

# E'town Chiropractic Center

## Confidential Patient Information

In order for us to understand your health problem properly, please complete this form neatly, accurately, and completely. Thank you.

Date \_\_\_\_\_ Email \_\_\_\_\_ cell# \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_ Home# \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital status S M W D # Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Office phone \_\_\_\_\_

Name of spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Contact # \_\_\_\_\_

Other Nearest Relative \_\_\_\_\_ Contact # \_\_\_\_\_

Heard about our office through? \_\_\_\_\_

Is this injury do to a work injury? Y N Is this injury do to auto accident? Y N

List present complaints:

Details of any accident/injury and when began:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

List other doctors consulted for present complaints and injuries:

Name: \_\_\_\_\_ When consulted \_\_\_\_\_

Diagnosis \_\_\_\_\_ Treatment \_\_\_\_\_

How long was treatment \_\_\_\_\_ Results \_\_\_\_\_

Name: \_\_\_\_\_ When consulted \_\_\_\_\_

Diagnosis \_\_\_\_\_ Treatment \_\_\_\_\_

How long was treatment \_\_\_\_\_ Results \_\_\_\_\_

Family Doctor \_\_\_\_\_ Date last seen \_\_\_\_\_

Please circle any of following conditions:

Pacemaker Cancer Skin Eruptions Heart Condition Epilepsy Pregnant Nerve Damage

Metal Implants: location \_\_\_\_\_ Recent surgery: location \_\_\_\_\_



**What surgeries have you had**

Type/When/Doctor/Remarks \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List former serious accidents and falls: (auto, work, home, leisure, sports, other - circle one)**

What/When/Symptoms/Treatment/Results \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List broken bones:**

What/When/Remarks \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List medications and/or diet supplements you take:**

What/Frequency/Doctors/Side Effects/Remarks \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Environment**

Work - (Please circle appropriate answer)

Seated/Standing - Work Bench/Desk/Counter/Other \_\_\_\_\_

Job involves - Lifting/Bending/Stooping/Twisting/Turning/Carrying/Walking/Standing/Other \_\_\_\_\_

Chair - Executive/Steno/Bench/Stool/Folding/Other \_\_\_\_\_ Shoes - High heels/Boots/Other \_\_\_\_\_

**Leisure**

Sedentary activities? Standing/Seated/Lying? TV/Reading/Card Games/Sewing/Other (Please describe) \_\_\_\_\_  
\_\_\_\_\_

Strenuous activities? Exercise - Type/Frequency/Length of time? \_\_\_\_\_  
\_\_\_\_\_

Sports - Type/Frequency/Length of time? \_\_\_\_\_

If you have discontinued sports or strenuous activities, why the change? \_\_\_\_\_

Exert Yourself - Frequently/Occasionally/Rarely/Never? Describe how? \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL/FAMILY HISTORY** S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dislocated joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reproductive disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ARC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bowel control loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes  No



# Patient Health Questionnaire - PHQ

ACN Group

ACN Use Only rev 9/11/2002

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

## 1. Describe your symptoms

\_\_\_\_\_  
\_\_\_\_\_

a. When did your symptoms start?

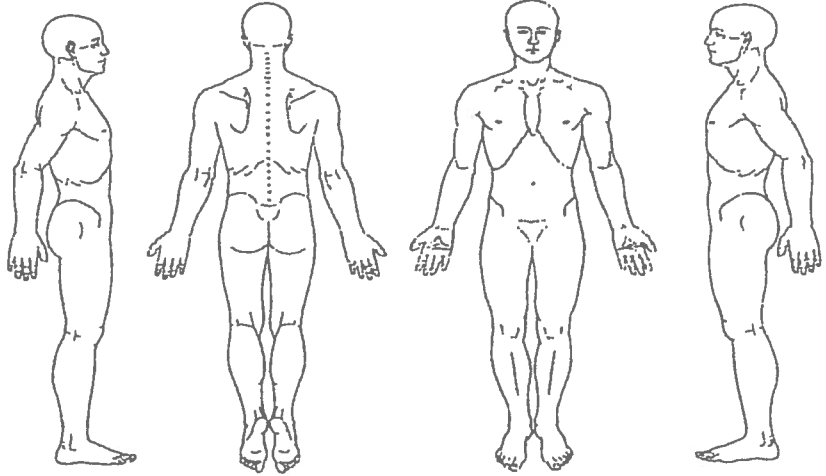
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

## 2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



## 3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

## 4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

## 5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

- None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Unbearable ⑩

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all    ② A little bit    ③ Moderately    ④ Quite a bit    ⑤ Extremely

## 6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

- ① All of the time    ② Most of the time    ③ Some of the time    ④ A little of the time    ⑤ None of the time

## 7. In general would you say your overall health right now is...

- ① Excellent    ② Very Good    ③ Good    ④ Fair    ⑤ Poor

## 8. Who have you seen for your symptoms?

- ① No One    ② Other Chiropractor    ③ Medical Doctor    ④ Physical Therapist    ⑤ Other

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_    ③ CT Scan date: \_\_\_\_\_  
② MRI date: \_\_\_\_\_    ④ Other date: \_\_\_\_\_

## 9. Have you had similar symptoms in the past?

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① Yes    ② No  
① This Office    ③ Medical Doctor    ⑤ Other  
② Other Chiropractor    ④ Physical Therapist

## 10. What is your occupation?

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Professional/Executive    ④ Laborer    ⑦ Retired  
② White Collar/Secretarial    ⑤ Homemaker    ⑧ Other  
③ Tradesperson    ⑥ FT Student
- ① Full-time    ③ Self-employed    ⑤ Off work  
② Part-time    ④ Unemployed    ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



This is a functional assessment questionnaire that is important to determine how your current health condition is affecting your daily life. Please fill out this form as accurately as you can.

In the space by each activity, write the number that corresponds with the level of restriction.

( 0 )-No difficulty, ( 1 )- Mild difficulty, ( 2 )- Moderate difficulty, ( 3 )- Severe difficulty, ( 4 )- Can't Do

Pain level: 0- 10, 0- no pain—10- unbearable pain: Rating: \_\_\_\_\_

Sleep: \_\_\_\_\_

Self Care -Dress, bath, shave, etc.: \_\_\_\_\_

Driving a car: \_\_\_\_\_

Job Performance: \_\_\_\_\_

Recreation: \_\_\_\_\_

Lifting 0-10 lbs: \_\_\_\_\_

Lifting 10-25 lbs: \_\_\_\_\_

Lifting 25+ lbs : \_\_\_\_\_

50 lbs +: \_\_\_\_\_

Walking: \_\_\_\_\_

Static standing: \_\_\_\_\_

Kneeling (e.g. weed garden) : \_\_\_\_\_

Overhead reaching: \_\_\_\_\_

Changing position from sit to stand: \_\_\_\_\_

Pet care: \_\_\_\_\_

Reading (concentration): \_\_\_\_\_

Computer use: \_\_\_\_\_

Feeding/eating: \_\_\_\_\_

Climb stairs: \_\_\_\_\_

Sexual activities: \_\_\_\_\_

Carry groceries: \_\_\_\_\_

Static sitting: \_\_\_\_\_

Household chores: \_\_\_\_\_

Lifting children: \_\_\_\_\_

Yard work: \_\_\_\_\_

Bending to tie/put on shoes: \_\_\_\_\_

Caring for family: \_\_\_\_\_

Getting into/out of car: \_\_\_\_\_

Going down stairs: \_\_\_\_\_





**E'town Chiropractic Center, 620A Westport Rd., Elizabethtown, KY. 42701**

**270-769-9844**

Kentucky State Law requires healthcare providers to obtain your **INFORMED CONSENT** prior to examination and treatment. The purpose of this form is to inform you, not alarm you. What you are being asked to sign is confirmation that you have been informed of the following:

**Examination & X-rays:** this office uses highly sensitive x-ray film, intensifying screens, and filters that provide high quality x-rays with the lowest possible x-ray exposure. The only noteworthy risk with taking x-rays deals with pregnancy. If there is any possibility that you are pregnant, inform us prior to any x-ray examination. If there is no possibility of this condition, the inherent risks are so rare that we have no available statistics to quantify their probability.

PLEASE CIRCLE ONE AND INITIAL: I AM / I AM NOT pregnant at this time / Does Not Apply Initial: \_\_\_\_\_

\*\*\*\*\*

**Chiropractic Adjustment/ Chiropractic Manipulative Therapy (CMT):** The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, which is not cause for alarm. There are some material risks involved in doing these procedures as they are as follows:

-Pain: Chiropractic treatments may result in a temporary increase in soreness in the area receiving treatment.

-Rib Fractures: Fractures caused by chiropractic care are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate, gentle treatments are used, minimizing the possibility of fractures to the ribs.

-Disc Injury: Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatment may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury *about 1 serious complication per 100 million low back manipulations* (2).

- Vertebral Artery Dissection (VAD)/Stroke: The overall incidence of vertebral artery dissection leading to stroke in the general population is about *2 per 1000 people* (3). Although chiropractic adjustments/manipulation has been implicated as a possible cause of stroke, this possibility is very rare. The best available data suggests that a stroke is secondary to chiropractic adjustment/manipulation may occur 1 per 500,000 patients (4)-a rate well below the overall risk in the general population. In comparison, the overall risk of death from taking non-steroidal anti-inflammatory drugs (i.e. Aspirin, Ibuprofen, Naproxen Sodium, etc.) is 4 per 10,000 patients (5). The risk of serious complications or death from spine surgeries of the neck is 11.25 per 1,000 patients (5). As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and tests that will likely reduce the potential for stroke even more.

-This list is of side-effects is not exhaustive and there could be other negative side-effects of various treatments rendered in this office.

Initial: \_\_\_\_\_

I understand the risks and possible negative side effects of Chiropractic Care, Massage Therapy, and other therapeutic modalities and treatments at E'town Chiropractic Center that are involved in my treatment, and I have had the chance to ask questions of the doctor and staff regarding these procedures and make an informed decision in the treatment of my condition(s). By initialing these sections and signing this statement I authorize Dr. Tindall and any or all members of E'town Chiropractic Center staff to treat me using the method designed by Dr. Tindall.

Chiropractic is a second largest system of health delivery. As with any health care delivery system, we cannot promise a cure for any system, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_



All the information that I have provided is true and factual to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### FINANCIAL RESPONSIBILITY STATEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's 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, against the Doctor's recommendation, my account balance will be immediately due and payable. I also agree to pay any and all expenses the Doctor may incur for the collection of my account.

Patient's Signature \_\_\_\_\_ S.S. # \_\_\_\_\_ Date \_\_\_\_\_

Other Responsible Party \_\_\_\_\_ S.S. # \_\_\_\_\_ Information taken by \_\_\_\_\_

### PATIENT CONSENT

#### FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

\_\_\_\_\_, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice 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. The Practice 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 that will be used by the Practice: a) a post card mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and necessary for the Practice to conduct specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
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 the Practice has already taken action in reliance on this Consent.
7. I understand that if I revoke this Consent at any time, the Practice 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 the Practice 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

\_\_\_\_\_  
Signature of Legal Representative  
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness



**E'TOWN CHIROPRACTIC & NATUROPATHIC CENTER  
620A WESTPORT ROAD  
ELIZABETHTOWN, KY 42701  
270-769-9844**

PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_

ATTORNEY \_\_\_\_\_

INSURANCE CARRIER \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

My attorney and/or insurance company are hereby requested and authorized to pay directly to: Dean W. Tindall, DC, DCP, DABCO any monies due to him on account, paid first by the paying insurance carrier, with any remaining balance to be paid for out of settlement made on my behalf.

Further, I agree to pay Dean W. Tindall, DC, DCP, DABCO the difference, if any, between the total amount of his charges and the amount paid him by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay Dean W. Tindall, DC, DCP, DABCO The full amount of his charges, should my condition be such that it is not covered by my policy, or for any reason the insurance carrier refuses to cover the claim.

Dated at: E'town Chiropractic- Elizabethtown, Kentucky

This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Witness \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

