Welcome to Our Office

Patient Information

Date: _____

Patient Name: _____
Last name, First name

Address: _____

City: _____

State: _____ Zip: _____

Email: _____

Sex: ☐ M ☐ F Age: _____ DOB: _____

Social Security #: _____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced ☐Partnered for ___years

Race: _____ Ethnicity: _____

Primary Language: _____

Occupation: _____

Patient Employer/School: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Primary Care Provider: _____

In case of Emergency, contact:

Name: _____ Phone: _____

How did you hear about our office: _____

_____

Communication Preferences

We will contact you the day before your appointment and if you miss any appointments. Would you like to receive reminders via:

☐Text messaging ☐Email ☐Both

Make sure to read and accept our welcome email.

Do you give the practice consent to call your home/cell phone with automated reminders and other information regarding your care?

☐Yes ☐No

Contact preference: ☐Home ☐Cell

Accident Information

Is this condition due to an accident? ☐Yes ☐No

Date: _____

Type of Accident: ☐Auto ☐Work ☐Other

To whom have you made a report of your accident?

☐Auto Insurance ☐Employer ☐Workers Comp ☐Other

Attorney Name: _____

Insurance

Health Insurance Company: _____

Who is the primary insured? _____

Relationship to patient: _____

Policy #: _____

Group #: _____

Is patient covered by secondary insurance? ☐Yes ☐No

Health Insurance Company: _____

Who is the primary insured? _____

Relationship to patient: _____

Policy #: _____

Group #: _____

Financial Policy

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to ☐HealthFirst ☐Kurtz Chiropractic and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify the previously listed party of any changes to my health care coverage. In some cases, exact insurance benefits can not be determined until the insurance company receives claims. I am responsible for the entire bill or balance of the bill as determined by the clinic and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to ☐HealthFirst ☐Kurtz Chiropractic for all covered medical services and supplies provided by the previously listed party and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by the clinic, and will constitute a continuing authorization, maintained on file, which will authorize and allow for direct payment to the previously listed party of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me.

The clinic may use my health care information and may disclose such information to the listed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Print Name of Patient, Guardian, or Personal Representative

_____

Signature of Patient, Guardian, or Personal Representative

_____ _____

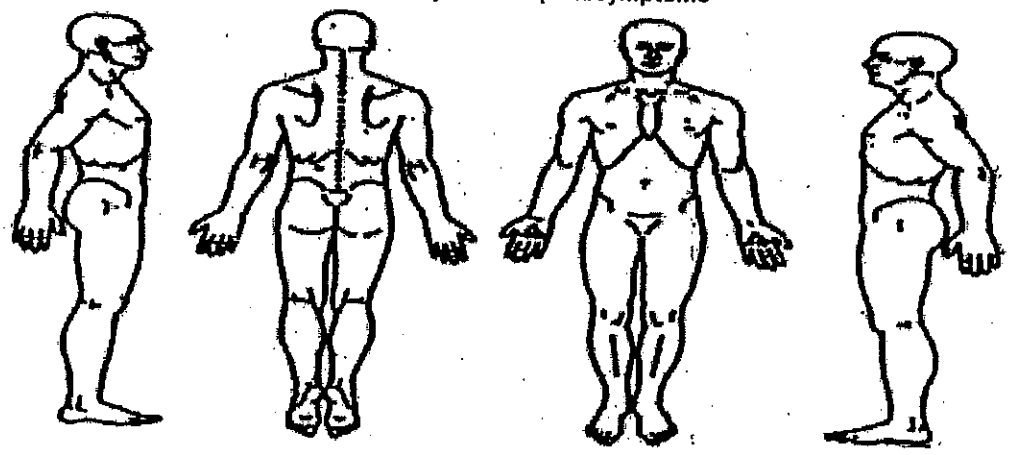
Date Relationship to Patient

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?
   - ☐ Constantly (76-100% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Occasionally (26-50% of the time).
   - ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?
   - ☐ Sharp
   - ☐ Dull
   - ☐ Diffuse
   - ☐ Achy
   - ☐ Burning
   - ☐ Shooting
   - ☐ Stiff
   - ☐ Numb
   - ☐ Tingly
   - ☐ Sharp with motion
   - ☐ Shooting with motion
   - ☐ Stabbing with motion
   - ☐ Electric like with motion
   - ☐ Other: _____

5. How are your symptoms changing with time?
   ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?
   ☐ Not at all ☐ A little bit ☐ Moderately Quite a bit ☐ Extremely

9. Who else have you seen for your problem?
   - ☐ Chiropractor
   - ☐ ER physician
   - ☐ Massage Therapist
   - ☐ Neurologist
   - ☐ Orthopedist
   - ☐ Physical Therapist
   - ☐ Primary Care Physician
   - ☐ Other: _____
   - ☐ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?
    ☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Date of Birth _____

Authorization To Release Medical Records:

PATIENT INFORMATION:

Name (Print) _____ DOB _____ SSN _____

INFORMATION TO BE RELEASED FROM

Name of Facility or provider: _____

Address: _____

INFORMATION TO BE SENT TO:

Kurtz Chiropractic Center
3011 Raleigh Road Parkway
Wilson NC, 27986
P: (252)234-0000 F: (252)291-3232

INFORMATION TO BE SENT TO:

Name of designated recipient:

_____

Address

_____

INFORMATION TO BE RELEASED: (CHECK ONE)

____The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
____ All Medical Records
____ Specific Information (please specify):

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE

____ Attorney ____ Insurance ____ Doctor _____Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

____ Drug/Alcohol abuse/treatment & diagnosis ____Sexually transmitted disease
____ HIV/AIDS diagnosis/treatment/testing ____Mental illness or psychiatric

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, Guardian, or Authorized representative)

Expiration: _____

Informed Consent to Treat

All health care professionals (e.g. doctors of chiropractic, medical doctors, physiotherapists, etc.) are required to advise patients of any possible risk that maybe associated with the treatment that they perform. Following are some of the potential, yet rare, risks you should note:

Chiropractic: _____ (initials here)

- While rare, some patients have experienced rib fractures, muscle/ ligament sprains or strains following spinal adjustments.
- There have also been reported cases of spinal disc injuries following adjustments, however no scientific studies have ever demonstrated such injuries are caused, or may be caused, by spinal adjustments.
- There have been reported cases of injury to the vertebral artery following cervical (neck) adjustments. Such injuries may result in stroke and/ or serious neurological impairment or injury. It is important to note that such an event is extremely rare and it is not necessarily the act of performing the adjustment, but an already present weakness in the artery brought out by the adjustment which results in injury.

Acupuncture: _____ (initials here)

- Some patients have experienced bruising and tenderness at the needle sites.
- It is possible, although extremely rare, for organ injuries to occur. Please note this is rare for experienced practitioners.
- It is possible for blood infections to occur if needles are reused. Although licensed acupuncturists are required to use sterile, disposable needles.

X-Ray: _____ (initials here)

- If I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.
- I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for x-ray exams.

Chiropractic care contributes to you overall well-being. The risk of injuries or complications for this treatment is substantially lower than those associated with many medical or other treatments, medications, and procedures given for the same symptoms. I do not expect the doctors to be able to anticipate and explain all possible risks and complications, I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor fells at the time, based upon the facts then, is in my best interest.

I have read the above consent form and I hereby request and consent to the performance of any treatment offered or recommended to me by my chiropractor. I do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time and I wish to have an x-ray examination performed now. I have also discussed or been given the opportunity to discuss with my chiropractor, the nature and purpose of these treatments in general, and my treatment in particular, as well as the contents of this form. I intend this consent to apply to all my present and future chiropractic care.

Patient signature_____ Patient Name_____ Date_____

Witness Signature_____

New Patient Goals

To the new patient:

Our office takes pride in the fact that we only work on cases we feel we can help. If we accept your case, there are several things we'd like you to know.

- We want you to feel free to ask questions should any arise. The more you understand about chiropractic, the better we can help you. If you need extra time with the doctor, we will arrange it during certain hours. This allows us to stay on schedule.
- We offer classes at no charge to help you understand more about your health.
- We encourage you to tell others about chiropractic once you start to feel better yourself. It helps more conditions than people realize.
- We make ever y effort to make financial arrangements with you, your family and friends. Please let us know if we can help. We also encourage you to take home a no obligation health evaluation form for each member of your family to check for signs of subluxation.
- We want you to select the type of chiropractic care best suited for your needs:
    - Acute/ pain relief care
    - Reconstructive/ strengthening care
    - Maintenance/ preventative care
    - All of the above
- We want you to follow our recommendation for care (e.g. rehabilitative exercises, use of supports, braces) and feel free to ask questions about their use.
- We will refer you to other health care professionals if your condition appears to warrant it. We want you to have the best care possible.
-

I have read the above and understand it fully

Patient Signature:_____ Date:_____

Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

Welcome to Our Office

HIPAA Privacy and Release of Information Authorization

Patient Name: Patient DOB:

I, _____ hereby authorize ☐ HealthFirst ☐ Kurtz Chiropractic and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/ organization and may no longer be protected by applicable federal and state privacy law. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if; its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof(e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____ _____

Patient Printed Name Patient Signature Date

Whom would you like to add to your account that we could talk to about your care? (Spouse, child, sibling) _____

Missed Appointment Policy

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Kurtz Chiropractic Center promptly if you are unable to attend an appointment. This time will be reallocated to someone in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care. If you fail to call at least 24 hours prior to your allotted appointment time, you will be charged a $15.00 missed appointment fee.

How to cancel your appointment:

To cancel your appointment, please call 252-234-0000; if you do not reach the receptionist you may leave a detailed message with our after-hours call center which is available to you 24/7. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

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

Pain Intensity

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 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 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.

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

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ **Date** _____

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

Pain Intensity

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.

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

Back Index Score