

1
one

WELCOME

ABOUT YOU

Today's Date: ___ / ___ / ___ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ___ / ___ / ___ Age: _____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

2
two

INSURANCE INFO

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___ / ___ / ___

Insured's Employer: _____
Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.
 (*Explain what happened*): _____

Please describe the pain & its location: _____

When did condition begin? ___ / ___ / ___

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

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone#: _____

3
three

PLEASE CONTINUE ON BACK

four

IN EVENT OF EMERGENCY

Who should we contact? _____
 Relation: _____
 Home Phone #: _____ Work Phone #: _____
 Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or ever had any of the following diseases or conditions?

| | | |
|---------------------------------------|--------------------------------------|------------------------------|
| Y N Heart Attack / Stroke | Y N Heart Surg./Pacemaker | Y N Heart Murmur |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse | Y N Artificial Valves |
| Y N Alcohol / Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N HIV+ / Aids | Y N Shingles | Y N Cancer |
| Y N Frequent Neck Pain | Y N Emphysema / Glaucoma | Y N Anemia |
| Y N High/Low Blood Pressure | Y N Psychiatric Problems | Y N Rheumatic Fever |
| Y N Severe/Frequent Headaches | Y N Kidney Problems | Y N Ulcers / Colitis |
| Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems | Y N Asthma |
| Y N Diabetes / Tuberculosis | Y N Difficulty Breathing | Y N Chemotherapy |
| Y N Lower Back Problems | Y N Artificial Bones / Joints | Y N Arthritis |

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any **past** serious accidents with dates: _____

Family Health History: _____

Do you: Take Supplements or Vitamins? Yes No / Exercise? Yes No

Are you on a special diet: Yes No / Since: ____ / ____ / ____

Do you smoke? No Yes / How Much? _____ How Long? _____

Are you wearing: Heel Lifts Sole lifts Inner soles Arch supports

What is the age of your mattress? ____ Is it comfortable? Yes No

For women: Are you taking Birth Control? Yes No

Are you Pregnant? No Yes/How long? ____ Nursing? Yes No

five

six

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY _____ STATE _____ ZIP _____

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: CASH Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Initials _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____ / ____ / ____

Adult Patient Parent or Guardian Spouse

PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Please describe your condition:

Signature: _____ Date: ____ / ____ / ____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness
Symbol → NNNN

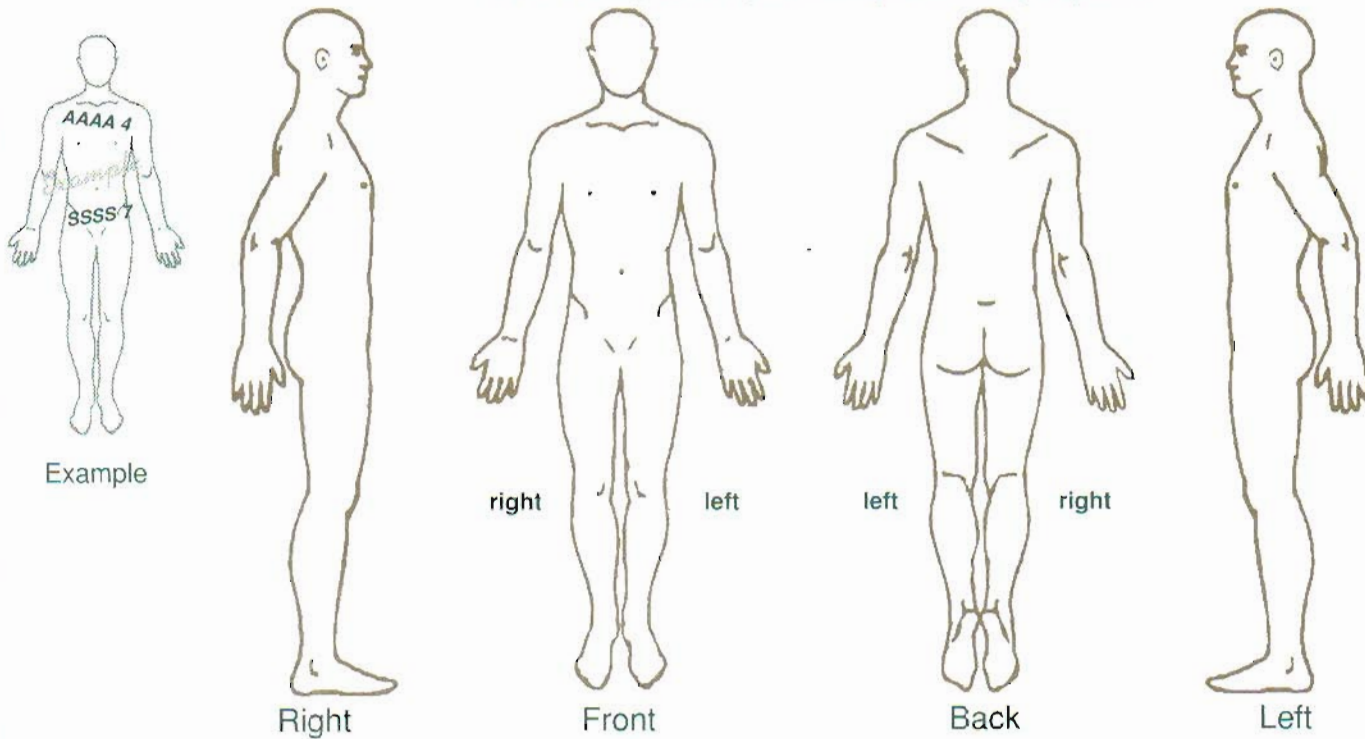
Pins & Needles
PPPP

Burning
BBBB

Aching
AAAA

Stabbing
SSSS

○ Circle any area of pain not represented by a symbol.



DOCTOR'S NOTES

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET 

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

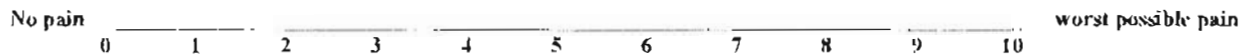
Instructions: Please circle the number that best describes the question being asked.

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.

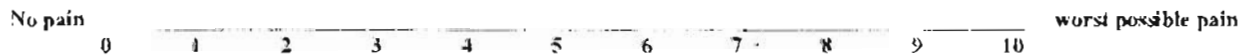
Example:



1 - What is your pain RIGHT NOW?



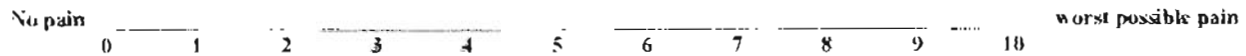
2 - What is your TYPICAL or AVERAGE pain?



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



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



OTHER COMMENTS:

Examiner _____

Reprinted from *Spine*, 18, Von Korf M, Deyo R.A, Cherkin D, Barlow SF. Back pain in primary care: Outcomes at 1 year. 855-862, 1993, with permission from Elsevier Science

SF36 Health Survey

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

- Excellent
- Very Good
- Good
- Fair
- Poor

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

- Much better than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Please **circle one number on each line.**)

| <u>Activities</u> | Yes, Limited A Lot | Yes, Limited A Little | Not Limited At All |
|--|--------------------------|-----------------------------|--------------------------|
| 3(a) Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports | 1 | 2 | 3 |
| 3(b) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | 1 | 2 | 3 |
| 3(c) Lifting or carrying groceries | 1 | 2 | 3 |
| 3(d) Climbing several flights of stairs | 1 | 2 | 3 |
| 3(e) Climbing one flight of stairs | 1 | 2 | 3 |
| 3(f) Bending, kneeling, or stooping | 1 | 2 | 3 |
| 3(g) Waling more than a mile | 1 | 2 | 3 |
| 3(h) Walking several blocks | 1 | 2 | 3 |
| 3(i) Walking one block | 1 | 2 | 3 |
| 3(j) Bathing or dressing yourself | 1 | 2 | 3 |

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(Please **circle one number on each line.**)

| | Yes | No |
|--|-----|----|
| 4(a) Cut down on the amount of time you spent on work or other activities | 1 | 2 |
| 4(b) Accomplished less than you would like | 1 | 2 |
| 4(c) Were limited in the kind of work or other activities | 1 | 2 |
| 4(d) Had difficulty performing the work or other activities (for example, it took extra effort) | 1 | 2 |

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)?

(Please **circle one number on each line.**)

| | Yes | No |
|--|-----|----|
| 5(a) Cut down on the amount of time you spent on work or other activities | 1 | 2 |
| 5(b) Accomplished less than you would like | 1 | 2 |
| 5(c) Didn't do work or other activities as carefully as usual | 1 | 2 |

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

Not at all

Slightly

Moderately

Quite a bit

Extremely

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

None

Very mild

Mild

Moderate

Severe

Very Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

Not at all

A little bit

Moderately

Quite a bit

Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

(Please circle one number on each line.)

| | All of the Time | Most of the Time | A Good Bit of the Time | Some of the Time | A Little of the Time | None of the Time |
|--|-----------------|------------------|------------------------|------------------|----------------------|------------------|
| 9(a) Did you feel full of life? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(b) Have you been a very nervous person? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(c) Have you felt so down in the dumps that nothing could cheer you up? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(d) Have you felt calm and peaceful? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(e) Did you have a lot of energy? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(f) Have you felt downhearted and blue? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(g) Did you feel worn out? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(h) Have you been a happy person? | 1 | 2 | 3 | 4 | 5 | 6 |
| 9(i) Did you feel tired? | 1 | 2 | 3 | 4 | 5 | 6 |

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

All of the time

Most of the time

Some of the time

A little of the time

None of the time

11. How TRUE or FALSE is each of the following statements for you?

(Please circle one number on each line.)

| | Definitely True | Mostly True | Don't Know | Mostly False | Definitely False |
|--|-----------------|-------------|------------|--------------|------------------|
| 11(a) I seem to get sick a little easier than other people | 1 | 2 | 3 | 4 | 5 |
| 11(b) I am as healthy as anybody I know | 1 | 2 | 3 | 4 | 5 |
| 11(c) I expect my health to get worse | 1 | 2 | 3 | 4 | 5 |
| 11(d) My health is excellent | 1 | 2 | 3 | 4 | 5 |

Thank You!



JANKE FAMILY CHIROPRACTIC

277 Tompkins Street
Cortland, NY 13045
(607) 662-0852

OFFICE POLICIES

APPOINTMENT POLICY

To provide you with the best care possible and assist you in becoming the healthiest you, Dr. Janke has designed a program in scheduling chiropractic adjustments at a rate that is designed to allow you to see the greatest changes in the shortest period of time. In the initial relief phase of care you will see that your appointments will be more frequent. For every twelfth visit over a period of four months, you will be given a re-examination to chart your progress. In order to support proper posture, exercises may also be prescribed at that time to strengthen areas of the spine that are weak

It is greatly appreciated that you not miss your scheduled appointments, as we have taken great care to set up each appointment so that you receive the quickest, most effective care possible. It is your responsibility to give us reasonable, advanced notice if you are not able to keep your appointment, or need to reschedule for any reason.

**** A \$30.00 charge will be applied for all 'No Call/No Show' broken appointments.****

At the time of each visit, please be sure to "sign-in" at the front desk. We sincerely attempt to honor each patient's scheduled time for his/her appointment. Therefore, if a patient is considerably late, s/he may be asked to wait for the next available appointment, or may even be asked to reschedule their appointment for another day & time.

Please note that the overall success of your chiropractic care depends on your dedication to being the best YOU and your desire to achieve optimum results. We understand that the frequency of the visits may seem like a lot, but it is a necessary part of our health care program that has been designed to help you achieve quicker results in a shorter period of time, the same as an exercise program at a gym.

WELLNESS ORIENTED WORKSHOP

All of our patients should know as much about their own care, their bodies, and Chiropractic as possible, to get the best benefit out of their care plan here. Our Health Care Classes are mandatory for new patients so we can start on the path to greater health. The class will take about 30-40 minutes and introduce you to Chiropractic and the role your nervous system plays in your health. We highly recommend you bring a friend or family member with you to the class.



JANKE FAMILY CHIROPRACTIC

Office Policies Continued...

ADVANCED WELLNESS CLASSES

Advanced Wellness Classes are scheduled each month to educate our patients on health care issues, and teach them better health habits for a healthier lifestyle. We suggest that all of our patients attend these classes, as it is an essential part of your overall health care program. Friends and relatives are also welcome to attend our classes, as this is a terrific way for them to discover the value of chiropractic care, as well as assist you in your goal of gaining better health.

FINANCIAL POLICY

* It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately you are responsible for all services, including those not reimbursed by third party payors.

* All payments are expected at the time of service if other financial arrangements have not been made.

Patient balances must not exceed \$150 at any time.

* As a courtesy we accept insurance assignment from certain insurance companies. All insurance assignment patients must pay their deductibles in full, and the co-payments at the time of service, or at the end of each week.

* If your account is turned over to our collection agency for non-payment, the patient is then responsible for all costs incurred to collect the debt in addition to the balance due.

* Should you discontinue care for any reason other than discharge by the doctor, any balance due will become immediately payable in full, regardless of any claims submitted.

* This office does not promise that an insurance company will reimburse you for the usual and customary charge submitted, nor will we enter into dispute with an insurance company over the amount of reimbursement.

Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions regarding your health care or any of our policies, please let us know. We thank you, in advance, for referring your friends and family members to us for care, and we are looking forward to building a strong doctor-patient relationship where we can both grow.

Please sign at the bottom after you have read and understand the office policies.

Name _____

Date _____

Signed _____

HIPAA COMPLIANCE

Dear Patients, with the new federal guidelines, the HIPAA Compliance, there are a number of items you should be aware of:

1-Your notes, travel card and files are private and will not be shared with any body else unless we have written permission from you, that includes other health care providers and facilities.

2-If you ever want a copy of your file feel free to ask for it and we will have a copy made for you at no charge to you.

3-If another health care provider or facility asks for your file, it MUST be accompanied by a written release from you.

4-If you have any questions about the privacy of your notes or file, feel free to bring it to the attention of Dr. Janke, who is your compliance contact person.

5-Your health information will never be used by this office for non-health related reasons.

6-If you have any questions regarding the HIPAA regulations or the privacy of your file; feel free to contact Dr. Janke at your convenience.

I have read and understand the above statements concerning the HIPAA regulations for this office. By signing below I attest to that statement.

Signature of Patient _____ date _____

Original copy of compliance dated April 16, 2003 in this office