Patient Information Sheet / Accurate Chiropractic Associates, LLC

Milford Medical Center, 800 Airport Road, Suite 103, Milford, DE 19963 302-422-0622/fax 424-8448

Date: _____

Last Name: _____ First: _____ M.I.: ____

Status: ___Married ___Single ___Widowed ___Divorced ___Children

SSN #: _____ Birth date: _____ Sex: ___M ___F

Address: _____

City: _____ Zip: _____

Telephone number: home_____ work_____

Permission to contact you at work or home about appointments/etc. ___Yes ___No

Patients Occupation: _____

Employer: _____

Employer Address: _____ Phone: _____

Name of spouse: _____ Phone: _____

Spouses Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Referred by: _____ Email Address: _____

Insurance Information

Insured Name: _____

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

Policy Number or I.D. Number: _____

Group Number: _____

Insurance Company: _____

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

Patient's relationship to insured: ____self, ____spouse, ____child, ____other, _____

Is this a work related injury? __Yes __No

Is this an auto accident? __Yes __No

Is there a law suit pending? __Yes __No

Date of accident: _____

Time of accident: _____ __AM __PM

Was accident reported, to whom? _____

Name of Attorney: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

If auto accident (agent) _____

Company: _____

Phone: _____

Send bill to: Name: _____

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

Office Use Only

Patient Number: _____ Type Pay: __CA __ 3P __BCBS __WC __AA __PI __MC Care started: _____

Diagnosis: ___Headache (G44.209) ___Migraine (G43.009)

___Cervical subluxations C1 to C7 (M99.01)

___Thoracic subluxations T1 to T12 (M99.02)

___Lumbar subluxations L1 to L5 (M99.03)

___Sacroiliac subluxations S1 (M99.04)

___Sciatica (R/M54.31) (L/M/54.32)

___Sprain/stain (847.0) cervical

___Sprain/strain (847.1) thoracic

___Sprain/strain (847.2) lumbar

___Sprain/strain (847.3) sacroiliac

___Other_____

Accurate Chiropractic Associates, LLC / Patient Questionnaire

Name:_____ Birthday:_____ Today's date:_____

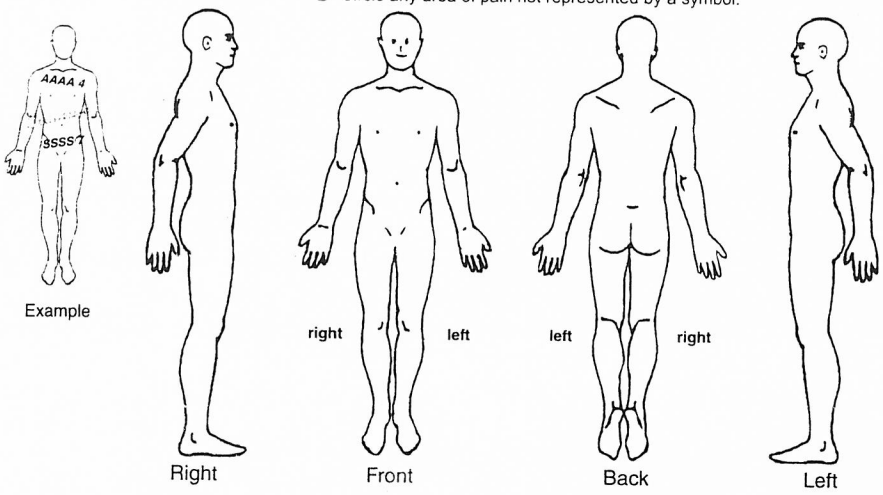
1. Have your ever had chiropractic care before? __yes___no Where:_____ When:_____
   Results: __good __bad __other_____
2. Who is your medical doctor?_____ Date of last: physical exam_____
   Spine or other x-rays:_____ Where?_____
3. How bad is your pain? (from no pain 0--2--4--6--8--10 to severe pain).
   a. Neck: 0--2--4--6--8--10
   b. Arm: __right __left 0--2--4--6--8--10
   c. Back: 0--2--4--6--8--10
   d. Leg: __right __left 0--2--4--6--8--10

Major Complaint/Reason for this visit.
Please describe your symptoms and mark the chart at left.

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	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

Circle any area of pain not represented by a symbol.



4. When did this condition start?_____ What caused it? _____
5. a. Did the pains start? __gradually or __all at once. _____
   b. Is the condition staying the: __same __improving __getting worse? _____
   c. Is the pain constant or does it come and go? __constant __comes and goes. _____
   d. Does it interfere with your: __work __sleep __daily routine __recreation? _____
6. Activities or movements that are painful to perform: __sitting __standing __walking __bending __lying down
   other:_____
7. What makes your condition better?_____
8. What makes your condition worse?_____
9. What kind of work do you do?_____
   a. Have you missed any time from work because of this problem? ___yes ___no. How long?_____
   b. When was the last day you worked?_____ Did your doctor take you out of work? ___yes ___no
   c. Are you working now? ___yes ___no, ___full ___light duty. When did you go back? _____
10. Have you been treated for this problem before? ___yes ___no. Who treated you?_____
    a. Where?_____
    b. What did they do or recommend?_____
    c. Did the treatments help?___yes ___no other_____
11. Do you take __muscle relaxors __pain killers __insulin __birth control pills __over-the-counter meds __ other prescriptions
12. Do you wear?__heel lifts__shoe lifts__orthotics__arch supports__back brace__hearing aids__artifical limbs__glasses/contact
13. Have you had any surgery?_____
14. Have you ever had an __auto accident or __work injury? __yes__no Past year__, Past 5 years__, Over 5 years__, Never__
    a. Did you receive treatment? __yes __no Results?_____
    b. Were there any complications? __yes __no What?_____

General Medical Conditions (Please describe)

Have you had any medical problems? ___Yes ___No What & When:_____

Have you had any surgeries? ___Yes ___No What?:_____

Musculo-skeletal injuries/problems/broken bones? ___Yes ___No _____

Bladder problems? ___Yes ___No Female problems? ___Yes ___No Male problems? ___Yes ___No _____

Stomach/bowel Problems? ___Yes ___No _____

Cardiovascular/Heart/Lung problems? ___Yes ___No _____

Ear, Eye, Nose or Throat problems? ___Yes ___No _____

Skin problems? ___Yes ___No _____

Do you have any problems with bleeding? ___Yes ___No _____

NECK, BACK, EXTREMITIES { put a 1 for current conditions, put a 2 for past conditions }

NECK
__pain in the neck
__neck stiffness
__neck weakness
__pinched nerve in neck
__neck feels out of place
__muscle spasms in neck
__grinding/poping sounds neck

SHOULDERS
__pain in joint L__ R__
__pain across shoulders
__can't raise arm L__ R__
__above shoulder level
__over head
__tension L__ R__
__pinched nerve L__ R__

MID-BACK
__mid-back pain
__mid-back stiffness
__pain between shoulders
__pain from front to back
__muscle spasms mid-back

ARMS & HANDS	left	right
__pain in upper arm	__	__
__pain in elbow	__	__
__pain in forearm	__	__
__pain in hand	__	__
__pain in fingers	__	__
__pins/needles in arm	__	__
__pins/needles in fingers	__	__
__numbness in arm __	__	
__numbness in fingers	__	__
__weakness of arm	__	__
__weakness of hand	__	__
__hands cold	__	__

LOW BACK	left	middle	right
__low back pain	__	__	__
__low back stiffness	__	__	__
__low back weakness	__	__	__
__pinched nerve	__	__	__
__low back out of place	__	__	__
__muscle spasms low	__	__	__

HIPS, LEGS, FEET	left	right
__pain in buttocks	__	__
__pain in hip joint	__	__
__pain down leg	__	__
__pain in knee	__	__
__pain in ankle	__	__
__pain in foot	__	__
__weakness of leg	__	__
__weakness of knee	__	__
__leg cramps	__	__

OTHER SYMPTOMS
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you execrise? __None __Moderate __Daily __Heavy

Your work activity: __Sitting __Standing __Light Labor __Heavy Labor Type of job:_____

Your habits: __Smoking __#per/day, __Alcohol __#drinks per week, __High Stress Level. Why?_____

Current medications/Vitamins:_____

Allergies:_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or ommissions that I may have made in the completion of this form.

Patient signature:_____Date:_____

Accurate Chiropractic Associates, LLC
Dr. Garrett Herring / Dr. Eric Ledford
800 Airport Road, Suite 103
Milford Medical Center
Milford, DE 19963
302-422-0622/ fax 302-424-8448

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I authorize the above-named doctor/doctors/clinic to administer chiropractic treatment to me and perform therapy, and I authorize such additional procedures, as the above-named doctor/doctors/clinic may consider desirable on the basis of findings and determinations made during the course of treatment. Also, I authorize the above-named doctor/doctors/clinic to consult with other professionals concerning my care and treatment.

I certify that I have read and understand the Authorization for Chiropractic Treatment and that I am aware of the possible risks and complications of chiropractic treatment. (See other side) **Initial:**_____

PAYMENT AGREEMENT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I understand that this chiropractic office will accept payment from my insurance carrier, and prepare any necessary reports, and forms to assist me in collection from the insurance carrier, and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for whatever charges are not paid by my insurance carrier. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I also understand and agree that if my account is turned over to a collection agency that I will be responsible for all court fees and the percentage charged by the collection agency.

MEDICAL RECORDS

I understand and agree that this chiropractic office will maintain the privacy of my medical records. I understand and agree that from time to time it may be necessary for this chiropractic office to transmit copies of my records to my insurance carrier, other health care professionals, and the legal profession for routine use and disclosure. I authorize this office to transmit my records for such a review if necessary. The transmission of my records may be by oral communication, paper communication, and/or by electronic communication. I understand and agree that after a period of seven years inactivity at this office my medical records may be destroyed.

Please read and sign the other side of this form.

Accurate Chiropractic Associates, LLC

Informed Consent to Chiropractic Treatment (Possible Risks & Complications)

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound or dry/wet hydrotherapy, massage or acupuncture may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment/manipulation. Complications although very rare could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to the intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment been described as very rare about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be ever further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered very rare.

Other treatment options which could be considered may include the following:

Over the counter analgesics: The risks of these medications include irritation to the stomach, liver and kidneys, and other side effects in a significant number of cases.
Medical care: typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs can include numerous adverse undesirable side effects and patient dependence in a significant number of cases.
Hospitalization in conjunction with medical care adds a risk of exposure to virulent communicable disease in a significant number of cases.
Surgery in conjunction with medical care adds a risk of an adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

In spite of the additional risks noted with the other treatment options, medical care, analgesics, meditations, hospitalization and surgery may be necessary in certain cases. These options may be used in conjunction with your chiropractic care under the direction of your medical doctor.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the above unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment and the possibility and probability of risks. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Date:_____ **Patient Signature:**_____

Patient Printed Name:_____

Accurate Chiropractic Associates, LLC
Milford Medical Center
800 Airport Road, Suite 103
Milford, DE 19963
302-422-0622 / Fax 302-424-8448

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I _____, hereby authorize Accurate Chiropractic Assoc., LLC (the "Practice") to use and/or disclose to *other health care professionals/physicians, to appropriate third party payers, to practice staff for insurance/billing procedures, or anyone I so designate to receive* the following specific health information: *copies of my medical records, billing information.*

2. I understand that this authorization is valid until I revoke this authorization.

3. I understand that the purpose or use of this disclosure I am granting is to *provide information for treatment, payment and health care operations .*

4. I expressly acknowledge that this authorization is voluntary.

5. The following is/are other criteria or limitations that I make regarding this authorization:

_____

_____

6. I understand that the office may receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

9. I understand that my health care and payment for my healthcare may be affected if I do not sign this form.

10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it if so requested.

11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

12. This authorization is valid as of ____/____/____, the date I have signed below.

_____ _____

Name of individual (Printed) Signature of individual

_____ _____

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

Witness:_____

Accurate Chiropractic Associates, LLC
Dr.Garrett Herring / Dr. Eric Ledford
Milford Medical Center
800 Airport Road, Suite 103
Milford, DE 19963-9803
302-422-0622 /fax 302-424-8448

Patient Request for Records

I, _____, do hereby authorize the release of my x-rays records, reports, medical records, reports or copies of such from_____ and request that they be transferred to:

Dr. _____
Address: 800 Airport Road, Suite 103
Milford Medical Center
Milford, DE 19963-9803
Fax 302-422-0520

Date: _____

Patient's Signature: _____

Date of records: _____

Date records sent: _____

Thank you for your time and attention regarding this matter.

ACCURATE CHIROPRACTIC ASSOCIATES
DR. HERRING/DR. LEDFORD
800 AIRPORT ROAD, SUITE 103
MILFORD, DE 19963
302-422-0622/302-424-8448 (FAX)

NAME: _____ DATE: _____

1. What is your current pain level (0 to 10)? _____

2. Have you had a flu shot within last 6 months?

   Yes_____ No_____

3. Have you had pneumonia shot within last 12 months?

   Yes_____ No_____

4. Please provide us with current weight and height.

   Weight_____

   Height_____

5. Do you use tobacco products?

   Yes_____ No_____

6. Please list all medications.

   _____

   _____