HI

Congress Chiropractic Clinic

Today's Date:_____

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell_____

Social Security #:_____ Age:_____ ❑ Male ❑ Female

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____

Name of Spouse or Nearest Relative:_____ Phone:_____

Your Occupation_____ Your Employer:_____

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance
❑Automobile Insurance ❑Worker's Compensation

Name of Insurance Co.:_____ Insured's Employer: _____

Insured's Social Security #:_____ Employer's Phone #:_____

Are you covered by more than one insurance company? ❑Yes ❑No Name _____

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

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

Describe Condition_____ Date of Last Physical Exam_____

SURGICAL HISTORY:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY __Job ❑Auto ❑Other 1._____Date:_____

❑Job ❑Auto ❑Other 2._____Date:_____

❑Job ❑Auto ❑Other 3._____Date:_____

(over please)

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please List & Rate Your symptoms(1-10, with 1 being least serious)

1._____ 2._____

3._____ 4._____

5._____ 6._____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT

WHEN AND HOW OCCURRED?_____

_____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED:_____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?_____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____

ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____

ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion❑constipation depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Patient's Signature:_____ Date:_____

NAME: _____ DATE: _____

E-MAIL ADDRESS: _____

CONGRESS CHIROPRACTIC CLINIC
ADDITIONAL COMPREHENSIVE HISTORY QUESTIONNAIRE

Chief Complaint: (what brings you into the office today?)...List all areas of complaint.

_____

_____

Onset: (when did the problem(s) begin; how long has it bothered you?

_____

_____

Palliative: (what makes it feel better?...rest, ice, medication(aspirin, tylenol, prescription, etc.)

_____

_____

Provocative: (what makes it worse?...bending, walking, standing, lifting, working, etc.)

_____

_____

Quality of symptoms: (how would you describe the symptoms?...sharp, stabbing, dull, throbbing, numbness or tingling, etc.)

_____

_____

Radiation of symptoms: (does your pain remain localized in one area or does it refer to another area, and if so; where does it go?)

_____

_____

Severity: (how would you rate the severity of pain?)
(please circle one) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10...(10 being the worst)

Timing: (is there a time of day that your condition is worse (please circle one) Morning, Afternoon, Evening and does your condition affect your sleep? Yes / No
if yes, please explain

_____

_____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

SECTION 1: Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2: Personal Care (e.g. washing, dressing)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but can manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty and stay in bed.

SECTION 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

SECTION 4: Walking

- Pain does not prevent me walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time.

SECTION 5: Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me sitting more than 1 hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6: Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7: Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

SECTION 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

SECTION 9: Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 10: Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient Name: Date: Score:

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer ever section and mark in each section only the one box that applies to you. We realise you may consider the two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1: Pain Intensity

- I have no pain at the moment.
- The pain is mild at the moment.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain is very severe, but comes and goes.
- The pain is severe and does not vary much.

SECTION 2: Personal Care (e.g. washing, dressing)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but can manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty and stay in bed.

SECTION 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor I can manage if they are conveniently placed (e.g., on a table.)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights.
- I cannot lift or carry anything.

SECTION 4: Reading

- I can read as much as I want to with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I cannot read as much as I want because of moderate neck pain.
- I cannot read as much as I want because of severe neck pain.
- I cannot read at all.

SECTION 5: Headache

- I have no headaches at all.
- I have slight headaches which come infrequently
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6: Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7: Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8: Driving

- I can drive my car without neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I cannot drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive my car at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9: Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleepless).
- My sleep is mildly disturbed (1-2 hours sleepless).
- My sleep is moderately disturbed (2-3 hours sleepless).
- My sleep is greatly disturbed (3-5 hours sleepless).
- My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10: Recreation

- I am able to engage in all recreational activities with no pain in my neck at all.
- I am able to engage in all recreational activities with some pain in my neck.
- I am able to engage in most, but not all, recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I cannot do any recreational activities at all.

Patient Name: Date: Score:

Activities that are affected by my current health problems

Name: _____ Date: _____

0 = No affect
1 = I am aware of my problem when I do this activity (Mild)
2 = I don't want to do this activity because of my problem (Moderate)
3 = I can't do this activity at all. (Severe)

Basic

_____ Bending
_____ Climbing Stairs
_____ Falling Asleep
_____ Kneeling
_____ Lifting
_____ Looking Over Shoulder
_____ Lying Down
_____ Rising Out of Chair
_____ Sitting
_____ Standing
_____ Staying Asleep
_____ Walking

Daily Living

_____ Caring for Infirm Family Member
_____ Child Care
_____ Computer Use (extended time)
_____ Computer Use (short time)
_____ Concentrating
_____ Driving
_____ Housework
_____ Lifting Children
_____ Lifting/Carrying Groceries
_____ Pet Care
_____ Reading
_____ Sexual Activity
_____ Yard Work

Occupational Duties

_____ Computer Work
_____ Desk Work
_____ Driving (at work)
_____ Lifting (at work)
_____ Using the Telephone

Personal Care

_____ Bathing
_____ Dressing
_____ Hair Care
_____ Shaving

Recreational Activities

_____ Cycling
_____ Drawing
_____ Exercise
_____ Golf
_____ Needle Work
_____ Piano
_____ Running
_____ Softball
_____ Swimming
_____ Tennis

FINANCIAL RESPONSIBILITY

I _____ am aware that I have a $_____deductible. According to my insurance carrier this is an amount that I freely choose. I am also aware that my insurance carrier only covers _____% of all charges after I pay my deductible. I understand that I am fully, and legally responsible for the deductible, as well as any percentage not covered by my carrier. If I am not able to pay these charges in full at this time, I will make arrangements to make payments on any and all charges for which I am responsible.

We accept cash, check, credit card and debit card for your convenience. There is a $30.00 fee for any returned checks.

I authorize and request the performance of chiropractic services for myself or my minor child so designated below, and give consent to any advisable and necessary procedures, laboratory, X-Rays, to be administered by the attending physician or by his supervised staff for diagnostic purposes and chiropractic treatments.

If default be made in payment, and if such default is not made good within 10 days the entire principle sum and accrued interest shall at once become due and payable without notice. Failure to exercise this option shall not constitute a waiver of the right to exercise the same at a later date for the same default and if placed in the hands of a collection agency, or an attorney of law for collection, the undersigned agrees to pay all costs of collection including reasonable attorney's fees. Presentment, protest and notice hereby waived.

I understand that it is my responsibility to know the benefits of my insurance policy and any co-payments that I may owe. I also understand that I am ultimately responsible for any balance due on my account for professional services rendered. I understand what my diagnosis is and what I am being treated for. I have read and completed this form and certify that all of the above information is correct to the best of my knowledge.

VIP-Our confirmation, on the phone, with your Insurance Company is not a guarantee of your coverage you are responsible for any unpaid balances, deductibles, or if coverage is denied.

PATIENT SIGNATURE:_____DATE:_____

SOCIAL SECURITY #:_____

GUARDIAN/SPOUSE SIGNATURE:_____

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

X_____ X_____

Patient Name (please print) Date

X_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

DR. KEVIN P. CONNER
Congress Chiropractic Clinic
7534 Congress Street
New Port Richey, FL 34653
(727) 847-3852

CONGRESS CHIROPRACTIC CLINIC

DR. KEVIN P. CONNER
CHIROPRACTIC PHYSICIAN

7534 CONGRESS STREET
NEW PORT RICHEY, FL. 34653-1105
TELEPHONE (727) 847-3852
FAX (727) 849-9900

MEMBER
NORTH SUNCOAST CHIROPRACTIC SOCIETY
AMERICAN CHIROPRACTIC ASSOCIATION
FLORIDA CHIROPRACTIC ASSOCIATION

INFORMED CONSENT

I,_____, hereby give permission to Dr. Conner to release any information to my insurance company, Hospitals or other Physicians, acquired in the course of my examination and treatment.

I,_____, hereby give permission to Dr. Conner and /or his Associate to administer treatment and perform such general procedures, as he/they may deem necessary in the diagnosis and / or treatment of my condition. If I have insurance, I understand that I am responsible for all payments until my insurance benefits are verified by this office, or if I am not covered.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

REASONS PATIENTS SEEK CHIROPRACTIC CARE

Pain, joint disorders, headache, dizziness, numbness, sciatica, disc bulging, osteoarthritis, carpal tunnel syndrome, bursitis, tendonitis, dysmenorrhea, digestive disorders, hiatal hernias, diminished reflexes, tension, stress, elevated blood pressure, sprains, strains (any area), partial ligament tearing, knee and foot disorders, impaired circulation, tinnitus, colic, swollen joints, scoliosis, numbness and tingling, auto accident injuries.

RISKS OF MANIPULATION

Chiropractic care has been shown to be generally helpful in many of the conditions listed; however, as in all health care, there are risks that may occur such as joint irritation, dizziness, fractures, any unforeseeable injury and rarely, incidence of stroke. Statistics show the risk is as little as one in one million adjustments for stroke and decreases over age 45. Alternative care to chiropractic is: drugs, surgery, physical therapy, or I can do nothing, but I elect to have chiropractic care.

I UNDERSTAND ALL OF THE ABOVE INFORMATION AND AM SIGNING THIS DOCUMENT FREELY AND VOLUNTARILY.

PATIENT'S SIGNATURE: X_____ **DATE:** X_____

CONGRESS CHIROPRACTIC CLINIC

DR. KEVIN P. CONNER
CHIROPRACTIC PHYSICIAN

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RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize _____
to release a copy of my patient records or x-rays containing protected health information to

_____.

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

X_____ X_____
Patient's or Patient's Legal Representative's Signature Patient's Date of Birth

X_____ Date Signed

Specific description of information to be disclosed: _____
_____
_____
_____

REQUEST FOR ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

I hereby request an accounting of all disclosures of my protected health information.

_____ _____
Patient's or Patient's Legal Representative's Signature Patient's Date of Birth

_____
Date Request is signed

CONGRESS CHIROPRACTIC CLINIC

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I, _____, have not been in any slip and fall or motor vehicle accidents that are currently open with or without an attorney.

Patient name _____

Date _____

Patient Signature _____