NEW PATIENT INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

(First, middle initial, last) (MM/DD/YYYY)

PHONE NUMBER: _____

ADDRESS: _____

_____

MARITAL STATUS: _____ **SPOUSE NAME:** _____

EMPLOYEE STATUS: _____ **OCCUPATION/JOB TITLE:** _____

EMPLOYERS NAME: _____ **PHONE NUMBER:** _____

Please circle yes or no to the following:

HAVE YOU BEEN TO A CHIROPRACTOR OR PHYSICAL THERAPY IN THE LAST YEAR?

YES **NO**

ARE YOU SEEKING TREATMENT FOR AN PRE-EXISTING INJURY?

YES **NO**

Please state when your CURRENT injury occurred below:

DATE: _____ **LOCATION:** _____

Please describe event: _____

_____

_____

ADVANTAGE CHIROPRACTIC, PLLC

1003 OAKHURST DR. SUITE 3
CHARLESTON, WV 25314

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPTIONS

I, _____ (patient's name), consent to Advantage Chiropractic, PLLC use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not limited to, quality assessment activities. Credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future payments for the provision of health care services to me, and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment or payment of healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction I biding on the Practice.
I have the right to revoke this consent, in writing, at any time, except to the extent that the Physician or the Practice has acted in reliance on this consent.

_____ _____
Signature of Patient or Personal Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (patient's name), acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Advantage Chiropractic, PLLC which describes the Practice's policies and procedure regarding the use and disclosure of an of my Protected Health Information created, received, or maintained by the Practice.

_____ _____
Patient Signature Date

_____
Print Name

FOR OFFICE USE ONLY IF NOTICE IS NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (Circle all that apply): Patient unavailable, Patient Physically Unable, Patient Unwilling

In effort to obtain Patient's acknowledgement, the Practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner (circle all that apply): Personally Mail Phone Follow-up Other: _____

_____

Jennifer R. Runyan, D.C. _____

Advantage Chiropractic, PLLC Date

ADVANTAGE CHIROPRACTIC, PLLC

1003 OAKHURST DR. SUITE 3
CHARLESTON, WV 25314

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctor to discuss my medical information in any way with anyone without my expressed written consent. By signing this form, I am designating the parties below with whom I wish Advantage Chiropractic, PLLC to be able to discuss my medical condition.

If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform Advantage Chiropractic, PLLC in writing of my decision.

In accordance with the above, I _____ (patient's name), hereby authorize Advantage Chiropractic, PLLC to discuss with and release my medical information to the following individuals:

_____ _____

_____ _____

The below individuals are authorized to pick up x-ray films on my behalf:

_____ _____

Furthermore, I understand that if any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded.

NOTIFY IN CASE OF EMERGENCY _____

_____ _____

Patient Signature Date

_____

Print Name

Advantage Chiropractic, PLLC
1003 Oakhurst Dr. Suite 3
Charleston, WV 25314

OFFICE POLICIES AND PROCEDURES AGREEMENT

PAYMENT INFORMATION: Co-pays are due at the time of service. If you have not met your deductible, we require you to pay the day of service for services rendered. There is a $25.00 no show fee if you do not call to cancel your appointment. If your balance accrues over $300.00, you will be placed on a payment plan until the balance is paid in full. If we do not receive a payment monthly, you will be sent to collections.

MASSAGE INFORMATION: We require a 2 hour notice for cancellation of massage therapy. If it is not cancelled 2 hours prior to appointment time, there is a $25 fee for 30 minute massage and a $50 fee for an hour massage. The same applies for no showing a massage as well. **If you show up more than 10 minutes late to your massage, you will not receive the massage and will be charged the $25 late cancellation fee as well.**

RISKS: Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains. Also, soreness and/or bruising may occur after a massage due to medications and/or muscle or blood disorders. I verify that I have read and understand the above information. Further, I am satisfied that all questions have been answered to my satisfaction.

_____ _____

Patient's Signature Date

_____

Print Name

_____

Witness

Oswestry k Pain Disability Questionnaire

Oswestry Disability Index

Please complete this questionnaire. It is designed to tell us how you pain affects your ability to function in every day life.

I have "Chronic Pain" or pain that has bothered me for 3 months or more:
☐Yes ☐No

Check one of the following:
☐Prior to Surgery ☐After Surgery 3 Months ☐After Surgery 1 year
☐After Surgery 6 weeks ☐After Surgery 6 Months ☐After Surgery 2 years

Please answer each section below by checking the One Choice that applies the most to you at this time. (You may feel that more than one of the statement relates to you at this time, but it is very important that you Please check only one choice that best describes your problem at this time.

Section 1: Pain Intensity

- ☐ I can tolerate the pain I have without having to use pain killers. [0 points]
- ☐ The pain is bad but I manage without taking pain killers. [1 point]
- ☐ Pain killers give complete relief from pain . [2 points]
- ☐ Pain killers give moderate relief from pain. [3 points]
- ☐ Pain killers give very little relief from pain. [4 points]
- ☐ Pain killers have no effect on the pain and I do not use them. [5 points]

Section 2: Personal Care

- ☐ I can look after myself normally without causing extra pain. [0 points]
- ☐ I can look after myself normally but it causes extra pain. [1 point]
- ☐ It is painful to look after myself and I am slow and careful. [2 points]
- ☐ I need some help but manage most of my personal care. [3 points]
- ☐ I need help every day in most aspects of self care. [4 points]
- ☐ I do not get dressed wash with difficulty and stay in bed. [5 points]

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain. [0 points]
- ☐ I can lift heavy weights but it gives extra pain. [1 point]

Oswestry Disability Index

Section 3: Lifting (Cont.)

- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned for example on a table. [2 points]
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. [3 points]
- ☐ I can lift only very light weights. [4 points]
- ☐ I cannot lift or carry anything at all. [5 points]

Section 4: Walking

- ☐ Pain does not prevent me walking any distance. [0 points]
- ☐ Pain prevents me walking more than 1 mile. [1 point]
- ☐ Pain prevents me walking more than 0.5 miles. [2 points]
- ☐ Pain prevents me walking more than 0.25 miles. [3 points]
- ☐ I can only walk using a stick or crutches. [4 points]
- ☐ I am in bed most of the time and have to crawl to the toilet. [5 points]

Section 5: Sitting

- ☐ I can sit in any chair as long as I like. [0 points]
- ☐ I can only sit in my favorite chair as long as I like. [1 point]
- ☐ Pain prevents me sitting more than 1 hour. [2 points]
- ☐ Pain prevents me from sitting more than 0.5 hours. [3 points]
- ☐ Pain prevents me from sitting more than 10 minutes. [4 points]
- ☐ Pain prevents me from sitting at all. [5 points]

Section 6: Standing

- ☐ I can stand as long as I want without extra pain. [0 points]
- ☐ I can stand as long as I want but it gives me extra pain. [1 point]
- ☐ Pain prevents me from standing for more than 1 hour. [2 points]
- ☐ Pain prevents me from standing for more than 30 minutes. [3 points]
- ☐ Pain prevents me from standing for more than 10 minutes. [4 points]
- ☐ Pain prevents me from standing at all. [5 points]

Oswestry Low Back Pain Disability Questionnaire
Oswestry Disability Index

Section 7: Sleeping

- ☐ Pain does not prevent me from sleeping well. [0 points]
- ☐ I can sleep well only by using tablets. [1 point]
- ☐ Even when I take tablets I have less than 6 hours sleep. [2 points]

Section 7: Sleeping (Cont.)

- ☐ Even when I take tablets I have less than 4 hours sleep. [3 points]
- ☐ Even when I take tablets I have less than 2 hours of sleep. [4 points]
- ☐ Pain prevents me from sleeping at all. [5 points]

Section 8: Sex Life

- ☐ My sex life is normal and causes no extra pain. [0 points]
- ☐ My sex life is normal but causes some extra pain. [1 point]
- ☐ My sex life is nearly normal but is very painful. [2 points]
- ☐ My sex life is severely restricted by pain. [3 points]
- ☐ My sex life is nearly absent because of pain. [4 points]
- ☐ Pain prevents any sex life at all. [5 points]
- ☐

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain. [0 points]
- ☐ My social life is normal but increases the degree of pain. [1 point]
- ☐ Pain has no significant effect on my social life apart from limiting energetic interests such as dancing. [2 points]
- ☐ Pain has restricted my social life and I do not go out as often. [3 points]
- ☐ Pain has restricted my social life to my home. [4 points]
- ☐ I have no social life because of pain. [5 points]

Oswestry Low Back Pain Disability Questionnaire

Oswestry Disability Index

Section 10: Traveling

- ☐ I can travel anywhere without extra pain. [0 points]
- ☐ I can travel anywhere but it gives me extra pain. [1 point]
- ☐ Pain is bad but I manage journeys over 2 hours. [2 points]
- ☐ Pain restricts me to journeys of less than 1 hour. [3 points]
- ☐ Pain restricts me to short necessary journeys under 30 minutes. [4 points]
- ☐ Pain prevents me from traveling except to the doctor or hospital. [5 points]

Interpretation:

Simply add up your points for each section and plug it in to the following formula in order to calculate your level of disability: **point total / 50 X 100 = % disability (aka: 'point total' divided by '50' multiply by ' 100 = percent disability)**

Example: on my last ODI I scored a 18. So, 18/50 x 100 = 36% disability:

ODI Scoring:

0% to 20% (minimal disability): Patients can cope with most activities of daily living. No treatment may be indicated except for suggestions on lifting, posture, physical fitness and diet. Patients with sedentary occupations (ex. secretaries) may experience more problems than others.

21%-40% (moderate disability): Patients may experience more pain and problems with sitting, lifting and standing. Travel and social life are more difficult. Patients may be off work. Personal care, sleeping and sexual activity may not be grossly affected. Conservative treatment may be sufficient.

41%-60% (severe disability): Pain is a primary problem for these patients, but they may also be experiencing significant problems in travel, personal care, social life, sexual activity and sleep. A detailed evaluation is appropriate.

61%-80% (crippled): Back pain has an impact on all aspects of daily living and work. Active treatment is required.

81%-100%: These patients may be bed bound or exaggerating their symptoms. Careful evaluation is recommended.