Orono Chiropractic

A Drugless Healthcare Practice

Today's Date (MM/DD/YYYY)

Your First Name | Your Middle Name (Or Initial) | Your Last Name

Birth Date (MM/DD/YYYY)

Gender at birth
O Male O Female

Marital Status
O Single O Married
O Divorced O Separated
O Widowed

Address

City | State | ZIP/Postal Code

Cell Phone | Home Phone | Email Address

Emergency Contact | Phone | Relationship

Primary Physician

If patient is a minor: Parent/Guardian Name | Phone

Please list any allergies you may have:

Please list all prescription medications including dosage and frequency:

Please list your pertinent medical history:

Patient signature: Date:

Parent/Guardian signature (if patient is a minor): Relationship:

CONFIDENTIAL HEALTH INFORMATION

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Please use this rating scale as a reference for answering the questions below. Please rate each activity to the best of your ability based on this scale.

["Comfort"] ["Discomfort"] ["Pain"]

0 1 2 3 4 5 6 7 8 9 10

Activity:	Pain Rating #:
Lying on back	
Lying on side	
Lying on stomach	
Sitting	
Standing	
Stretching	
Walking	
Running	
Sports	
Lifting	
Bending	
Kneeling	
Pulling	
Reaching	

Neck Index

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 can tolerate the pain I have without having to use pain medication.
1. The pain is very mild at the moment.
2. The pain is moderate at the moment.
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.

Personal Care (Washing, Dressing, etc.)

0 I can take care of myself normally without causing increased pain.
1. I can take care of myself normally, but it increases my pain.
2. It is painful to take care of myself, and I am slow and careful.
3. I need help, but I am able to manage most of my personal care.
4. I need help every day in most aspects of my care.
5. I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting

0 I can lift heavy objects without increased pain.
1. I can lift heavy objects, but it causes increased pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g. on the table).
3. Pain prevents me from lifting heavy weights, 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.

Reading

0 I can read as much as I want with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I can hardly read at all because of moderate pain in my neck.
5. I cannot read 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.

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 in concentrating when I want.
3. I have a lot of difficulty in concentrating when I want.
4. I have a great deal of difficulty in 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 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.

Driving

0 I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive at all because of severe pain in my neck.
5. I cannot drive my car at all.

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).

Recreation

0 I am able to engage in all of my recreation activities with no pain in my neck.
1. I am able to engage in all of my recreation activities with some pain in my neck.
2. I am able to engage in most, but not all, of my recreation activities because of pain in my neck.
3. I am able to engage in only a few of my recreation activities because of pain in my neck.
4. I can hardly do any recreation activities because of pain in my neck.
5. I cannot do any recreation activities at all.

Patient Initials: _____

Back Index

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 severe and does not vary much.

Personal Care

0 I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of dressing or washing 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, but I manage if they are conveniently positioned (e.g. on a table).
3. Pain prevents me from lifting heavy weights off the floor.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at the most.

Walking

0 I have no pain on walking.
1. I have some pain on walking, but it does not increase with distance.
2. I cannot walk more than one mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

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 one hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain right away.

Standing

0 I can stand as long as I want without pain.
1. I have some pain on standing, but it does not increase with time.
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain right away.

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 night's sleep is reduced by less than ¼.
3. Because of pain, my normal night's sleep is reduced by less than ½.
4. Because of pain, my normal night's sleep is reduced by less than ¾.
5. Pain prevents me from sleeping at all.

Social Life

0 My social life is normal and gives me no pain.
1. My social life is normal, but increases the degree of pain.
2. Pain has no significant effect 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.

Travelling

0 I get no pain while travelling.
1. I get some pain while travelling, but none of my usual forms of travel make it any worse.
2. I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while travelling, which compels me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.
6.

Changing Degree of Pain

0 My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Patient Initials: _____

Functional Rating Index

Complete this page if your discomfort is affecting something other than neck or back pain.

Pain Intensity

0 No pain
1. Mild pain
2. Moderate pain
3. Severe pain
4. Worst possible pain

Sleeping

0 Perfect sleep
1. Mildly disturbed sleep
2. Moderately disturbed sleep
3. Greatly disturbed sleep
4. Totally disturbed sleep

Personal Care (washing, dressing, etc.)

0 No pain; no restrictions
1. Mild pain; mild restrictions
2. Moderate pain; need to go slowly
3. Moderate pain; need some assistance
4. Severe pain; need 100% assistance

Traveling (driving, etc.)

0 No pain on long trips
1. Mild pain on long trips
2. Moderate pain on long trips
3. Moderate pain on short trips
4. Severe pain on short trips

Work

0 Can do usual amounts of work, plus unlimited amounts of extra work
1. Can do usual work; no extra work
2. Can do 50% of usual work
3. Can do 25% of usual work
4. Cannot work

Recreation

0 Can do all activities
1. Can do most activities
2. Can do some activities
3. Can do a few activities
4. Cannot do any activities

Frequency of Pain

0 No pain
1. Occasional pain; 25% of the day
2. Intermittent pain; 50% of the day
3. Frequent pain; 75% of the day
4. Constant pain; 100% of the day

Lifting

0 No pain with heavy weights
1. Increased pain with heavy weight
2. Increased pain with moderate weight
3. Increased pain with light weight
4. Increased pain with any weight

Walking

0 No pain; any distance
1. Increased pain after 1 mile
2. Increased pain after ½ mile
3. Increased pain after ¼ mile
4. Increased pain with all walking

Standing

0 No pain after several hours
1. Increased pain after several hours
2. Increased pain after 1 hour
3. Increased pain after ½ hour
4. Increased pain with any standing

Patient Initials: _____

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Date of Initial Treatment: • Today's Date	/ / *(MM/DD/YYYY)*
Date of Acute Manifestation: • Date of injury that prompted today's visit **OR** • Date of recent flare up of a previous injury that prompted today's visit **OR** • Today's date if today's visit is for a check-up	/ / *(MM/DD/YYYY)*
Date of Onset: • (Usually) Same date as Acute Manifestation	/ / *(MM/DD/YYYY)*

I certify by my signature that the above information is true and accurate to the best of my knowledge.

Name: _____

Signature: _____ Date: _____

If patient is a minor:
Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT

Who We Are and Our Legal Obligations to You You are coming to Orono Chiropractic to receive medical care. Orono Chiropractic is a full service chiropractic care provider specializing in sports injury rehabilitation, muscular therapy, and nutrition counseling.

The law requires us to protect the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to this health information. This Notice of Privacy Practices outlines our legal obligations regarding your health information. We are required to comply with the terms of this Notice of Privacy Practices, effective April 14, 2003. We reserve the right to change the terms of this Notice of Privacy Practices and to make the new terms effective for all health information we possess. We will communicate any changes by providing you with a new copy of the Notice of Privacy Practices the next time you receive treatment at our facility after any such change.

How We May Use or Disclose Your Health Information

We collect health information from you and store it in a chart or on our computer system. This is your medical record. Although this record belongs to Orono Chiropractic, the information in the record belongs to you. The law allows us to use or disclose your health information for the following purposes:

1. *For Treatment.* We may use your health information to provide you with medical treatment or services. For example, if you are receiving chiropractic care at our facility, a chiropractor may review your medical record and release medical information if it is necessary to provide you treatment.
2. *For Payment.* We may use and disclose your health information for purposes of receiving payment for treatment and services that you receive. For example, we may send a bill for your services to your health insurance company, and this bill may contain certain information such as your name and the service we provided to you.
3. *For Health Care Operations.* We may use and disclose your health information for the operation of our facility. For example, we may disclose information to our employees for training purposes, to evaluate performances, to assess the quality of care provided in our facility, and to determine how to improve the health care we provide.
4. *Follow Up Contact.* We may use your health information to check on you or to provide you with information regarding other treatment or treatment options.
5. *Directories.* Unless you inform us that you do not want us to do this, we will disclose your location and general condition to persons who call us and request you by name.
6. *Notification.* We may also disclose your health information to notify or assist in notifying a family member, your personal representative, or other persons responsible for your care about your location or general condition
7. *Public Health Agencies.* We may use or disclose your health information for public health activities such as assisting public health authorities in preventing or tracking disease and maintaining customer records of medical supplies in the event of product recall. We are required to report initial diagnosis of sexually transmitted diseases and communicable diseases to state public health agencies.
8. *Health and Safety and Law Enforcement.* We are required to disclose information to law enforcement if we suspect child abuse or neglect. In the exercise of our professional judgment,

we may report information in the case of adult abuse. Your health information may also be disclosed to avert a serious threat to health or safety of you or any other person. Finally, we may disclose health information to assist law enforcement officials in their duties.

9. *Required by Law.* We will disclose health information if we are required to by law, such as pursuant to a judicial or administrative subpoena. We may also be required to disclose information for specialized government functions such as protection of public officials or reporting to various branches of the armed services.
10. *Fundraising.* We might contact you to raise funds for our facility or to raise political awareness for issues related to health care. You are entitled to opt out of such contacts.
11. *Health Information.* We might send you general newsletters or other information that promotes your health as well as other helpful information regarding our facility.
12. *Worker's Compensation.* Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation.
13. *Other Uses.* **Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent we have taken action in reliance upon the authorization.**

Your Rights Regarding Your Health Information

You have certain rights with respect to your health information. They are listed below. If you would like to exercise any of these rights or if you have questions regarding your rights, please contact: **Orono Chiropractic, Attn: Privacy Officer, 15 Forest Avenue, Orono, ME 04473 – 207-866-7000.**

1. You have the right to request that we limit our uses and disclosures of your health information, as you specify. We may not agree to your request.
2. You have the right to request that we communicate with you through alternative means or locations, and we will respect any reasonable requests.
3. You have the right to review and obtain a copy of your health information. We have the right to charge you a fee for the cost of providing you with such a copy.
4. You have the right to request that we amend your health information. We will review your request but not necessarily make the amendments you request.
5. You have the right to obtain an accounting of disclosures that we have made of your health information except disclosures for treatment, payment, health care operations, disclosures authorized by you, and disclosures for certain government functions.
6. You have the right to revoke any authorization you made for the use or disclosure of your health information except to the extent we have already relied on the authorization.
7. You have the right to receive a paper copy of this notice.

Complaints

You may complain to us if you think we have violated your privacy rights. We will listen to your complaint and do our best to address it. You will not be retaliated against for bringing a complaint. Please direct complaints to **Orono Chiropractic, Attn: Privacy Officer, 15 Forest Avenue, Orono, ME 04473 – 207-866-7000.** You can also file a complaint with the Department of Health and Human Services, Office of Civil Rights.

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Written Authorization to Release Healthcare Information

If I have been diagnosed or treated for any of the following, I understand that Orono Chiropractic needs my specific consent. I do authorize release of this information and waive the right to review records before they are released unless I have specifically initialed under the "I DO NOT" section in the table below.

I DO authorize release of information regarding DRUGS AND/OR ALCOHOL ABUSE. By Federal Law, such information may not be re-disclosed by the recipient without specific written consent.	I DO NOT _____ (Initial here)
I DO authorize release of information regarding MENTAL HEALTH treatment.	I DO NOT _____ (Initial here)
I DO authorize disclosure of information regarding HIV INFECTION, ARC, OR AIDS.	I DO NOT _____ (Initial here)
I DO waive the right to review records before they are released. I understand that such review must be supervised.	I DO NOT _____ (Initial here)
I DO authorize consent to release information regarding my appointment dates/times to persons who call and request me by name and date of birth.	I DO NOT _____ (Initial here)

I understand that:

- I may inspect or cope the protected health information to be used or discussed.
- I may revoke this authorization in writing by contacting Orono Chiropractic, ATTN: Administrator
- Information used or disclosed pursuant to authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment in which case you may refuse to provide that research-related treatment).

This authorization shall remain in effect from the date signed below until:

[ ] _____ (specify expiration date) [ ] NO EXPIRATION DATE

Name: _____

Signature: _____ Date: _____

If patient is a minor – Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

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Informed Consent To Treat

I hereby request and consent to the performance of procedures, including various modes of physio therapy, chiropractic adjustments, examinations, acupuncture, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by this location and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or as back-up, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with this location provider and/or with other office or clinic personnel the nature and purpose of the procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect this location provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti- inflammatories, muscle relaxants and painkillers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name: _____

Signature: _____ Date: _____

If patient is a minor – Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Signature: _____ Date:_____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Practice Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional letters, emails, or health information to me as an extension of my care in the office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I may request a copy of the Financial Policy and Missed Appointment Policy at any time.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**