE

I certify that the above information is true and correct. I hereby authorize the release of any information required to secure payment for services rendered. I also authorize and direct that any insurance or medical coverage benefit payments to which I may be entitled shall be paid directly to

I understand and agree that I am financially responsible for and will promptly pay any non-covered services including, but not limited to, deductible and copay.

The patient understands and agrees to allow this chiropractic office to use their Patient Health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

PATIENT'S SIGNATURE_____ DATE_____

Main Street Chiropractic Wellness Center

145 S. Rochdale Suite A & B

RochesterHills, Michigan 48309

Main Street Chiropractic Wellness Center

PATIENT CONDITION INFORMATION

Name:_____

Main complaint and symptoms: _____

Describe the pain: ☐ Sharp ☐ Dull ☐ Tightness ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

Does the pain radiate into your arms or legs? ☐ Yes ☐ No Which?_____

How frequent is the condition? ☐ Constant ☐ Intermittent ☐ Daily ☐ Night only

How long does it last? ☐ All Day ☐ Few Hours ☐ Minutes

When did you first notice this problem? _____

Has your condition ☐ Improved ☐ Gotten worse or ☐ Stayed the same since its onset?

Was your condition ☐ Caused or ☐ Aggravated by an accident? ☐ Yes ☐ No.

If your above answer is yes. please check the type of accident? ☐ Auto ☐ On Job ☐ Other.

Describe the Accident_____

_____

What makes your condition worse? ☐ Sitting ☐ Standing ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting

Other _____

Does anything make it feel better? _____

Have you had any previous treatment for this or similar conditions? ☐ Yes ☐ No.

When?_____Treated how long?_____ Who treated you? _____

Results?_____

Have you been under previous chiropractic care? ☐ Yes ☐ No Who? _____

List and describe the nature of any Surgery. Trauma. Injury. or Medications: _____

_____

_____

Women: Is there any possibility that you're pregnant? ☐ Yes ☐ No Date of Last Menstrual Period:_____

INFORMED CONSENT

Informed consent is more than just a signed document. The following categories will be or have been discussed.

- What's wrong? or your diagnosis.
- What tests will be ordered: the reason for them: and results expected to achieve.
- Whether or not Chiropractic can be helpful in this case.
- Alternative treatments and your options.
- A treatment plan outlined for your case with expected time frame for results.
- Cost of this Treatment.

These categories have been discussed with me in my report of findings: and I am authorizing the doctor to treat my conditions within the parameters outlined. to the best of his ability.

PATIENT'S SIGNATURE_____DATE:_____

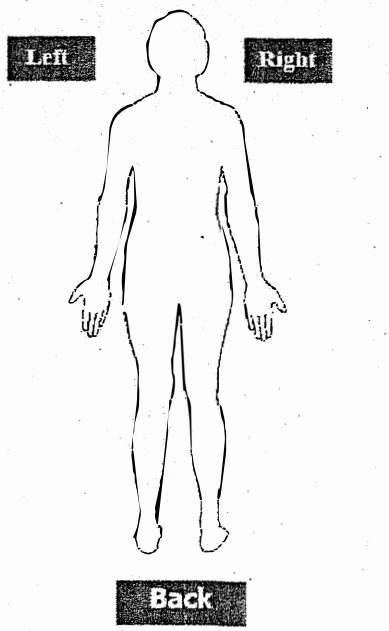
Main Street Chiropractic Wellness Center
145 S. Rochdale Suite A & B
Rochester Hills, Michigan 48309

Name _____ Date _____ Case # _____

Symptoms that can be related to Spinal Nerves

Past	Present	No		Past	Present	No	
☐	☐	☐	Scalp Disorders	☐	☐	☐	Low Back Pain
☐	☐	☐	Head Pain or Headaches	☐	☐	☐	Low Back Weakness
☐	☐	☐	Neck Pain	☐	☐	☐	Low Back Stiffness
☐	☐	☐	Shoulder Pain or Stiffness	☐	☐	☐	Hip Pain or Stiffness
☐	☐	☐	Arm Pain	☐	☐	☐	Buttock Pain
☐	☐	☐	Tennis Elbow	☐	☐	☐	Leg Cramps
☐	☐	☐	Loss of Arm Power	☐	☐	☐	Tingling, Numbness, or Pain of Leg
☐	☐	☐	Loss of Grip				
☐	☐	☐	Tingling, Numbness, or Pain of Hand	☐	☐	☐	Knee Trouble
				☐	☐	☐	Foot Trouble
☐	☐	☐	Mid Back Pain	☐	☐	☐	Tingling, Numbness, or Pain of Foot
☐	☐	☐	Mid Back Tension				
☐	☐	☐	Pain in Ribs				

Please mark area of pain on diagram.



No Symptoms _____ Extreme Symptoms

Please place an "X" on the line above to indicate your level of PAIN.

Family History

	Father	Mother	Siblings	Grandparents	Children
Cancer	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Aneurysm	☐	☐	☐	☐	☐
Alcohol Use	☐	☐	☐	☐	☐
Tobacco Use	☐	☐	☐	☐	☐
Drug Use	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Family Members Still Alive	☐	☐	☐	☐	☐
Other Hereditary Disorders	☐	☐	☐	☐	☐

How many children do you have? _____

What are their current ages? _____

Personal Habits

Type	Amount	Per *
Exercise		
Dairy Products		
Soda Pop		
Coffee/Tea		
Alcoholic Beverages		
Tobacco (any type)		
Drugs (any type)		
Vitamins		

* Please write Day, Week, or Month as applicable.

Occupation

What is your trade? _____

Does your job require you to:

☐ Sit ☐ Stand ☐ Bend ☐ Walk ☐ Lift

How much? _____

Dr.'s Notes: _____

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Patient Name: _____ Date: _____

OSWESTRY DISABILITY INDEX – NECK

This questionnaire has been designed to give the doctor information about how your back pain has affected your ability to manage everyday life. Please answer every section and circle only ONE in each section. We realize that you may feel that two of the statements in any one section relate to you, but please mark ONLY the 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 is moderate at the moment.
(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.

SECTION 2 – 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 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 .

SECTION 3 – LIFTING
(0) I can lift heavy weights without extra pain.
(1) I can lift heavy weights but it gives 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, but I can manage light to medium weight if they are conveniently positioned.
(4) I can lift very light weights.
(5) I cannot lift or carry anything at all.

SECTION 4 – READING
(0) I can read as much as I want to with no pain in my my neck.
(1) I can read as much as I want to with slight pain in my neck.
(2) I can read as much as I want with moderate pain in my neck.
(3) I cannot read as much as I want because of moderate pain in my neck.
(4) I can hardly read at all because of severe pain in my neck.
(5) I cannot read at all .

SECTION 5 - HEADACHES
(0) I have no headaches at all.
(1) I have slight headaches that come infrequently.
(2) I have moderate headaches that come infrequently.
(3) I have moderate headaches that come frequently.
(4) I have severe headaches that come frequently.
(5) I have headaches all the time.

SECTION 6 – CONCENTRATION
(0) I can concentrate fully when I want to with no difficulty.
(1) I can concentrate fully when I want to with slight difficulty.
(2) I have a fair degree of difficulty in concentrating when I want to.
(3) I have a lot of difficulty concentrating when I want to.
(4) I have a great deal of difficulty concentrating when I want to.
(5) I cannot concentrate at all.

SECTION 7 – WORK
(0) I can do as much work as I want to.
(1) I can do my usual work, but no more.
(2) I can 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.

SECTION 8 – DRIVING
(0) I can drive my car without any neck pain.
(1) I can drive my car as long as I want with slight pain in my neck.
(2) I can drive my car as long as I want with moderate pain in my neck.
(3) I cannot drive my car as long as I want because of moderate pain in my neck.
(4) I can hardly drive at all because of severe pain in my neck.
(5) I cannot drive my car at all.

SECTION 9 - SLEEPING
(0) I have no trouble sleeping.
(1) My sleep is slightly disturbed (less than 1 hr sleepless).
(2) My sleep is mildly disturbed (1-2 hrs. sleepless).
(3) My sleep is moderately disturbed (2-3 hrs. sleepless).
(4) My sleep is greatly disturbed (3-5 hrs. sleepless).
(5) My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – RECREATION
(0) I am able to engage in all my recreational activities with no neck pain at all.
(1) I am able to engage in all my recreational activities, with some pain in my neck.
(2) I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck.
(3) I am able to engage in a few of my usual recreational activities because of pain in my neck.
(4) I can hardly do any recreational activities because of pain in my neck.
(5) I cannot do any recreational activities at all.

SCORE: _____

Patient Signature: _____

FLIP OVER ⇨

Patient Name: _____ Date: _____

OSWESTRY DISABILITY INDEX – LOWER BACK

This questionnaire has been designed to give the doctor information about how your back pain has affected your ability to manage everyday life. Please answer every section and circle only ONE in each section. We realize that you may feel that two of the statements in any one section relate to you, but please mark ONLY the statement that most closely describes your problem.

SECTION 1 – 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 severe and does not vary much.

SECTION 2 – PERSONAL CARE
(0) I would 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 though it causes some pain.
(2) Washing and dressing increases the pain, but I manage without changing 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 pain, I am unable to do some washing and dressing without help.
(5) Because of pain, I am unable to do any washing and dressing without help.

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

SECTION 4 – WALKING
(0) I have no pain on walking.
(1) I have some pain on walking, but it does not increase with distance.
(2) I cannot walk more than 1 mile without increasing pain.
(3) I cannot walk more than ½ mile without increasing pain.
(4) I cannot walk more that ¼ mile without increasing pain.
(5) I cannot walk at all without increasing pain.

SECTION 5 - 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 ½ hour.
(4) Pain prevents me from sitting more that 10 min.
(5) I avoid sitting because it increases pain right away.

SECTION 6 - STANDING
(0) I can stand as long as I want without pain.
(1) I have some pain on standing, but it does not increase with time.
(2) I cannot stand for longer than an hour without increasing pain.
(3) I cannot stand for longer than ½ hour without increasing pain.
(4) I cannot stand for longer than 10 min without increasing pain.
(5) I avoid standing, because it increases the pain right away.

SECTION 7 – 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 night's sleep is reduced by less than ¼.
(3) Because of pain, my normal night's sleep is reduced by less than ½.
(4) Because of pain, my normal night's sleep is reduced by less than ¾.
(5) Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE
(0) My social life is normal and gives me no pain.
(1) My social life is normal, but increases the degree of pain.
(2) Pain has no significant effect on my social life, apart from limiting 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

SECTION 9 - TRAVELING
(0)I get no pain while traveling.
(1) I get some pain while traveling, but none of my usual forms of travel makes it any worse.
(2) I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
(3) I get extra pain while traveling, which compels me to seek alternative forms of travel.
(4) Pain restricts all forms of travel.
(5) Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN
(0) My pain is rapidly getting better.
(1) My pain fluctuates, but is definitively getting better.
(2) My pain seems to be getting better, but improvement is slow at present.
(3) My pain is neither getting better nor worse.
(4) My pain is gradually worsening.
(5) My pain is rapidly worsening.

SCORE: _____

Patient Signature: _____

Main Street Chiropractic Wellness Center

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time. ***If you do not wish to receive further information from this office, please contact us at (248) 656-2273.***
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date state below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Patient Date

Main Street Chiropractic Wellness Center

145 S. Rochdale Suite A & B

Rochester Hills, Michigan 48309

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. The process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive care.

We may conduct some diagnostic and examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/per one million persons/yea and risk of death has been estimated as 104 per one million users.

It is also important you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other options about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I see chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian:_____ Signature: _____ Date:_____

Witness Name:_____ Signature: _____ Date:_____