CONFIDENTIAL PATIENT INFORMATION

First & Last Names_____ Today's Date _____/_____/_____

Date of Birth _____/_____ /_____ Age_____ Sex: Male / Female (circle one)

Marital Status_____ Nickname_____

E-mail_____

Address_____

City_____ State_____ Zip code _____

Phone: Home _____ Work_____ Cell _____

Which number do you prefer our office to text apt. reminders by: ☐ cell phone ☐ home phone ☐ work phone

Occupation_____ Employer_____

Guardian/Spouse's Full Name _____ Their phone _____

Emergency Contact if different than above _____ Their phone _____

If using insurance, person who carries insurance policy _____

Their relationship to patient _____ Their DOB ___/____/___ Their phone _____

Their Address if different _____

Who can we thank for referring you to our office? _____

Does your visit today regard an injury as a result of ☐ Work injury? ☐ Car Accident? ☐ Other injury?

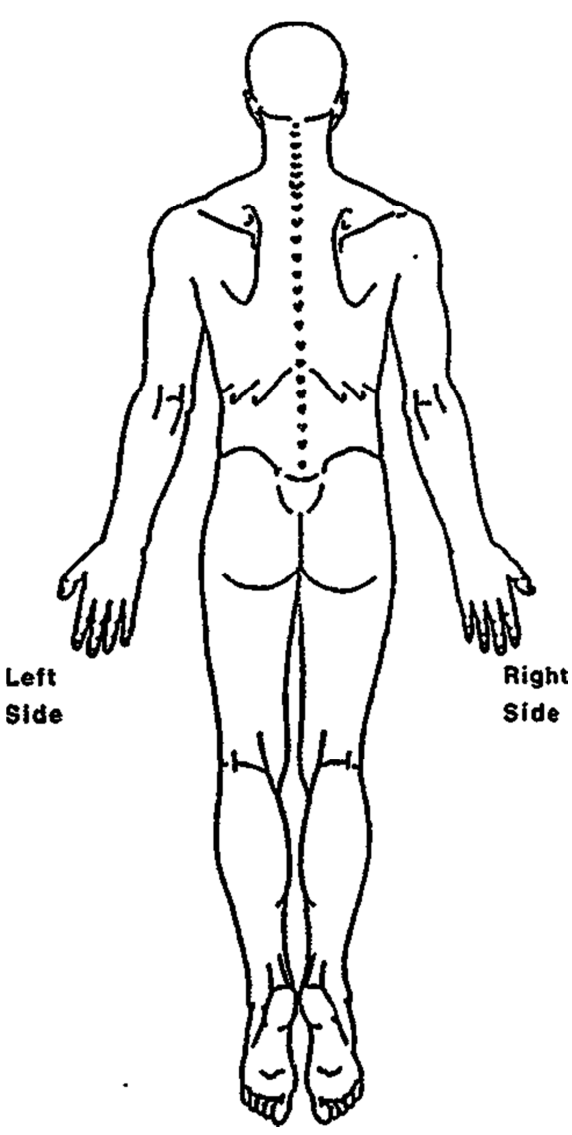
WHY THESE FORMS ARE IMPORTANT: We are a chiropractic and wellness office that centers on helping you reach your optimum health potential. Our first goal is to locate and eliminate any and all interference to reaching your maximum potential while addressing the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. We appreciate your thoroughness in completing these forms so that we may accurately fulfill the requirements of your health insurance (if applicable) and allow us to more accurately determine your current health status. We are honored you have chosen our clinic to help you reach for your true health potential. We look forward to helping you go for Gold Medal Health.

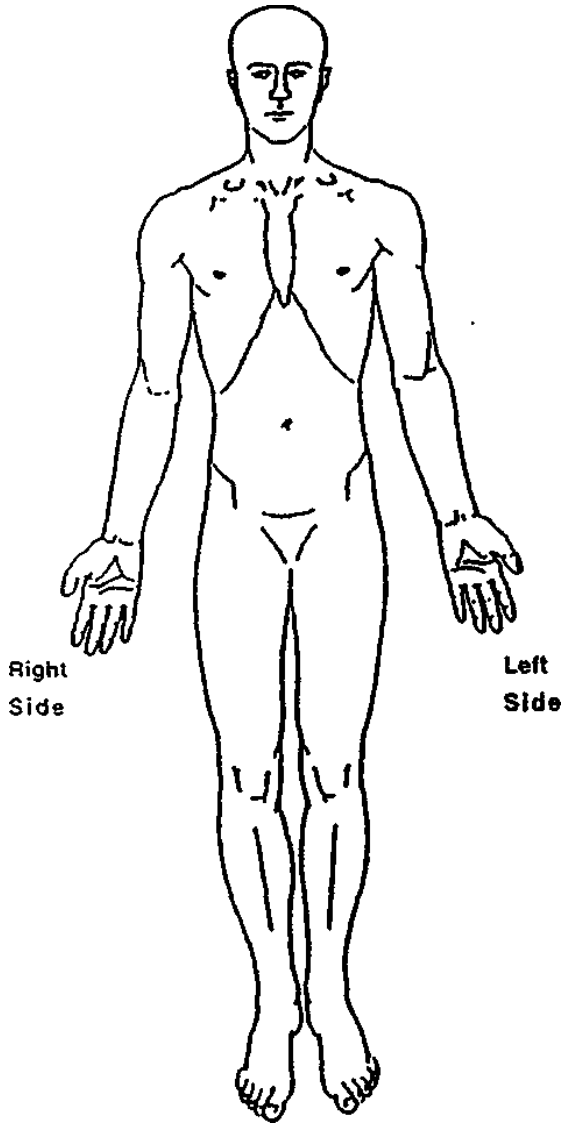
Patient name _____

BODY DIAGRAM

Please use the diagram at below to draw in any areas of complaint or concern. If no problem areas, please leave blank and sign and date below. Use these symbols if necessary:

XXX Sharp 000 Dull Ache /// Burning Pain ^^^Numbness *** Pins and needles or tingling





_____ _____

Patient or Authorized person's Signature Date

_____ _____

Doctor's signature Date

Patient name _____

Functional Rating Index (FRI)

For use with NECK AND/OR BACK PROBLEMS ONLY.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

	0	1	2	3	4
1. Pain Intensity	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
2. Sleeping	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
3. Personal Care (washing, dressing, etc.)	No pain, no restrictions	Mild pain, no restrictions	Moderate pain, need to go slowly	Moderate pain, need some assistance	Severe pain, need 100% assistance
4. Travel (driving, etc.)	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
5. Work	Can do usual work plus unlimited extra	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
6. Recreation	Can do all activities	Cannot do most activities	Can do some activities	Can do a few activities	Cannot do any activities
7. Frequency of pain	No pain	Occasional pain, 25% of the day	Intermittent pain, 50% of the day	Frequent pain, 75% of the day	Constant pain, 100% of the day
8. Lifting	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
9. Walking	No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking
10. Standing	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any walking

_____ ___/___/___ Total Score: _____

Patient or Authorized person's Signature Date

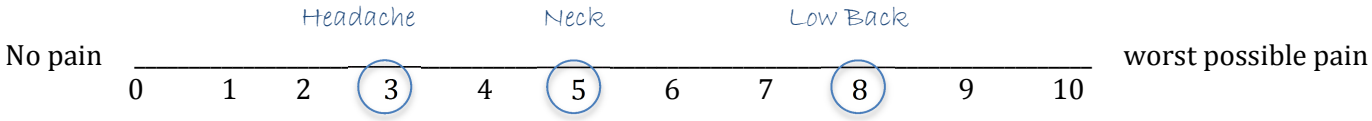
Patient name _____

QUADRUPLE VISUAL ANALOGUE SCALE

Please read carefully:
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____ ___/___/___

Patient or Authorized person's Signature Date

Patient name _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Cummins Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ___/___/___ 🗀*Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ___-___-___ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ___/___/___ 🗀 *Witness Initials*

Patient or Authorized person's Signature Date

Patient name _____

PATIENT POLICIES

To help you receive our best, all patients are accepted for care under the following policies. Please Initial.

Appointment Scheduling/Missed Appointments:

If you start care, and in order to expect the results you desire, it is crucial to stick to the treatment plan agreed to and outlined by Dr. Cummins. The work on your spine for your health is cumulative. As such, when appointments are missed, you may actually lose ground. Rescheduling is easy. Help us give you the best care possible. If you need to miss an appointment, please call the office and make up your missed appointment within the next week.

If you need to miss an appointment, please give us notice via phone. This procedure allows us to serve our patients in a timely manner. No show appointments without notification are subject to a $10.00 charge.

Initial _____

Financial Agreements: It is your payment that allows us to provide high levels of professional care, maintain our facility, and pay staff. If, for any reason you cannot keep your financial agreement, inform us immediately to eliminate any misunderstandings. If you have the desire and commitment to receive care in our office, we will make every attempt to make affordable arrangements.

Office fee schedule

Service	**Fee**
Consultation (Discuss concerns bringing you to office)	Complimentary
Initial Exam	$20 - $140
X-Rays (per view)	$40 - $120
Spinal Adjustment	$60
Medicare Spinal Adjustment	$26-36
Therapeutic Exercises	$45
Taping	$30
Periodic Dynamic Exam /Re-Evaluation	$88

Initial _____

Insurance Benefits: While Cummins Chiropractic & Wellness will gladly verify benefits for all patients with health insurance, this is a courtesy and our verification of benefits is not a guarantee of payment. Your health insurance policy is a contract between you and the insurance company you have chosen. Cummins Chiropractic & Wellness is not responsible in the event your insurance does not cover something it originally stated it would, regardless of stated benefits. You are ultimately responsible for payment for services rendered.

Initial _____

Remember

Spinal correction takes time. If you do not feel satisfied with your body's responses, please make an appointment to discuss this with the doctor. We are here to help and listen.

By my signature below, I state that I have read, understand, and agree to follow these policies.

_____ ___/___/___

Patient or Authorized person's Signature Date